Form approved

OMB No. 0920-1333

Exp. Date 4/30/2024

Feeding My Baby and Me: IFPS-III: Month 24

The information you are being asked to provide is authorized to be collected under Section 301 of The Public Health Service Act (42 USC 241). Providing this information is voluntary. CDC will use this information in its study, Feeding My Baby and Me (also known as the Infant Feeding Practices Study III), in order to learn more about the choices mothers make in feeding their babies and toddlers in the first 2 years of life. This information will provide important information to support efforts to improve the health of our nation’s children. This information will be shared with a contractor, Westat, with which CDC has entered into an agreement to assist with carrying out this study.

**Public reporting burden of this collection of information varies from 2 to 24 minutes with an average of 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-**1333**)**

**DEMOGRAPHICS**

**A9. Are you currently {CHILD'S NAME}’s caregiver?**

* Yes (GO TO A29)
* No

**[IF A9 = NO, END SURVEY, MAY BE ELIGIBLE FOR FUTURE SURVEYS. SHOW SURVEY INELIGIBILITY SCREEN AND THEN END SURVEY.]**

**[START SURVEY INELIGIBILITY SCREEN]**

We’re sorry, you are not eligible to complete this survey if you are not currently the study child’s caregiver. Thank you for everything you have done to make this study a success. We wish the best to you and to your family.

**[END SURVEY INELIGIBILITY SCREEN]**

**A29. Have you moved out of the United States?**

* Yes
* No

**A31. WIC is a nutrition and health program for Women, Infants, and Children. WIC benefits include food, checks or vouchers for food, health care referrals, and nutrition education. Since your child was 1 year old, did you ever get WIC food or vouchers for your child?**

* Yes, my child got WIC food
* No

**A22. Since your child was 1 year old, did you, or your family ever receive:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t know** |
| Supplemental nutrition assistance benefits, sometimes called SNAP or Food Stamps? |  |  |  |
| Temporary assistance to needy families, sometimes called TANF or welfare? |  |  |  |
| Free or reduced price meals from the National School Lunch or School Breakfast Program, or the Summer Foods Program? |  |  |  |
| Are you receiving any food or free meals from another source such as a food bank, church, or community center? |  |  |  |

**FEEDING**

**Foods Your Child Eats**

**[PROGRAMMER: LIST EACH REPETITION OF INSTRUCTIONS AND THE GRID THAT FOLLOWS THOSE INSTRUCTIONS ON A SEPARATE PAGE]**

**In the past 7 days, how often was {CHILD'S NAME} fed each food listed below?** Include feedings by everyone who feeds the child and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Breast milk and infant formula** | **Feedings per day** | **Feedings per week** |
| Toddler milk (includes follow up formulas or toddler formulas) |  |  |

