Form Approved
OMB No.**0920**-XXXX
Exp. Date xx/xx/20xx

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*)

Section A: General Health

1. In general, how would you describe your child's health?	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
1.1. If fair or poor, explain:	________________ *(free type)*
2. Since your child was born, has he/she had any of the following?	
2.1. Seizures	☐ No ☐ Yes
2.2. Hearing problems	☐ No ☐ Yes
2.3. Vision problems	☐ No ☐ Yes
2.4. Eating or swallowing problems	☐ No ☐ Yes
2.5. Problems digesting food, including stomach/intestinal problems, constipation, or diarrhea	☐ No ☐ Yes
2.6. Other condition If yes, describe:	☐ No ☐ Yes ________________ *(free type)*
2.7. Hospitalization If yes, describe:	☐ No ☐ Yes ________________ *(free type)*
3. Has your child received all the recommended vaccines for their age on schedule?	☐ No ☐ Yes If **YES**, go to Section B: Breastfeeding
3.1. What was the primary reason for not receiving the recommended vaccines?	☐ 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)*
3.2. What was the specific reason for the suggestion or decision for your child to not receive all the recommended vaccines on	

schedule?	__________________ *(free type)*
Section B: Breastfeeding	
4. Was this child EVER breastfed or fed breast milk?	☐ No ☐ Yes
4.1. If yes, how old was this child when he or she COMPLETELY stopped breastfeeding or being fed breast milk?	_____ days *(1 digit)* **OR** _____ weeks *(1 digit)* **OR** _____ months *(2 digits)* **OR** ☐ check this box if still breastfeeding
5. How old was this child when he or she was FIRST fed formula?	_____ days *(1 digit)* **OR** _____ weeks *(1 digit)* **OR** _____ months *(2 digits)* **OR** ☐ check this box if child has never been fed formula
6. Did any of the below reasons affect your decision to not breastfeed or to stop breastfeeding your baby?	☐ check this box if still breastfeeding and go to the next question
6.1. My baby had trouble sucking or latching on	☐ No ☐ Yes
6.2. My baby had trouble swallowing	☐ No ☐ Yes
6.3. Breastfeeding was too painful	☐ No ☐ Yes
6.4. My baby became sick and could not be breastfed	☐ No ☐ Yes
6.5. My baby was not gaining enough weight	☐ No ☐ Yes
6.6. My baby was too irritable and fussy	☐ No ☐ Yes
6.7. My baby lost interest and began to wean him or herself	☐ No ☐ Yes
6.8. I was worried about passing Zika virus to my baby	☐ No ☐ Yes
6.9. Other	☐ No ☐ Yes, specify: _________________ *(free type)*
7. 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.*	_____ days *(1 digit)* **OR** _____ weeks *(1 digit)* **OR** _____ months *(2 digits)*
Section C. Sleep	
8. Does your child have any problems falling asleep?	☐ Often ☐ Sometimes ☐ Never
9. Does your child wake up a lot at night?	☐ Often ☐ Sometimes ☐ Never
10. Does your child snore a lot or have difficulty breathing at night?	☐ Often ☐ Sometimes ☐ Never
11. Does your child have restless sleep, or often change position during the night?	☐ Often ☐ Sometimes ☐ Never
12. Do you think that your child has sleeping difficulties?	☐ Often ☐ Sometimes ☐ Never
Section D. Family Functioning	
13. Since your child was born, did your family have problems paying for any of this child's medical or health care bills?	☐ No ☐ Yes
14. Since your child was born, have you or other family members:	☐ No ☐ Yes
14.1. Stopped working because of this child's health status?	☐ No ☐ Yes

Question	Response
14.2. Cut down on the hours you work because of this child's health or health conditions?	
15. 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.	☐ Less than 1 hour per week ☐ 1-4 hours per week ☐ 5-10 hours per week ☐ 11 or more hours per week
16. DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?	☐ No ☐ Yes
17. 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.*	☐ No ☐ Yes
18. 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 <u>child care</u> for this child?	☐ No ☐ Yes
19. 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?	☐ Never ☐ Rarely ☐ Somewhat often ☐ Very often
20. At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive:	
20.1. Cash assistance from a government welfare program?	☐ No ☐ Yes
20.2. Food Stamps or Supplemental Nutrition Assistance Program benefits?	☐ No ☐ Yes
20.3. Government assistance with childcare?	☐ No ☐ Yes
21. DURING THE PAST 6 MONTHS, how much income did your family make in a month? Please include income from all members in your household.	☐ < 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