



Appendix 5



Promoting Healthy Development Survey - Reduced-item Version (ProPHDS)

Version for Parents of Children 10-18 Months Old

(10 – 18 months)

Your Child's Health Care

- ❖ This survey is about discussions you may have had with your child's doctors or other health providers in the last 12 months.
- ❖ By completing this survey, you are indicating that you have given your consent to participate.
- ❖ This survey is confidential. Do not write your name or your child's name on this survey.
- ❖ If you choose to not answer the survey, the decision will have no effect on the health care you or your child receive or on your health care benefits.
- ❖ If you begin to answer the questions and then change your mind, you may stop at any time. Also, if there are particular questions that you don't want to answer, you may skip them. If you choose to skip or not answer any questions it will have no effect on the health care you or your child receive or on your health care benefits

Instructions

1. Please use a BLUE or BLACK ink pen to complete this survey.
2. Answer all the questions by checking the box on top of your answer like this:

Yes

No

SECTION I: DISCUSSIONS WITH YOUR CHILD'S DOCTORS OR OTHER HEALTH PROVIDERS

A doctor or other health provider could be a general doctor, a specialist, a pediatrician, a nurse practitioner, a physician assistant, a nurse or any one else your child would see for health care.

1. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) Things you can do to help your child grow and learn	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) The kinds of behaviors you can expect to see in your child as he/she gets older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Vitamins and foods your child should eat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Bed and naptime routines	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Words and phrases your child uses and understands	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Night waking and fussing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Whether your child uses a bottle	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) How your child may start to explore away from you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

2. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) Guidance and discipline techniques to use with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Toilet training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) What you should do if your child swallows certain kinds of poisons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Using a car-seat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) How to make your house safe	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Importance of reading with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Whether your child watches television (TV)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Issues related to childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) Resources for parents and families in your community	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION II: EXPERIENCE OF CARE

The next questions ask about your overall experiences with the health care your child has received from his or her doctors or other health providers in the last 12 months.

3. In the <u>last 12 months</u> , how often did your child's doctors or other health providers. . .	Never	Sometimes	Usually	Always
a) Take time to understand the specific needs of your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Respect you as an expert about your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Help you feel like a partner in your child's care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Explain things in a way that you can understand	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Show respect for your family's values, customs and how you prefer to raise your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION III: HEALTH CONCERNS ABOUT YOUR CHILD

The next few questions ask about concerns parents or guardians sometimes have about their child.

4. * Do you have any concerns about . . .	Yes	A little	Not at all
a) Your child's learning, development or behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) How your child talks and makes speech sounds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) How your child understands what you say	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) How your child uses his or her arms and legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) How your child behaves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) How your child gets along with others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

5. In the last 12 months, did your child's doctors or other health providers ask if you have concerns about your child's learning, development or behavior?

1
Yes

2
No

3
I don't remember

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6. In the **last 12 months**, did your child's doctors or other health providers give you specific information to address your concerns?

- Yes
 No
 I don't remember
 I did not have any concerns

7. In the **last 12 months** did your child's doctors or other health providers:

	Yes	No
a) Refer your child to another doctor or other health provider	<input type="checkbox"/>	<input type="checkbox"/>
b) Test your child's learning and behavior	<input type="checkbox"/>	<input type="checkbox"/>
c) Note a concern about your child that should be watched carefully	<input type="checkbox"/>	<input type="checkbox"/>
d) Refer your child for speech-language or hearing testing	<input type="checkbox"/>	<input type="checkbox"/>

8. In the **last 12 months**, did your child's doctors or other health providers have your child pick up small objects, stack blocks, throw a ball or recognize different colors?

- Yes
 No
 I don't remember
 My child is too young to do these kind of activities

9. In the **last 12 months**, did your child's doctor or other health care provider have you fill out a questionnaire about specific concerns or observations you may have about your child's physical ability, communication or social behaviors?

- Yes →Go to Question 9a
 No →Go to Question 10

9a. Did this questionnaire ask about your concerns or observations about how your child **talks or makes speech sounds**?

- Yes
 No

9b. Did this questionnaire ask about your concerns or observations about how your child **interacts with you and others**?

- Yes
 No

SECTION IV: QUESTIONS ABOUT YOUR FAMILY

A child's doctors or other health providers sometimes ask questions about a child's family. These questions help them provide the best care possible for your child. These questions can be asked in a survey that you fill out before the visit, in the waiting room or when you talked with your child's doctor or other health provider during your child's visit.

	Yes	No
10. In the last 12 months , did your child's doctors or other health providers ask you:		
a) If you or someone in your household drinks alcohol or uses other substances	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) If you ever feel depressed, sad or have crying spells	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) If you have someone to turn to for emotional support	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) To talk about any changes or stressors in your family or home	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) If you have any firearms in your home	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION V: YOUR CHILD'S PERSONAL DOCTOR OR NURSE

11. A **personal doctor or nurse** is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner or a physician assistant. Do you have one or more person(s) you think of as your child's personal doctor or nurse?

1
Yes

2
No → Go to Question 12

11 a. Which of these people do you think of as your child's personal doctor or nurse? Please mark one or more.

1
Name #1

2
Name 2

3
Name 3

4
Name 4

5
Name 5

6
Other Person

SECTION VI: YOUR CHILD, YOU, AND YOUR FAMILY

These last questions are about your child, you, and your family. We are asking these questions to better understand the children and families we care for so that we can improve our services. Remember this survey is **confidential** and results will be kept completely anonymous.

12. Is the child named in this survey your first child?

1
Yes

2
No

3
The question does not
apply to me

13. Is your child of Hispanic or Latino origin or descent?

1
Hispanic or Latino

2
NOT Hispanic or Latino

14. What is your child's race? Please mark one or more.

- 1 White
 2 Black or African American
 3 Asian
 4 American Indian or Alaskan Native
 5 Native Hawaiian or Other Pacific Islander
 6 Other

15. How many days in a typical week do you or other family members read a book with your child?

- 1 No Days (0 days)
 2 1-2 days
 3 3-4 days
 4 5-6 days
 5 Everyday (7 days)

16. How many hours in a typical day does your child watch TV or watch videos?

- 1 0 hours
 2 Less than 1 hour
 3 1 -2 hours
 4 More than 2 hours
 5 We don't own a TV

17. What is the highest grade or level of school that you have completed?

- 1 8th grade or less
 2 Some high school, but did not graduate
 3 High school graduate or GED
 4 Some college or 2-year degree
 5 4-year college graduate
 6 More than a 4-year college degree

18. How many days in the last week have you felt depressed?

- 1 0 days
 2 1 day
 3 2 days
 4 3 days
 5 4 days
 6 5 days
 7 6 days
 8 All 7 days

19. In the last 12 months, have you had two weeks or more during which you felt sad, blue, depressed or lost pleasure in things you usually cared about or enjoyed?

- 1 Yes
 2 No

20. How much trouble have you had paying for . . .

	A Lot of Trouble	Some Trouble	No Trouble
a) Child's health and medical expenses	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b) Supplies like formula, food, diapers, clothes and shoes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c) Healthcare for yourself	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

YOU'RE DONE!!

Thank you for completing the survey. Please put the survey in the envelope provided and drop it off in the "completed survey" box before you leave.

You have helped make a difference.