

PARENT'S STUDY ID: _____ - ____ - _____
CHILD'S STUDY ID: _____ - ____ - _____

Form Approved
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Fecha: / /
 D D M M M Y Y Y Y

Staff Administered: _____

PARENT-CHILD Enrollment Questionnaire

City: _____

Clinic: _____

First we have a few questions about you.

1. What is your relationship to *[Child's name]*?

- ₀ Mother
₁ Father
₂ Legal guardian (Specify relationship: _____)

2. What is your birthdate?

 / /
D D M M M Y Y Y Y ₇₇ *Don't know* ₈₈ *Refused*

3. What is the highest level of education that you have completed?

- ₁ Less than primary ₂ Primary ₃ Secondary ₄ Technical ₅ University or more ₆ None
₇₇ *Don't know* ₈₈ *Refused*

4. What is your household's socioeconomic stratum?

- ₁ 1 ₂ 2 ₃ 3 ₄ 4 ₅ 5 ₆ 6 ₇₇ *Don't know* ₈₈ *Refused*

Next we are going to ask you about who helps provide care for *[Child's name]*.

5. Does *[Child's name]* live with you?

- ₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

6. How many adults and children live in the same household as *[Child's name]*, including *[Child's name]*?

_____ adults (18+ years) _____ children (<18 years) ₇₇ *Don't know* ₈₈ *Refused*

❖ **If, according to question #6, there are no other children in the household, go to question #8.**

7. How old are each of the other children that live in the household with *[Child's name]*?Age of *[Child's name]*: _____ (circle: months years)

Age of other child (1): _____ years

Age of other child (2): _____ years

Age of other child (3): _____ years

Age of other child (4): _____ years

Age of other child (5): _____ years

Age of other child (6): _____ years

Age of other child (7): _____ years

Age of other child (8): _____ years

8. Please tell me which of the following people have helped provide care for *[Child's name]* on a regular basis since *[Child's name]*'s birth.

	<i>Does this person care for [Child's name]?</i>	<i>If yes, where?</i>	<i>If yes, on average, how often?</i>	<i>On average, how many children are cared for with [Child's name]?</i>	<i>On average, how many people are providing care?</i>
Child's mother	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ Refused	_____ days/week _____ hours/day	_____ children	_____ people
Child's father	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ Refused	_____ days/week _____ hours/day	_____ children	_____ people
Non-parental partner of <i>[Child's name]</i> 's mother/ father	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ Refused	_____ days/week _____ hours/day	_____ children	_____ people
Child's sibling under age 18 (age _____)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ Refused	_____ days/week _____ hours/day	_____ children	_____ people
Child's sibling over age 18 (age _____)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ Refused	_____ days/week _____ hours/day	_____ children	_____ people
Child's grandparent	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Refused	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____	_____ days/week _____ hours/day	_____ children	_____ people

		<input type="checkbox"/> ₈₈ <i>Refused</i>			
Other adult relative	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ <i>Refused</i>	_____ days/week _____ hours/day	_____ children	_____ people
Friend or neighbor	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ <i>Refused</i>	_____ days/week _____ hours/day	_____ children	_____ people
Unrelated adult (including a professional at a child care center)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ <i>Refused</i>	_____ days/week _____ hours/day	_____ children	_____ people
Other (specify: _____)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>	<input type="checkbox"/> ₃ In child's home <input type="checkbox"/> ₂ In someone else's home <input type="checkbox"/> ₁ In a childcare center <input type="checkbox"/> ₀ Other: _____ <input type="checkbox"/> ₈₈ <i>Refused</i>	_____ days/week _____ hours/day	_____ children	_____ people

9. How satisfied are you with the amount of help you receive in caring for *[Child's name]*?

- ₅ Very satisfied
₄ Somewhat satisfied
₃ Not satisfied or unsatisfied
₂ Somewhat unsatisfied
₁ Very unsatisfied
₈₈ *Refused*

Now we have questions about any feeding or crying difficulties *[Child's name]* may be having.

10. How often is *[Child's name]* hard to feed?

- ₁ All or most of the time
₂ Some of the time
₃ Rarely
₄ Never

11. Below is a list of things that children sometimes do at meal times. Please tell me how often

you think [*Child's name*] does each of these things. Response options include rarely or never, some of the time, or almost always.

