Study Specific Number

The First 1,000 Days of Life

24 Months Survey

Infant Nutrition

1. In the past 7 days, how often was your child fed each food listed below? Include feedings by everyone who feeds the child and include snacks and night-time feedings.

(Please put ZERO in the column if your child was not fed any of foods listed below.)

	Times	Per week *OR* Per day	
Breast milk			
Water			
Formula			
Cow's milk			
Soy milk, rice milk, goat milk			
100% fruit or 100% vegetable juice			
Juice drinks, soft drinks, sweet tea, Kool Aid, vitamin drinks, etc			
Cereal			
Dairy foods: yogurt, cheese, ice cream, pudding, etc.			
Soy foods: tofu, frozen soy desserts, etc.			
Other cereals and starches: breakfast cereals			
biscuits, crackers, breads, pasta, rice, etc			
Eggs			
Vegetables			
Fruit			
Meat, chicken, combination dinners			
Fish or shellfish			
Peanut butter, other peanut foods, or nuts			
French fries			
Sweet foods: candy, cookies, cake, etc			
Other (Please specify)			

2. Does your child eat fast food (e.g. fries and hamburger) a. Yes b. No

   If yes how many times a week? ----------

3. Does your child have allergy to any food?
   a. Yes b. No c. Not sure
   3a. If yes , please select:

   a. Itching b. Nausea c. Vomiting d. Bloody diarrhea e. Abdominal pain f. Hives g. Eczema

4. Are there any difficulties with feeding your child?

a. Yes b. No c. Not Sure

4. a. If yes, please specify:

a. Picky eater b. Does not eat enough c. Choking d. Reflux e. Spitting
f. Other

Infant Growth & Development

5. How much does your child weigh? ----- lb -----oz

6. How tall is your child? ----- inches

7. When was the last time your child was weighed/ measured?

a. Within the past week b. Within the past two weeks
c. More than two weeks ago d. Not sure

8. Where was your child weighed/ measured?

a. Medical office/clinic b. Home c. Not sure d. Other

9. Do you have concerns about your child's weight?

a. Yes b. No c. Not sure

10. Have you made a visit to the child's doctor for your child being sick or injured?
(Please do not include routine well child visit)

a. Yes b. No c. Not sure

10a. If yes, how many times in the past six months?

a. 0-2 b. 3-6 c. more than 6 times

11. Do you have concerns with your child's health?

a. Yes b. No c. Not sure

12. Does your child have any health problems? a. Yes b. No

12a. If Yes:

a. Ear infections b. Colds c. Upper respiratory d. Wheezing
e. Vomiting f. Seizures g. Constipation/Diarrhea h. Eczema i. Allergies
j. Developmental concern k. Iron deficiency
l. None m. Other Please specify

13. Has your child been diagnosed with any medical condition or disorder?

a. Yes b. No c. Not sure

13a. if yes:

a. Asthma b. Over weight c. Developmental delay d. Anemia e. Other

14. Has your child received all the recommended immunizations?

a. Yes b. No c. Not sure

14a. If no, why?

a. Appointment was delayed b. Vaccine safety concerns

15. Is your child currently taking any vitamin/supplement?

a. Yes b. No c. Not sure

16. Is your child currently taking any prescribed medication?

a. Yes b. No c. Not sure

17. Does your child take any “over-the-counter” medications on a regular basis?

a. Yes b. No c. Not sure

18. Is your child regularly being cared for outside of your home?

a. Yes b. No c. Not sure

18a. If yes, are you satisfied with the child care that you have?

a. Yes b. No c. Not sure

19. Does your child sleep all night?

a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

20. How often does your child sleep in your bed?

a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

21. Do you use television to help your child sleep?

a. Yes b. No c. Sometimes

22. Do you have the television on while your child is eating?

a. Yes b. No c. Sometimes

23. How much time each day does your child spend:

a. With the television or a video **on** in the home (including daycare)?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

b. Looking at or playing with a computer or tablet/smartphone?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

c. Playing outside?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

d. Being read to?
□None □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

Dental

1. Have you started to clean your child's teeth as soon as the first tooth appeared?

   a. Yes b. No c. Not sure

2. Do you brush/clean your child's teeth twice a day?

   a. Yes b. No c. Not sure

Developmental Milestones

Please indicate if your child is doing any of these activities:
Children at your child's age are not necessarily expected to use all the behaviors listed.