**In the past 7 days, how often was {CHILD'S NAME} fed each beverage listed below?** Include feedings by everyone who feeds the child and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD'S NAME}** was fed the beverage once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD'S NAME}** was fed the beverage less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD'S NAME}** was not fed the beverage at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Beverages** | **Feedings per day** | **Feedings per week** |
| Water: include tap, bottled, or unflavored sparkling water |  |  |
| 100% pure fruit juice or 100% pure vegetable juice |  |  |
| Regular soda or pop that contains sugar. Don't include diet soda or diet pop |  |  |
| Sweetened fruit drinks such as Kool-Aid, lemonade, sweet tea, Hi-C, cranberry cocktail, Gatorade, or flavored milk (e.g., chocolate, strawberry, vanilla) |  |  |
| Unsweetened cow's milk (includes milk added to foods such as cereals) |  |  |
| Unsweetened other milk such as soy milk, rice milk, or goat milk. |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Grains** | **Feedings per day** | **Feedings per week** |
| Hot or cold cereal (do not include baby cereal) |  |  |
| Rice, pasta, breads (includes, rice, pasta, toast, rolls, bagels, cornbread, tortillas, bread in sandwiches, pancakes, waffles, crackers, etc.) |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Meats and Other Protein Foods** | **Feedings per day** | **Feedings per week** |
| Meat (not processed): chicken, turkey, pork, beef, or lamb |  |  |
| Processed meat: baby food meats, combination dinners, bacon, ham, lunch meats, hot dogs, etc. |  |  |
| Fish or shellfish |  |  |
| Eggs  |  |  |
| Beans: Refried beans, black beans, white beans, baked beans, beans in soup, pork and beans, or any other cooked dried beans. Don't include green beans. |  |  |
| Peanut butter, other peanut foods, or nuts |  |  |
| Soy foods: tofu, frozen soy desserts, etc. |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Fruits and Vegetables** | **Feedings per day** | **Feedings per week** |
| Fruits: fresh, frozen, or canned, pureed baby food, or in squeezable pouches. Don't include juice. |  |  |
| Potatoes: baked, boiled, or mashed potatoes, or sweet potatoes |  |  |
| Fried potatoes including French fries, home fries, or hash browns |  |  |
| Green leafy vegetables: spinach, kale, collards, lettuce, or other green leafy vegetables |  |  |
| Other vegetables: fresh, frozen, or canned, or in squeezable pouches (other than green leafy or lettuce salads, potatoes, or cooked dried beans) |  |  |
| Tomato sauces: Mexican-type salsa with tomato, spaghetti noodles with tomato sauce, or mixed into foods such as lasagna (do not include tomato sauce on pizza) |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Dairy** | **Feedings per day** | **Feedings per week** |
| Cheese: all types (include cheese as a snack, on a sandwich, or in foods such as lasagna, quesadillas, or casseroles). Do not count cheese on pizza |  |  |
| Other dairy products, such as pudding or yogurt. Don't include sugar free or plain kinds |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Sweets and Desserts** | **Feedings per day** | **Feedings per week** |
| Ice cream or other frozen dairy desserts, such as frozen yogurt and sherbet. Don't include sugar free kinds |  |  |
| Sugar free frozen dairy desserts or sugar free pudding, plain or sugar free yogurt, or other sugar free dairy products |  |  |
| Sweet foods: candy, cookies, cake, doughnuts, muffins, pop-tarts, etc. Don't count frozen or sugar free desserts |  |  |

**In the past 7 days, how often was {CHILD’S NAME} fed each food listed below?** Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

* + If **{CHILD’S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
	+ If **{CHILD’S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
	+ If **{CHILD’S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]**

|  |  |  |
| --- | --- | --- |
| **Snacks and Other Foods** | **Feedings per day** | **Feedings per week** |
| Pizza: frozen pizza, fast food pizza, homemade pizza, or other pizza |  |  |
| Snacks such as potato chips, corn chips, pretzels, or popcorn |  |  |

**C55. How many times does {CHILD'S NAME} eat (such as breakfast, lunch, dinner, or snacks) on a normal day?**

* 1
* 2
* 3
* 4
* 5
* 6
* 7
* 8 or more

**Feeding Breast Milk**

**E5. [ASK IF E4 FROM PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Has {CHILD'S NAME} stopped directly feeding at your breast?**

* Yes
* No (GO TO E11)

**E6. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped feeding directly from your breast? Do not answer about pumped or expressed milk. You will be asked about that later. (Day 0 is the day your child was born)**

 My child completely stopped feeding at my breast at \_\_\_ days OR \_\_\_ weeks OR \_\_\_ months

**E8. What were the two most important reasons for your decision to stop feeding your child directly at your breast?**

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]**

|  |  |  |
| --- | --- | --- |
|  | **Most important reason** | **Second most important reason** |
| I wanted or needed someone else to feed my child |  |  |
| Breast milk alone did not satisfy my child |  |  |
| I wanted my body back to myself |  |  |
| I was sick or had to take medicine |  |  |
| I could not breastfeed while working or going to school |  |  |
| My child lost interest in nursing or began to wean himself or herself |  |  |
| I was pregnant |  |  |
| Other reason |  |  |

**E11. [ASK IF E10 FROM PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped pumping or hand-expressing breast milk?**

* Yes
* No (GO TO E16)

**[IF E11 = VALID SKIP, SKIP TO E16]**

**E12. How old was {CHILD'S NAME} when you completely stopped pumping or hand-expressing breast milk? (Day 0 is the day your child was born). Do not answer about feeding your child your pumped breast milk. You will be asked about that later.**

I completely stopped pumping or hand-expressing my breast milk at\_\_\_ days OR \_\_\_ weeks OR \_\_\_ months