	Rarely or never ₀	Some of the time ₁	Almost Always ₂	<i>Don't know</i> ₇₇	<i>Refused</i> ₈₈	<i>Not Applicable</i> ₆₆
Excessive spitting up						
Excessive drooling						
Gagging/retching/coughing						
Difficulty swallowing						
Difficulty latching or sucking at breast or bottle						
Arching back/squirming away						
Refuses to open mouth						
Spits food out						
Eats too fast						
Turns head away from food/shakes head no						
Chews/sucks on food but does not swallow						
Swallows in "gulps"						
Any other feeding difficulties at mealtimes (Specify: _____)						

12. How many hours per day would you say [*Child's name*] cries, on average:
 ₀ <1 hour ₁ 1-3 hours ₂ 3-6 hours ₃ 6-9 hours ₄ 9-12 hours ₅ >12 hours
 ₇₇ *Don't know* ₈₈ *Refused*

13. In general, how easy is it to calm [*Child's name*] when he or she is crying or fussy? Please only select one answer.
 ₀ Very easy
 ₁ Somewhat easy
 ₂ Somewhat difficult
 ₃ Very difficult
 ₇₇ *Don't know*
 ₈₈ *Refused*

Let's now update our information about [*Child's name*]'s healthcare.

14. What type of health insurance does [*Child's name*] have?

₁ Contributory ₂ Subsidized ₃ Not insured ₄ Specialized ₅ Exception
 ₆ Indeterminate / independent ₇₇ *Don't know* ₈₈ *Refused*

15. What is the name of [*Child's name*]'s health insurance provider?

Name: _____ ₇₇ *Don't know* ₈₈ *Refused*



CHILD'S STUDY ID: _____ - ____ - _____

Since *[Child's name]*'s last study visit, have you:

16. Taken [Child's name] to a regular well-child check-up or sought medical care for [Child's name] because she or he was showing symptoms of being sick (for example, a fever, rash)?	<input type="checkbox"/> ₁ Yes → Number of times: _____ Clinic name (1): _____ Clinic name (2): _____ Clinic name (3): _____ Clinic name (4): _____ Clinic name (5): _____ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused If NO, please skip to Question # 21.
17. Since [Child's name]'s last study visit, did [Child's name] have any of the following tests? Say "yes" or "no" to each one I mention. Did [Child's name] have a...	
Cranial ultrasound	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
MRI	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
CAT scan	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Hearing test	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Vision test	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Developmental assessment	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Did [Child's name] have any other tests I didn't mention?	<input type="checkbox"/> ₁ Yes → test: _____ _____ Clinic name: _____ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
18. Since [Child's name]'s last study visit, did you see a medical specialist? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused	
If YES, what type of medical provider did [Child's name] see? Say "yes" or "no" to each one I mention. Did [Child's name] see a...	
Pediatrician	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Occupational or physical therapist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Speech-language specialist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Neurologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Gastroenterologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Ophthalmologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Audiologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
Developmental Specialist	<input type="checkbox"/> ₁ Yes (Clinic name: _____)

	(Type of specialist: _____) <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Did <i>[Child's name]</i> see any other type of medical provider I didn't mention?	<input type="checkbox"/> Yes (Provider type: _____ Clinic name: _____) <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
19. Since <i>[Child's name]</i> 's last study visit, has <i>[Child's name]</i> spent one night or more in the hospital?	<input type="checkbox"/> Yes → Number of times: _____ Hospital name (1): _____ Hospital name (2): _____ Hospital name (3): _____ Hospital name (4): _____ Hospital name (5): _____ <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
20. Now I will give you a list of conditions. Please say "yes" or "no" if, since <i>[Child's name]</i> 's last study visit, a healthcare provider told you that <i>[Child's name]</i> might have this illness. Did they say that <i>[Child's name]</i> had?	
Zika virus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Dengue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Chikungunya	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Yellow Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Cytomegalovirus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Toxoplasmosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Parvovirus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>
Did they tell you <i>[Child's name]</i> had something else I didn't mention?	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Refused</i>

21. Since your last study visit, have you or *[Child's name]* enrolled in another Zika virus study?

- Yes, I did → Which study? _____
- Yes, my child did → Which study? _____
- Yes, my child and I did → Which study? _____
- No
- Don't know*
- Refused*

Next, we have additional questions about you and your family and friends.

