Study Specific Number

_____

APPROVED: Inova IRB
Date Approved: January 10, 2019
IRB File # 15-1804

The First 1,000 Days of Life … And Beyond

60 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
Water			
Cow's milk - whole			
Cow's milk – low fat			
Cow's milk –fat free			
Other milk Products			
100% fruit or 100% vegetable juice			
Juice drinks, soft drinks, sweet tea, Kool Aid, vitamin drinks, etc			
Diet 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. Do you keep fresh fruits and vegetables available for your child?
   a. Yes b. No c. Not sure

4. Does your child have an allergy or bad reaction to any foods?
   a. Yes b. No c. Not sure

4a. If yes, how did he/she react when was fed the problem food? Please select:
a. Itching b. Nausea c. Vomiting d. Bloody diarrhea e. Abdominal pain f. Hives g. Eczema h. other:_____

5. Is your child a picky eater?
   a. Yes b. No c. Not Sure

Child Growth & Development

6. How much does your child weigh? _____ lb _____oz

7. How tall is your child? _____ inches

8. 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

9. Where was your child weighed/ measured?
   a. Medical office/clinic b. Home c. Not sure d. Other

10. Do you have concerns about your child's weight?
    a. Yes b. No c. Not sure

11. Have you made a visit to your child's doctor because your child was sick or injured?
    (Please do not include routine well child visit)
    a. Yes b. No c. Not sure
    11a. If yes, how many times in the past six months?
    a. 0-2 b. 3-6 c. more than 6 times

12. Has your child visited an urgent care or emergency department?
    a. Yes b. No c. Not sure
    12a. If yes, how many times in the past six months?
    a. 0-2 b. 3-6 c. more than 6 times

13. Do you have concerns about your child's health?
    a. Yes b. No c. Not sure

14. Does your child have health problems? a. Yes b. No
    14a. If Yes (please check all that apply):
    a. Ear infections b. Colds c. Upper respiratory d. Wheezing
    f. Vomiting g. Seizures h. Constipation/Diarrhea i. Eczema j. Allergies
    k. Developmental concern l. Iron deficiency
    m. None n. Other Please specify ☐

15. Has your child been diagnosed by a health care provider with a medical condition or disorder?
    a. Yes b. No c. Not sure
    15a. if yes, is there a diagnosis of:
    a. Asthma b. Over weight c. Developmental delay d. Anemia
    e. Developmental Delay f. Other ☐

16. Has your child received all the recommended immunizations?
    a. Yes b. No c. Not sure
    16a. If no, why?
    a. Appointment was delayed b. Vaccine safety concerns

17. Is your child currently taking any vitamin/supplement?
    a. Yes b. No c. Not sure

18. Is your child currently taking any prescribed medication?
    a. Yes b. No c. Not sure

19. Has your child taken any antibiotics in the last 6 months?
    a. Yes b. No c. Not sure
    19a. If yes, how many courses [ ] ?
    And for what:
    a. Ear infection b. Skin infection c. Lung Infection d. Urine Infection e. Throat f. Sinus
    g. Other Please specify [ ]

20. Does your child take any "over-the-counter" medications on a regular basis?
    a. Yes b. No c. Not sure

21. Do you have a pet at home?
    a. Yes b. No
    21a. If yes, what kind?
    a. Dog b. Cat c. Bird d. Fish 5. Rabbit 6. Other Please specify : [ ]

22. Is your child regularly being cared for by someone other than the mother or father?
    a. Yes b. No c. Not sure
    22a. If yes, where have they been receiving care?
    a. Home b. Outside of home

23. Is your child enrolled in preschool program?
    a. Yes b. No c. Not sure

24. Does your child have any siblings?
    a. Yes b. No
    24a. If yes, how many? [ ]

25. Does your child have any half-siblings?
    a. Yes b. No

26. Does your child sleep through the night?
    a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

27. How often does your child sleep in your bed?
    a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

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

a. Yes b. No c. Sometimes

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

a. Yes b. No c. Sometimes

30. 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

<u>Dental</u>

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

   a. Yes b. No c. Not sure

2. Has your child been to a dentist?

   a. Yes b. No

   How many cavities has 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
Wants to please friends		
Likes to sing, dance and act		
Can tell what is real and what is make believe		
Is sometimes demanding and sometimes very cooperative		
Speaks very clearly		
Tells a simple story using full sentences		
	Yes	No
Uses future tense; for example, "Grandma will be here"		
Says their name and address		
Counts 10 or more things		
Can draw a person with at least 6 body parts		
Can print some letters and numbers		
Copiers a triangle or square		
Stands on one foot for 10 seconds		
Hops on one foot		
Can do a somersault		
Can skip		
Uses a fork and spoon		
Swings and climbs		
Can use the toilet on their own		
Brushes his/her teeth		
Gets dressed without help		
Reference: https://www.cdc.gov/ncbddd/actearly/milestones/milestones-5yr.html		