**E13. What were the two most important reasons for your decision to stop pumping or hand-expressing breast milk?**

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]**

|  |  |  |
| --- | --- | --- |
|  | **Most important reason** | **Second most important reason** |
| Pumping milk no longer seemed worth the effort it required |  |  |
| Too many challenges related to pumping at work or school |  |  |
| Pumping supplies cost too much  |  |  |
| I was not getting enough pumped milk  |  |  |
| I had enough milk stored to reach my breastfeeding goal |  |  |
| I was pregnant  |  |  |
| I was sick or had to take medicine |  |  |
| Other reason |  |  |

**E16. [ASK IF E15 FROM PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped feeding your child pumped or expressed breast milk?**

* Yes
* No (GO TO E24)

**[IF E16 = VALID SKIP, GO TO E19]**

**E17. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed any pumped or expressed breast milk? Do not answer about feeding directly at your breast. (Day 0 is the day your child was born)**

My child completely stopped being fed pumped or expressed breast milk at\_\_\_ days OR \_\_\_ weeks OR \_\_\_ months

**E19. [IF E4 OR E15 HAVE DATE IN ANY SURVEY AND E5 ≠ NO AND E16 ≠ NO, ASK E19. ONCE ANSWERED, DO NOT ASK AGAIN IN FUTURE SURVEYS] Did you feed your child breast milk (at the breast or pumped/expressed milk) as long as you wanted?**

* Yes
* No

**Feeding Formula**

**E24. [ASK IF E23 INCLUDES DATE FROM PREVIOUS SURVEY AND R HAS NOT ALREADY ANSWERED YES] Has {CHILD'S NAME} stopped being fed infant formula?**

* Yes
* No (GO TO C51a)

**E25. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed infant formula? (Day 0 is the day your child was born)**

My child completely stopped feeding infant formula at \_\_\_ days OR \_\_\_ weeks OR \_\_\_ months

**E26. What were the two most important reasons for your decision to stop feeding your child infant formula?**

**[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]**

|  |  |  |
| --- | --- | --- |
|  | **Most important reason** | **Second most important reason** |
| My child started drinking other milk(s) (such as cow's milk, soy milk, rice milk, or goat's milk) |  |  |
| My child started drinking other drinks (such as water, juice, sweetened fruit drinks, or soda or pop) |  |  |
| I fed my child my breast milk |  |  |
| I fed my child breast milk from someone else |  |  |
| My doctor told me to stop |  |  |
| I thought it was time to be done  |  |  |
| Other reason |  |  |

**[PROGRAMMER: IF C51a AT MONTH 15 = YES, GO TO C95]**

**C51a. Has {CHILD'S NAME} stopped drinking anything from a bottle?**

* Yes
* No, my child is still drinking from a bottle (GO TO C95)
* My child never drank anything from a bottle (GO TO C95)

**C51b. How old was {CHILD’S NAME} when {FILL: HE/SHE} stopped using a bottle?**

Weeks\_\_\_\_ Months \_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_\_

**C95. During the past week, how often was {CHILD'S NAME} put to bed with a bottle, or a sippy cup, with anything other than water?**

* At most bedtimes, including naps
* At most night bedtimes, but not naps
* At most naps, but not night bedtimes
* Only occasionally at bedtimes, including naps
* Never

**Solid Foods**

**The next questions are about food you feed your child.**

**C30. How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed ...**

**Answer for each food listed. Please include any amount of food given - even if it was just a small amount fed from a spoon, a bottle or your hands.**

**[DO NOT DISPLAY FOODS ENDORSED IN MONTH 6 OR MONTH 12]**

|  |  |
| --- | --- |
| Cow's milk, or other dairy products made with cow's milk | NEXT TO EACH ROW:**[HAVE A DROP DOWN OPTION FOR LESS THAN ONE MONTH ALL OTHER RESPONSES ARE MONTH WRITE-IN]** \_\_\_\_ MONTH My baby has not eaten this food yet |
| Soy milk or other soy food (including infant formula made with soy) |
| Eggs |
| Peanuts, peanut butter, or peanut butter puffs such a Bamba snacks |
| Tree nuts (such as, almonds, pecans, walnuts) |
| Sesame seed or tahini |
| Fish |
| Shellfish |
| Wheat (such as bread, crackers, noodles) |

**These next questions are about the food eaten in your household in the last month, and whether you were able to afford the food you need.**

**A24a. The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more. Was that often, sometimes, or never true for (you/your household) in the last month?**

