Study Specific Number

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The First 1,000 Days of Life … And Beyond

36 Months Survey

Child 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 Day *OR* Per Week	
Pediatric formula/Breast milk			
Water			
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 an allergy or sensitivity 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

Child 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 f. Wheezing
d. Vomiting e. Seizures f. Constipation/Diarrhea g. Eczema h. Allergies
i. Developmental concern j. Iron deficiency
k. None l. 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. Is your child currently taking any vitamin/supplement?

a. Yes b. No c. Not sure

15. Is your child currently taking any prescribed medication?

a. Yes b. No c. Not sure

16. Does your child take any "over-the-counter" medications on a regular basis?

a. Yes b. No c. Not sure

17. 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

18. Does your child sleep all night?

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

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

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

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

a. Yes b. No c. Sometimes

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

a. Yes b. No c. Sometimes

22. 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. Do you brush/ your child's teeth or help your child brush teeth daily?

   a. Yes b. No c. Not sure

2. Has your child been to a dentist?

   a. Yes b. No

3. How many cavities have your child had? ☐

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 adults and friends		
Shows affection for friends without prompting		
Takes turns in games		
Shows concern for crying friend		
Understands the idea of "mine" and "his" or "hers"		
Shows a wide range of emotions		
Separates easily from mom and dad		
May get upset with major changes in routine		
Dresses and undresses self		
Follows instructions with 2 or 3 steps		
Can name most familiar things		
Understands words like "in," "on," and "under"		

Says first name, age, and sex		
Names a friend		
Says words like “I,” “me,” “we,” and “you” and some plurals (cars, dogs, cats)		
Talks well enough for strangers to understand most of the time		
Carries on a conversation using 2 to 3 sentences		
Can work toys with buttons, levers, and moving parts		
Plays make-believe with dolls, animals, and people		
Does puzzles with 3 or 4 pieces		
Understands what “two” means		
Copies a circle with pencil or crayon		
Turns book pages one at a time		
Builds towers of more than 6 blocks		
Screws and unscrews jar lids or turns door handle		
Climbs well		
Runs easily		
Pedals a tricycle (3-wheel bike)		
Walks up and down stairs, one foot on each step		

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

	YES	NO
Does your child enjoy being swung, bounced on your knee, etc.?		
Does your child take an interest in other children?		
Does your child like climbing on things, such as up stairs?		
Does your child enjoy playing peek-a-boo/hide-and-seek?		
Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?		
Does your child ever use his/her index finger to point, to ask for something?		
Does your child ever use his/her index finger to point, to indicate interest in something?		
Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?		
Does your child ever bring objects over to you (parent) to show you something?		
Does your child look you in the eye for more than a second or two?		
Does your child ever seem oversensitive to noise? (e.g., plugging ears)		
Does your child smile in response to your face or your smile?		
Does your child imitate you? (e.g., you make a face-will your child imitate it?)		
If you point at a toy across the room, does your child look at it?		
Does your child walk?		
Does your child look at things you are looking at?		
Does your child make unusual finger movements near his/her face?		
Does your child try to attract your attention to his/her own activity?		
Have you ever wondered if your child is deaf?		
Does your child understand what people say?		
Does your child sometimes stare at nothing or wander with no purpose?		
Does your child look at your face to check your reaction when faced with something unfamiliar?		

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?					

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

Is there anything more you would like to tell us about **you and your baby?**

If you require assistance in locating resources related to the above questions we asked, please call 211 and request a referral for assistance or go to www.211.org

References

Some of the questions have been adopted and modified from CDC.

M-CHAT
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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.