	YES	NO
Copies others, especially adults and older children		
Gets excited when with other children		
Shows more and more independence		
Shows defiant behavior (doing what he has been told not to)		
Plays mainly beside other children, but is beginning to include other children, such as in chase games		
Points to things or pictures when they are named		
Knows names of familiar people and body parts		
Says sentences with 2 to 4 words		
Follows simple instructions		
Repeats words overheard in conversation		
Points to things in a book		

Finds things even when hidden under two or three covers		
Begins to sort shapes and colors		
Completes sentences and rhymes in familiar books		
Plays simple make-believe games		
Builds towers of 4 or more blocks		
Might use one hand more than the other		
Follows two-step instructions such as “Pick up your shoes and put them in the closet.”		
Names items in a picture book such as a cat, bird, or dog		
Stands on tiptoe		
Kicks a ball		
Begins to run		
Climbs onto and down from furniture without help		
Walks up and down stairs holding on		
Throws ball overhand		
Makes or copies straight lines and circles		

CSBS

This Checklist is designed to identify different aspects of development in infants and toddlers. Many behaviors that develop before children talk may indicate whether or not a child will have difficulty learning to talk. This Checklist should be completed by a caregiver when the child is between **6 and 24 months of age** to determine whether a referral for an evaluation is needed. The caregiver may be either a parent or another person who nurtures the child daily. Please check all the choices that best describe your child’s behavior. If you are not sure, please choose the closest response based on your experience.

Children at your child’s age are not necessarily expected to use all the behaviors listed.

Emotion and Eye Gaze

1. Do you know when your child is happy and when your child is upset?
   □Not Yet □ Sometimes □ Often

2. When your child plays with toys, does he/she look at you to see if you are watching?
   □Not Yet □ Sometimes □ Often

3. Does your child smile or laugh while looking at you?
   □Not Yet □ Sometimes □ Often

4. When you look at and point to a toy across the room, does your child look at it?
   □Not Yet □ Sometimes □ Often

Communication

5. Does your child let you know that he/she needs help or wants an object out of reach?
   □Not Yet □ Sometimes □ Often

6. When you are not paying attention to your child, does he/she try to get your attention?
□Not Yet □ Sometimes □ Often

7. Does your child do things just to get you to laugh?
□Not Yet □ Sometimes □ Often

8. Does your child try to get you to notice interesting objects—just to get you to look at the objects, not to get you to do anything with them?
□Not Yet □ Sometimes □ Often

Gestures

9. Does your child pick up objects and give them to you?
□Not Yet □ Sometimes □ Often

10. Does your child show objects to you without giving you the object?
□Not Yet □ Sometimes □ Often
11. Does your child wave to greet people?
□Not Yet □ Sometimes □ Often

12. Does your child point to objects?
□Not Yet □ Sometimes □ Often

13. Does your child nod his/her head to indicate *yes*?
□Not Yet □ Sometimes □ Often

Sounds

14. Does your child use sounds or words to get attention or help?
□Not Yet □ Sometimes □ Often

15. Does your child string sounds together, such as *uh oh, mama, gaga, bye bye, bada*?
□Not Yet □ Sometimes □ Often

16. About how many of the following consonant sounds does your child use:
ma, na, ba, da, ga, wa, la, ya, sa, sha?
□ None □1–2 □ 3–4 □ 5–8 □ over 8

Words

17. About how many different words does your child use meaningfully that you recognize (such as *baba* for bottle; *gaggie* for doggie)?
□None □ 1–3 □ 4–10 □11–30 □over 30

18. Does your child put two words together (for example, *more cookie*, *bye bye Daddy*)?
□Not Yet □ Sometimes □ Often

Understanding

19. When you call your child's name, does he/she respond by looking or turning toward you?
□Not Yet □ Sometimes □ Often

20. About how many different words or phrases does your child understand without gestures? For example, if you say “where’s your tummy,” “where’s Daddy,” “give me the ball,” or “come here,” without showing or pointing, your child will respond appropriately.
□ None □ 1–3 □ 4–10 □ 11–30 □over 30

Object Use

21. Does your child show interest in playing with a variety of objects?
□Not Yet □ Sometimes □ Often

22. About how many of the following objects does your child use appropriately:
cup, bottle, bowl, spoon, comb or brush, toothbrush, washcloth,
ball, toy vehicle, toy telephone?
□ None □1–2 □ 3–4 □ 5–8 □ over 8

23. About how many blocks (or rings) does your child stack?
Stacks

□ None □ 2 blocks □ 3–4 blocks □5 or more

24. Does your child pretend to play with toys (for example, feed a stuffed animal, put a doll to sleep, put an animal figure in a vehicle)?
□Not Yet □ Sometimes □ Often

Do you have any concerns about your child’s development?
□ Yes □ No

If yes, please describe:

