

Toddler Wellness Overview Survey

A Survey of the Health and Development of Rhode Island Toddlers

MAKE HE[♥]LTH PART OF YOUR FAMILY
RHODE ISLAND DEPARTMENT OF HEALTH



TWOS

Your experiences, thoughts and feelings are important!
Please complete the survey and mail it in the enclosed postage paid envelope.

Your help is voluntary, and your answers are completely confidential.

Your answers will help us improve the health of toddlers
throughout Rhode Island.

If you would like to learn more about TWOS,
call the Family Health Information Line at 1-800-942-7434.

Our staff speaks English and Spanish.

The first set of questions are about the general health, behavior, and home life of your two-year-old child. Please check the box next to your answer, or circle as directed.

All questions should be answered for your two-year-old child only.

1. Is this child living with you now?

- No
 Yes ► *Go to Question 3*

2. How long was your child in your care?

___ Weeks OR ___ Months

If child was in your care less than 12 months
► *Go to Question 39 (page 6)*

3. How much does your child weigh?

___ Pounds OR ___ Kilograms
 I don't know

4. How tall is your child?

___ Inches OR ___ Centimeters
 I don't know

5. In general, how would you rate the health of your child?

- Excellent
 Good
 Fair
 Poor

6. Did you breastfeed or pump breast milk to feed your child?

- No ► *Go to Question 8*
 Yes

7. How long did you breastfeed or pump breast milk to feed this child?

___ Weeks OR ___ Months

- Less than 1 week
 I am still breastfeeding or feeding pumped breast milk to my child

8. How many ounces (oz) of milk, cheese, yogurt, or formula does your child eat or drink in a 24 hour period?

___ Ounces

9. How many ounces (oz) of juice does your child drink in a 24 hour period?

___ Ounces

10. Does your child have tooth decay or cavities?

- No
 Yes
 I don't know if my child has tooth decay or cavities

11. During the last 12 months, has a doctor or other health care professional said that your child has asthma, bronchitis, wheezing or shortness of breath?

- No ► *Go to Question 13*
 Yes

12. Was your child prescribed treatment?

- No
- Yes

13. Which of the following things can your child do now? Check the box that best describes how often your child demonstrates the following behavior.

- | | Most of the Time | Sometimes | Rarely or Never |
|---|--------------------------|--------------------------|--------------------------|
| a. Points to familiar objects in picture book | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Uses 2 word phrases like "Mommy come" | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. People outside of the family understand at least half of what he/she says | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. He/she asks for help when doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Says "I'm sorry" or apologizes for misbehavior | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Turns pages in a children's book one page at a time ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Points to at least 6 body parts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Follows two-part directions like 'Please pick up your toys and put them away.' | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Uses at least 20 words | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Drinks from a bottle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Falls asleep with a bottle or cup | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(question 13, continued)

- | | Most of the Time | Sometimes | Rarely or Never |
|---|--------------------------|--------------------------|--------------------------|
| l. Sits for meals at regular times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Follows a bedtime routine and has a regular bedtime .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Watches more than 2 hours of TV/Video daily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14. Please read each statement below, and check the box that best describes how often your child demonstrates the following behavior.

- | | Most of the Time | Sometimes | Rarely or Never |
|--|--------------------------|--------------------------|--------------------------|
| a. Likes to be hugged or cuddled | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Settles him/herself down after periods of exciting activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does things over and over and can't seem to stop (Such as rocking, hand flapping, spinning) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cries a lot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Acts aggressively when frustrated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Refuses to eat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Has trouble falling asleep ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(question 14, continued)

- | | Most of the Time | Sometimes | Rarely or Never |
|--|--------------------------|--------------------------|--------------------------|
| h. Wakes up at night and needs help to get back to sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. How often has anyone expressed concerns about your child's behaviors? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. How often are you concerned about your child's eating behaviors? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

15. Do you have any concerns about your child's behavior or development?

- No
- Yes ► What? Please tell us:

(Please use the comment page at the end of this survey if more space is needed.)

