

CHILD'S STUDY ID: _____ - ____ - _____
PARENT'S STUDY ID: _____ - ____ - _____
Date: ____ / ____ / ____
 D D M M M Y Y Y Y

Form Approved
OMB No. 0920-1190
Exp. Date 02/28/2021

Staff Administered: _____

PARENT-CHILD Enrollment Questionnaire

First we have a few questions about you and your household.

1. What is your relationship to this child?

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

2. What is your birthdate?

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

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

5. Does your child live with you?

- ₁ Yes ₀ No ₇₇ Don't know ₈₈ Refused

6. Including you and your child, how many adults and children live in the same household with your child?

_____ 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 your child, not including your child enrolled in ZEN?

Age of other child (1): _____ years ₇₇ Don't know ₈₈ Refused
Age of other child (2): _____ years ₇₇ Don't know ₈₈ Refused
Age of other child (3): _____ years ₇₇ Don't know ₈₈ Refused

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

- Age of other child (4): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (5): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (6): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (7): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (8): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (9): _____ years ₇₇ *Don't know* ₈₈ *Refused*
Age of other child (10): _____ years ₇₇ *Don't know* ₈₈ *Refused*

Now we want to learn a bit more about who helps provide care for your child.

8. First, tell me about how often you have provided care for your child since your child's birth.
- a. How many days per week do you provide care for your child?
_____ days/week ₈₈ *Refused*
 - b. On days when you provide care for your child, how many hours per day?
_____ hours/day ₈₈ *Refused*
 - c. Has someone helped you to provide care for your child on a regular basis since your child's birth?
₁ Yes ₀ No ₈₈ *Refused*

❖ **If question #8c is "No", then go to question #10.**

9. Please think about the three people (such as family members or professional caregivers) who have helped provide care for your child on a regular basis most often since your child's birth, other than you. I will ask you some questions about each of these people.

Person (1)	
9a. For the first person you've thought of, what is this person's relationship to your child? I will read you a list of options and please select the best one.	<input type="checkbox"/> ₀ Child's mother <input type="checkbox"/> ₁ Child's father <input type="checkbox"/> ₂ Non-parental partner of your child's mother/ father <input type="checkbox"/> ₃ Child's grandparent <input type="checkbox"/> ₄ Child's relative under age 18 (including a sibling younger than 18) <input type="checkbox"/> ₅ Other adult relative (including a sibling 18 or older) <input type="checkbox"/> ₆ Friend or neighbor <input type="checkbox"/> ₇ Unrelated adult (including a professional at a child care center) <input type="checkbox"/> ₈ Other <input type="checkbox"/> ₈₈ <i>Refused</i> <input type="checkbox"/> ₆₆ <i>Not applicable</i> – I do not have another person who cares for my child (<i>If not applicable, skip to question #10</i>).
	If other, specify: _____
9b. Does this person help care for your child in the following locations?	
In the child's home	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>
In someone else's home	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>

<p>In a childcare center/nurse Other</p>	<p><input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i> <input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i></p> <p>If other, specify: _____</p>
<p>9c. How many days per week does this person help care for your child?</p>	<p>_____ days per week <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>9d. On days when this person helps care for your child, how many hours per day?</p>	<p>_____ hours per day <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>9e. On average, how many additional children does this person care for at the same time as your child?</p>	<p>_____ children <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>9f. On average, how many additional people also provide care for your child alongside this person?</p>	<p>_____ people <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>Person (2)</p>	
<p>9g. For the second person you've thought of, what is this person's relationship to your child? I will read you a list of options and please select the best one.</p>	<p><input type="checkbox"/>₀ Child's mother <input type="checkbox"/>₁ Child's father <input type="checkbox"/>₂ Non-parental partner of your child's mother/ father <input type="checkbox"/>₃ Child's grandparent <input type="checkbox"/>₄ Child's relative under age 18 (including a sibling younger than 18) <input type="checkbox"/>₅ Other adult relative (including a sibling 18 or older) <input type="checkbox"/>₆ Friend or neighbor <input type="checkbox"/>₇ Unrelated adult (including a professional at a child care center) <input type="checkbox"/>₈ Other <input type="checkbox"/>₈₈ <i>Refused</i> <input type="checkbox"/>₆₆ <i>Not applicable</i> – I do not have another person who cares for my child (<i>If not applicable, skip to question #10</i>).</p> <p>If other, specify: _____</p>
<p>9h. Does this person help care for your child in the following locations?</p> <p>In the child's home</p> <p>In someone else's home</p> <p>In a childcare center/nurse</p> <p>Other</p>	<p><input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i> <input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i> <input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i> <input type="checkbox"/>₁ Yes <input type="checkbox"/>₀ No <input type="checkbox"/>₈₈ <i>Refused</i></p> <p>If other, specify: _____</p>
<p>9i. How many days per week does this person help care for your child?</p>	<p>_____ days/week <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>9j. On days when this person helps care for your child, how many hours per day?</p>	<p>_____ hours/day <input type="checkbox"/>₈₈ <i>Refused</i></p>
<p>9k. On average, how many additional children does this person care for at the same time as your child?</p>	<p>_____ children <input type="checkbox"/>₈₈ <i>Refused</i></p>