* Often true;
* Sometime true;
* Never true

**A24b. (I/we) couldn't afford to eat balanced meals**

* Often true;
* Sometime true
* Never true

**A24c. In the last month, did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?**

* Yes
* No (GO TO A24E)

**A24d. How often did this happen?**

* Every week
* Some weeks but not every week
* Only 1 or 2 weeks

**A24e. In the last month, did you ever eat less than you felt you should because there wasn't enough money for food?**

* Yes
* No

**A24f. In the last month, were you ever hungry but didn't eat because there wasn't enough money for food?**

* Yes
* No

**FOOD ALLERGIES**

**These next questions are about problems with food {CHILD'S NAME} has had, either through breast milk or from eating directly.**

**F3. [ASK ONLY IF NOT YES IN PREVIOUS MONTHS] Has your child ever had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?**

* Yes
* No (GO TO H26a)

**F4. [ASK IF F3 = YES] In the table below, please indicate which foods {CHILD'S NAME} had a problem with such as an allergic reaction, sensitivity, or intolerance. Include foods {CHILD'S NAME} reacted to through breast milk as well as foods {FILL: HE/SHE} ate directly.**

**{CHILD'S NAME} had a problem with…**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Cow's milk or other dairy products (not including infant formula made with cow's milk) |  |  |
| Infant formula made with cow's milk |  |  |
| Soy milk or other soy food (including infant formula made with soy) |  |  |
| Eggs |  |  |
| Peanuts, peanut butter, or peanut oil |  |  |
| Tree nuts (such as, almonds, pecans, walnuts) |  |  |
| Sesame seed, tahini, or sesame seed oil |  |  |
| Fish |  |  |
| Shellfish |  |  |
| Wheat, gluten, or wheat starch |  |  |
| Other food or ingredient (Please specify ) |  |  |

**F5. [ASK IF YES TO ANY ITEM IN F4] Was {CHILD'S NAME} diagnosed as allergic to [INSERT EACH ITEM IN F4 THAT IS A YES RESPONSE] by a health care provider.**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Cow's milk or other dairy products (not including infant formula made with cow's milk) |  |  |
| Infant formula made with cow's milk |  |  |
| Soy milk or other soy food (including infant formula made with soy) |  |  |
| Eggs |  |  |
| Peanuts, peanut butter, or peanut oil |  |  |
| Tree nuts (such as, almonds, pecans, walnuts) |  |  |
| Sesame seed, tahini, or sesame seed oil |  |  |
| Fish |  |  |
| Shellfish |  |  |
| Wheat, gluten, or wheat starch |  |  |
| Other food or ingredient (Please specify ) |  |  |

**HEALTH AND LIFESTYLE**

**H26a. How much did {CHILD'S NAME} weigh the last time {FILL: HE/SHE} was weighed at a doctor's visit?**

\_\_\_\_\_\_ pounds \_\_\_\_\_\_ ounces

**H26b. What was the month and year of those measurements?**

\_\_\_\_\_\_ month \_\_\_\_\_ day

**H26c. How long was {CHILD'S NAME} the last time {FILL: HE/SHE} was measured at a doctor's visit?**

\_\_\_\_\_\_\_ inches

**H26d. What was the month and year of those measurements?**

\_\_\_\_\_\_ month \_\_\_\_\_ day

**H30. Currently, would you describe {CHILD'S NAME} as overweight, normal weight or thin?**

* Overweight
* Normal weight
* Thin

**H24. Which of the following problems did {CHILD'S NAME} have during the past month?**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Fever |  |  |
| Diarrhea or vomiting |  |  |
| Ear infection |  |  |
| Severe respiratory infection (e.g., pneumonia, bronchiolitis) |  |  |
| Wheeze |  |  |
| Eczema (atopic dermatitis) |  |  |
| COVID-19 |  |  |

**H25. In the past three months, did {CHILD'S NAME} take any antibiotics?**

* Yes
* No
* Don't know

**H29. Has {CHILD'S NAME} ever been referred to a developmental specialist or program for developmental concerns or follow up (such as speech therapist, occupational therapist, Early Intervention program)?**

* Yes
* No
* Don't know

**H10. What is your weight now?**

\_\_\_\_\_ POUNDS

**H20. Are you currently pregnant?**

* Yes
* No

**END SCREEN:**

**Thank you for everything you have done to make this study a success. We wish the best to you and to your family.**