The Childhood Autism Spectrum Test (CAST)

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

	Yes	No
1. Does s/he join in playing games with other children easily?		
2. Does s/he come up to you spontaneously for a chat?		
3. Was s/he speaking by 2 years old?		
4. Does s/he enjoy sports?		
5. Is it important to him/her to fit in with the peer group?		
6. Does s/he appear to notice unusual details that others miss?		
7. Does s/he tend to take things literally?		
8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)?		
9. Does s/he like to do things over and over again, in the same way all the time?		
10. Does s/he find it easy to interact with other children?		
11. Can s/he keep a two-way conversation going?		
12. Can s/he read appropriately for his/her age?		
13. Does s/he mostly have the same interests as his/her peers?		
14. Does s/he have an interest which takes up so much time that s/he does little else?		
15. Does s/he have friends, rather than just acquaintances?		
16. Does s/he often bring you things s/he is interested in to show you?		
17. Does s/he enjoy joking around?		
18. Does s/he have difficulty understanding the rules for polite behavior?		
19. Does s/he appear to have an unusual memory for details?		
20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)?		
21. Are people important to him/her?		
22. Can s/he dress him/herself?		
23. Is s/he good at turn-taking in conversation?		
24. Does s/he play imaginatively with other children, and engage in role-play?		
25. Does s/he often do or say things that are tactless or socially inappropriate?		
26. Can s/he count to 50 without leaving out any numbers?		
27. Does s/he make normal eye-contact?		
28. Does s/he have any unusual and repetitive movements?		
29. Is his/her social behavior very one-sided and always on his/her own terms?		
30. Does s/he sometimes say "you" or "s/he" when she/he means "I"?		
31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts?		
32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about?		
33. Can s/he ride a bicycle (even if with stabilizers/training wheels)?		
34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems?		
35. Does s/he care how s/he is perceived by the rest of the group?		
36. Does s/he often turn conversations to his/her favorite subject rather than following what the other person wants to talk about?		
37. Does s/he have odd or unusual phrases?		

SPECIAL NEEDS SECTION
Please complete as appropriate

38. Have teachers/health visitors ever expressed any concerns about his/her development? Yes No
If Yes, please specify.....

39. Has s/he ever been diagnosed with any of the following?:

Language delay	Yes	No
Hyperactivity/Attention Deficit Disorder (ADHD)	Yes	No
Hearing or visual difficulties	Yes	No
Autism Spectrum Condition, incl. Asperger's Syndrome	Yes	No
A physical disability	Yes	No
Other (please specify): _____	Yes	No

FOR EACH QUESTION, PLEASE SELECT THE ANSWER THAT BEST REPRESENTS YOUR CHILD/FAMILY

	Almost Never	Sometimes	Usually	Almost Always
1. My child eats breakfast…	☐	☐	☐	☐
2. Our family eats meals together…	☐	☐	☐	☐
3. Our family eats while watching TV…	☐	☐	☐	☐
4. Our family eats fast food…	☐	☐	☐	☐
5. Our family uses microwave or ready to eat foods…	☐	☐	☐	☐
6. My child eats fruits and vegetables at meals or snacks…	☐	☐	☐	☐
7. My child drinks soda pop or sugar drinks…	☐	☐	☐	☐
8. My child drinks low fat milk at meals or snacks…	☐	☐	☐	☐
9. Our family limits eating of chips, cookies, and candy…	☐	☐	☐	☐
10. Our family uses candy as a reward for good behavior…	☐	☐	☐	☐
11. My child spends less than 2 hours on TV/games/computer per day..	☐	☐	☐	☐
12. Our family limits the amount of TV our child watches…	☐	☐	☐	☐
13. Our family allows our child to watch TV in their bedroom…	☐	☐	☐	☐
14. Our family provides opportunities for physical activity…	☐	☐	☐	☐
15. Our family encourages our child to be active every day…	☐	☐	☐	☐
16. Our family finds ways to be physically active together…	☐	☐	☐	☐
17. My child does physical activity during his/her free time…	☐	☐	☐	☐
18. My child is enrolled in sports or activities with a coach or leader…	☐	☐	☐	☐
19. Our family has a daily routine for our child's bedtime…	☐	☐	☐	☐
20. My child gets 9 hours of sleep a night…	☐	☐	☐	☐

Maternal / Paternal Health

Please select any health conditions you have had and/or are currently experiencing:

- ☐ None
- ☐ Currently Pregnant
- ☐ 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: _____

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