9l. On average, how many additional people also provide care for your child alongside this person?	_____ people <input type="checkbox"/> ₈₈ <i>Refused</i>
Person (3)	
9m. For the third person you've thought of, what is this person's relationship to your child? I will read you a list of options and please select the best one.	<input type="checkbox"/> ₀ Child's mother <input type="checkbox"/> ₁ Child's father <input type="checkbox"/> ₂ Non-parental partner of your child's mother/ father <input type="checkbox"/> ₃ Child's grandparent <input type="checkbox"/> ₄ Child's relative under age 18 (including a sibling younger than 18) <input type="checkbox"/> ₅ Other adult relative (including a sibling 18 or older) <input type="checkbox"/> ₆ Friend or neighbor <input type="checkbox"/> ₇ Unrelated adult (including a professional at a child care center) <input type="checkbox"/> ₈ Other <input type="checkbox"/> ₈₈ <i>Refused</i> <input type="checkbox"/> ₆₆ <i>Not applicable</i> – I do not have another person who cares for my child (<i>If not applicable, skip to question #10</i>). If other, specify: _____
9n. Does this person help care for your child in the following locations?	
In the child's home	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>
In someone else's home	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>
In a childcare center/nurse	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>
Other	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ <i>Refused</i>
If other, specify: _____	
9o. How many days per week does this person help care for your child?	_____ days/week <input type="checkbox"/> ₈₈ <i>Refused</i>
9p. On days when this person helps care for your child, how many hours per day?	_____ hours/day <input type="checkbox"/> ₈₈ <i>Refused</i>
9q. On average, how many additional children does this person care for at the same time as your child?	_____ children <input type="checkbox"/> ₈₈ <i>Refused</i>
9r. On average, how many additional people also provide care for your child alongside this person?	_____ people <input type="checkbox"/> ₈₈ <i>Refused</i>

10. How satisfied are you with the amount of help you receive in caring for your child?
- 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 crying patterns your child may be having.

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

11. How many hours per day would you say your child 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*

12. In general, how easy is it to calm your child when he or she is crying or fussy?
_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 your child's healthcare.

13. What type of health insurance does your child have?
_1 Contributory _2 Subsidized _3 Not insured _4 Specialized _5 Exception
_6 Indeterminate / independent _77 *Don't know* _88 *Refused*

14. What is the name of your child's health insurance provider?
Name: _____ _77 *Don't know* _88 *Refused*
_66 *Not applicable*

15. Since your child's birth, have you sought medical care for your child? <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>	If Yes: Number of times: _____ Clinic name (1): _____ Clinic name (2): _____ Clinic name (3): _____ Clinic name (4): _____ Clinic name (5): _____
16. Without including tests done as part of the study, since your child's last study visit, did your child have any of the following tests? Say "yes" or "no" to each one of the tests that I mention. Did your child have a...	
Cranial ultrasound	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____
MRI of the head	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____

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

CAT scan of the head	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____
Hearing test	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____
Vision test	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____
Developmental assessment	<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> If Yes: Number of visits: _____ Clinic name (1): _____ Clinic name (2): _____
Did your child have any other tests I didn't mention?	<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> If Yes: Test (1): _____ Clinic name (1): _____ Test (2): _____ Clinic name (2): _____ Test (3): _____ Clinic name (3): _____ Test (4): _____ Clinic name (4): _____ Test (5): _____ Clinic name (5): _____
17. Since your child's last study visit, did you see a medical specialist? <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> If YES, what type of medical specialist did your child see? Say "yes" or "no" to each one I mention. Did your child see a...	
Pediatrician	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Occupational or physical therapist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Speech-language specialist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Neurologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Gastroenterologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Ophthalmologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____)

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

	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Audiologist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
ENT	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Geneticist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Developmental Specialist	<input type="checkbox"/> ₁ Yes (Clinic name: _____) Type of specialist: _____ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
Did your child see any other type of medical specialist I didn't mention?	<input type="checkbox"/> ₁ Yes (Provider type: _____ Clinic name: _____) <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i>
18. Since your child's last study visit, has your child spent one night or more in the hospital?	<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> If Yes: Number of times: _____ Hospital name (1): _____ Hospital name (2): _____ Hospital name (3): _____ Hospital name (4): _____ Hospital name (5): _____
19. Now I will give you a list of conditions. Please say "yes" or "no" if, since your child's last study visit, a healthcare provider told you that your child might have this illness. Did they say that your child had?	
Zika virus	<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>
Dengue	<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>
Chikungunya	<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>
Yellow Fever	<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>
Cytomegalovirus	<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>
Rubella	<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>
Toxoplasmosis	<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>
Syphilis	<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>
Chicken Pox	<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>
Parvovirus	<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>
Herpes	<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>
Did they tell you your child had something else I didn't mention?	<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> If Yes, specify: _____

20. Since your last study visit, have you or your child enrolled in another Zika virus study?

₁ Yes, I did → Which study? _____

₂ Yes, my child did → Which study? _____

₃ Yes, my child and I did → Which study? _____

₀ No

₇₇ *Don't know*

₈₈ *Refused*

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

21. What is your marital status?
- ₁ Married
 - ₂ Free Union
 - ₃ Single, divorced, or widowed
 - ₄ Other, specify: _____
 - ₇₇ *Don't know*
 - ₈₈ *Refused*

22. We are interested in how you feel about the following statements. I will read each statement to you from your point of view. 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.

23. 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*

24. Since the birth of the child enrolled in ZEN, 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*

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

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

25. Since your baby's birth, has anyone done any of the following things in the child's house? 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.

Note any questions from parents below: _____