Parent-Child Interactions Survey

1. I play with my child and show him or her things about toys.	Not very often	Sometimes	Often
2. I hug and kiss my child.	Not very often	Sometimes	Often
3. I mostly talk to my child when he is crying.	Not very true	Sometimes true	Mostly true
4. I help my child learn by talking and showing him or her new things.	Not very true	Sometimes true	Mostly true
5. I look at or read children's books to my child.	Not very often	Sometimes	Often
6. My child does not calm down or seem very interested when I talk to him.	Mostly true	Sometimes true	Not very true
7. I make up games or songs for my child.	Not very often	Sometimes	Often
8. When my child looks at or touches a toy, I talk to him about the toy.	Not very often	Sometimes	Most of the time
9. When my child is looking at me, I talk or make sounds with him.	Not very often	Sometimes	Often
10. My child doesn't seem to like me.	Mostly true	Sometimes true	Not very true
11. I enjoy feeding my child or eating with him.	Not very often	Sometimes	Often
12. I talk to my child in a special way.	Not very often	Sometimes	Often
13. My child is not very much fun to be with.	Mostly true	Sometimes true	Not very true
14. I can make my child feel better when he or she is upset.	Not very often	Sometimes	Often
15. When my child looks at or touches something, the first thing I say is "no."	Mostly true	Sometimes true	Not very true
16. Most of the time I like my child.	Not very true	Sometimes true	Mostly true
17. My child does not need my help learning new things.	Mostly true	Sometimes true	Not very true
18. I talk with my child when feeding or eating with him or her.	Not very often	Sometimes	Most of the time

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to check the column indicating *how often* you felt or thought a certain way.

	Never	Almost Never	Some-times	Fairly Often	Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?					
2. In the last month, how often have you felt that you were unable to control the important things in your life?					
3. In the last month, how often have you felt nervous and "stressed"?					
4. In the last month, how often have you felt confident about your ability to handle your personal problems?					
5. In the last month, how often have you felt that things were going your way?					
6. In the last month, how often have you found that you could not cope with all the things that you had to do?					
7. In the last month, how often have you been able to control irritations in your life?					
8. In the last month, how often have you felt that you were on top of things?					
9. In the last month, how often have you been angered because of things that were outside of your control?					
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?					

If you have any serious concerns about your mental health,

please call **211** and request a referral for assistance.

Maternal Health

1. Please select any medical conditions you have had and/or are currently experiencing:

☐ None
☐ High blood pressure
☐ Diabetes
☐ Thyroid
☐ Heart Problems
☐ Asthma
☐ Genetic/Congenital Abnormality
☐ Skin Conditions
☐ Allergies
☐ Irritable Bowel
☐ Migraines
☐ Stress/ Anxiety
☐ Depression
☐ Mental Illness
☐ Alcohol or Drug Abuse
☐ Nutrition disorders
☐ Cancer Type: _____
☐ Other problems Please specify: _____

1a. If you have selected any of the above medical conditions, do you take any medication daily?
a. No b. Yes please specify ---------

2. Please select any of the following that you take:

□ None
□ Prenatal vitamins
□ Vitamins and supplements
□ Herbs and natural remedies

3. If you follow a special diet, please select one of the following:

□ Vegetarian □ Vegan □ Ethnic □ Specialty Diet

4. Do you exercise regularly? □ Yes □ No

If yes, can you tell me what type and how much you usually exercise?

□ Stretching or strengthening, such as using weights or range of motion
□ Walking, swimming or biking
□ Aerobic exercise such as running, stair climbing, rowing, skiing, including machines
□ Other

Duration of exercise
(total minutes per day)
□ Less than 6 minutes
□ 6 to 15 minutes
□ 15 to 30 minutes
□ More than 30 minutes

Frequency of exercise

□ Daily
□ 3-5 times a week
□ 1-2 times a week
□ Less than once a week

Current Weight: _____

Life Events Evaluation

Please select any events that have occurred in your life over the past 6 months:

□ Personal health problems
□ Personal social problems
□ Problems with current partner
□ Family disruption
□ Problems with your finances
□ Problems with your own children
□ Problems with your in-laws
□ Problems within your close family
□ Serious illness in your close family
□ Death within your close family
□ Loss of job (you or your partner)
□ Problems within your work environment
□ Work transfer (you or your partner)
□ Change in residence
□ Problem in finding stable housing
□ Current partner is away often
□ Accidents, robberies, or similar events

References

Some of questions have been adopted and modified from CDC.

CSBSDP
Communication and Symbolic Behavior Scales Developmental Profile by Amy M. Wetherby & Barry M. Prizant

Parent-Child Interactions Survey
Frances Page Glascoe, Parent-Child Interactions Scale. From Brigance A and Glascoe FP. Brigance Infant toddler Screens. North Billerica, MA: Curriculum Associates, 2002 www.curriculumassociates.com. The publisher gives permission for the scales to be used as long as the above is cited

Perceived Stress Scale
The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 386-396.
Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) *The Social Psychology of Health.* Newbury Park, CA: Sage, 1988.

The rest of questions have been developed by Inova Translational Medicine Institute Research Team.