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| **Parent Questionnaire** |
| **Participant ID** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Assessor** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(free type)* |
| **Name of Data Clerk** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(free type)* |
| **Date of assessment** | \_\_\_\_\_\_ (day – *2 digits*) \_\_\_\_\_\_ (month – *2 digits*) \_\_\_\_\_\_\_\_\_\_ (year – *4 digits*) |
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| **Section A: General Health** |
| 1. In general, how would you describe your child’s health?
	1. If fair or poor, explain:
 | 🞏 Excellent 🞏 Very good 🞏 Good 🞏 Fair 🞏 Poor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)*  |
| 1. Since your child was born, has he/she had any of the following?
	1. Seizures
	2. Hearing problems
	3. Vision problems
	4. Eating or swallowing problems
	5. Problems digesting food, including stomach/intestinal problems, constipation, or diarrhea
	6. Other condition

If yes, describe:* 1. Hospitalization

If yes, describe:  | 🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)* 🞏 No 🞏 Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)*  |
| 1. Has your child received all the recommended vaccines for their age on schedule?
	1. What was the primary reason for not receiving the recommended vaccines?
	2. What was the specific reason for the suggestion or decision for your child to not receive all the recommended vaccines on schedule?
 | 🞏 No 🞏 YesIf **YES**, go to Section B: Breastfeeding🞏 A healthcare provider told us not to 🞏 I decided to delay some or all of the vaccines🞏 I decided my child would not receive any of the vaccines🞏 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)*  |
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| **Section B: Breastfeeding** |
| 1. Was this child EVER breastfed or fed breast milk?
	1. If yes, how old was this child when he or she COMPLETELY stopped breastfeeding or being fed breast milk?
2. How old was this child when he or she was FIRST fed formula?
3. Did any of the below reasons affect your decision to not breastfeed or to stop breastfeeding your baby?
	1. My baby had trouble sucking or latching on
	2. My baby had trouble swallowing
	3. Breastfeeding was too painful
	4. My baby became sick and could not be breastfed
	5. My baby was not gaining enough weight
	6. My baby was too irritable and fussy
	7. My baby lost interest and began to wean him or herself
	8. I was worried about passing Zika virus to my baby
	9. Other
4. How old was this child when he or she was FIRST fed anything other than breast milk or formula?*Include juice, cow’s milk, sugar water, baby food, or anything else that your child might have been given, even water.*
 | 🞏 No 🞏 Yes\_\_\_\_\_ days *(1 digit)*  **OR** \_\_\_\_\_ weeks *(1 digit)* **OR** \_\_\_\_\_ months *(2 digits)* **OR**  🞏 check this box if still breastfeeding\_\_\_\_\_ days *(1 digit)*  **OR** \_\_\_\_\_ weeks *(1 digit)* **OR** \_\_\_\_\_ months *(2 digits)* **OR**  🞏 check this box if child has never been fed formula🞏 check this box if still breastfeeding and go to the next question🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(free type)* \_\_\_\_\_ days *(1 digit)*  **OR** \_\_\_\_\_ weeks *(1 digit)*  **OR** \_\_\_\_\_ months *(2 digits)*  |
| **Section C. Sleep** |
| 1. Does your child have any problems falling asleep?
2. Does your child wake up a lot at night?
3. Does your child snore a lot or have difficulty breathing at night?
4. Does your child have restless sleep, or often change position during the night?
5. Do you think that your child has sleeping difficulties?
 | 🞏 Often 🞏 Sometimes 🞏 Never🞏 Often 🞏 Sometimes 🞏 Never🞏 Often 🞏 Sometimes 🞏 Never🞏 Often 🞏 Sometimes 🞏 Never🞏 Often 🞏 Sometimes 🞏 Never |
| **Section D. Family Functioning** |
| 1. Since your child was born, did your family have problems paying for any of this child’s medical or health care bills?
2. Since your child was born, have you or other family members:
	1. Stopped working because of this child’s health status?
	2. Cut down on the hours you work because of this child’s health or health conditions?
3. IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.
4. DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?

 1. Does this child receive care for at least 10 hours per week from someone other than his or her parent or guardian? *This could be a day care center, preschool, family child care home, nanny, au pair, babysitter or relative.*
2. Have you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for this child?
3. SINCE THIS CHILD WAS BORN, how often has it been very hard to get by on your family’s income – hard to cover the basics like food or housing?
4. At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive:
	1. Cash assistance from a government welfare program?
	2. Food Stamps or Supplemental Nutrition Assistance Program benefits?
	3. Government assistance with childcare?
5. DURING THE PAST 6 MONTHS, how much income did your family make in a month? Please include income from all members in your household.
 | 🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 Less than 1 hour per week 🞏 1-4 hours per week 🞏 5-10 hours per week 🞏 11 or more hours per week 🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 Never 🞏 Rarely 🞏 Somewhat often 🞏 Very often  🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 No 🞏 Yes🞏 < R$500🞏 R$500-R$1,499🞏 R$1,500-R$2,999🞏 R$3,000-R$6,999🞏 > R$7,000🞏 Do not know |