❖ **If, according to question #1, this participant is the legal guardian, go to question #30.**

22. What was your relationship with *[Child's name]*'s father (mother) when he/she was born? Were you:

- ₁ Married
- ₂ Free Union
- ₃ Single
- ₄ Divorced
- ₅ Widowed
- ₆ Other (Specify: _____)
- ₇₇ *Don't know*
- ₈₈ *Refused*

23. When *[Child's name]* was born, were you and your baby's father (mother) living together....

- ₁ All or most of the time
- ₂ Some of the time
- ₃ Rarely
- ₄ Never
- ₈₈ *Refused*
- ₆₆ *Not applicable*

24. What is your relationship with *[Child's name]*'s father (mother) now? Are you:

- ₁ Married
- ₂ Free Union
- ₃ Single
- ₄ Divorced
- ₅ Widowed
- ₆ Other (Specify: _____)
- ₇₇ *Don't know*
- ₈₈ *Refused*

25. Are you and *[Child's name]*'s father (mother) currently living together....

- ₁ All or most of the time
- ₂ Some of the time
- ₃ Rarely
- ₄ Never
- ₆₆ *Not applicable*

26. Are you in a new relationship?

- ₁ Yes, married to a new partner
- ₂ Yes, romantically involved with a new partner
- ₃ No
- ₆₆ *Not applicable*

27. Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always	Almost always disagree (1)	Frequently disagree (2)	Occasionally Disagree (3)	Almost Always Agree(4)	Always Agree (5)	<i>Refused (88)</i>

	disagree (0)						
Philosophy of life							
Aims, goals, and things believed important							
Amount of time spent together							

28. How often would you say the following events occur between you and your mate?

	Never (0)	Less than once a month (1)	Once or twice a month (2)	Once or twice a week (3)	Once a day (4)	More often (5)	Refused (88)
Have a stimulating exchange of ideas							
Calmly discuss something together							
Work together on a project							

29. The dots on the following line represent different degrees of happiness on your relationship. The middle point, "happy", represents the degree of happiness in most relationships. Please circle the response which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6	88
Extremely unhappy	Fairly unhappy	A little unhappy	Happy	Very happy	Extremely happy	Perfect	Refused

30. We are interested in how you feel about the following statements. I will read each statement to you. Please indicate how you feel about each statement.

	Very strongly disagree (1)	Strongly disagree (2)	Mildly disagree (3)	Neutral (4)	Mildly Agree (5)	Strongly agree (6)	Very strongly agree (7)	Refused (88)
There is a special person who is around when I am in need.								
There is a special person with whom I can share my joys and sorrows.								
My family really tries to help me.								
I get the emotional help and support I need from my family.								
I have a special person who is a real source of comfort to me.								
My friends really try to help me.								
I can count on my friends when things go wrong.								

I can talk about my problems with my family.								
I have friends who with whom I can share my joys and sorrows.								
There is a special person in my life who care about my feelings.								
My family is willing to help me make decisions.								
I can talk about my problems with my friends.								

Now, we have a few questions about any concerns you might have about your financial situation.

31. How often would you say you worry about having enough money to pay for things you need, such as food, shelter, or clothes for you and your family?

₄ Always ₃ Often ₂ Sometimes ₁ Rarely ₀ Never ₇₇ *Don't know* ₈₈ *Refused*

32. Have you ever been unable to pay or delayed payment for medical care, including medications, hospital stays, and doctors' visits?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

33. Was there a time since your last visit when you or someone in your household needed to see a doctor or buy medicine but could not because of cost?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

Lastly, we have a few questions about your household environment.

34. Since your last study clinic visit, has anyone in [Child's name]'s household done any of the following? Say "yes" or "no" to each option.

Used any pesticides, insecticides, or rat poison in or around your home	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Smoked cigarettes inside your home?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Smoked marijuana inside your home?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Used drugs such as crack, cocaine, or heroin?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>

Thank you for completing this questionnaire. Please let me know if you have any questions.