16. When your child was less than 12 months old, how often did he/she sleep in the same bed with you or someone else?

- Never
- Sometimes
- Always

17. Over the past 6 months, who did your child spend most of his/her daytime hours with Monday through Friday?

- With me
- With my husband or partner
- At a day care center
- At a family day care center
- With relatives or friends (grandparents, etc.)
- Other ► Please tell us:

18. How often do you or your husband or partner read stories to your child?

- Never
- Rarely
- A few times a week
- Every day or night

19. How often in the past month have you or any family member taken your child on any kind of outing, (such as to a park, playground, library, or other children's program)?

- Once a month or less
- About 2 or 3 times a month
- Several times a week
- About once a day

20. How often does your child use a carseat when riding in a motor vehicle?

- Never
- Sometimes
- Most of the time
- All the time

21. On average, about how much time is your child in the same room or motor vehicle with someone who is smoking?

_____ Hours a day

- Less than one hour a day
- Never [My child is never in the same room or car with someone who is smoking.]
- Other ► Please tell us:

22. Does your home have a yard where your child can play safely?

- No
- Yes

The next questions are about the health care services your two-year-old child receives.

23. Do you have health insurance for your child (for example, Blue Cross, Medicaid, or Rite Care)?

- No ► *Go to Question 25*
- Yes

24. What type of insurance is your child covered by?

- Private Insurance (for example, Blue Cross, United, Aetna)
- Rite Care (United, Neighborhood, Blue Chip, etc.)
- Medicaid
- Other ► Please tell us:

25. Do you take your child for well-child visits? (Routine health care)

- No ► *Go to Question 28*
- Yes

26. Where do you usually take your child for well-child visits?

- Hospital clinic
- Private doctor's office
- Health center (Allenberry, Blackstone Valley, Thundermist, etc.)
- Other ► Please tell us:

27. How satisfied are you with the health care your child receives?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

Comments ► Please tell us:

28. Does your child see any specialist(s) or therapist(s)?

- No ► *Go to Question 31*
- Yes

29. What type of specialists?

Please check all that apply.

- Nutritionist or Dietician
- Speech or language therapist
- Audiologist (hearing specialist)
- Ophthalmologist or Optometrist (eye specialist)
- Neurologist (brain and spinal cord specialist)
- Cardiologist (heart specialist)
- Psychologist or Social worker
- Physical or Occupational therapist
- Surgeon
- Other ► Please tell us:

30. Have you been satisfied with the specialty care your child has received?

- No
- Yes

31. Has your child ever been enrolled in or received services from any of the following programs? Please check all that apply.

- Early Intervention Program (EI)
- SSI (Supplemental Security Income)
- Medical or Developmental Specialty Care (such as the Child Development Center at RI Hospital)
- WIC (the Special Supplemental Nutrition Program for Women, Infants and Children)
- None of the above

32. How many times has your child ever had an accident or injury that needed to be checked by a doctor, nurse, or other health care provider?

_____ Times

- Never ► *Go to Question 34*

33. How was your child hurt? Please check all that apply.

- Injury involving a car
- Burn
- Cut(s)
- Fall
- Choking (couldn't breathe)
- Poisoning
- Other ► Please tell us:

34. Has your child ever been seen in an Emergency Room?

- No
- Yes ► How many times? Please tell us:

► Why? Please tell us:

35. Since you brought your baby home after birth, has your child ever been hospitalized?

- No ► *Go to Question 37*
- Yes

36. For each time this child was hospitalized overnight, what was the reason?

Please tell us:

1st time: _____
2nd time: _____
3rd time: _____

37. Has a health care provider ever discussed childhood lead poisoning with you?

- No
- Yes

38. Have any of the following things ever prevented you from getting health care for your child?

- a. It was too expensiveNo Yes
- b. Inconvenient office hoursNo Yes
- c. Right type of service was not availableNo Yes
- d. Too far to travelNo Yes
- e. No transportationNo Yes
- f. Didn't have a regular health care providerNo Yes
- g. Couldn't find a provider who would see my childNo Yes
- h. Attitude of provider or staffNo Yes
- i. Couldn't miss school or work ...No Yes
- j. No child care for other childrenNo Yes
- k. No insuranceNo Yes
- l. Insurance did not coverNo Yes
- m. Other ► Please tell us:

The next questions are about your health and living situation.

39. Have you been pregnant since your two-year-old was born?

- No ► Go to Question 41
- Yes

40. When you first found out you were pregnant, how did you feel? (If you have had more than one pregnancy since the birth of your two-year-old, please consider just the first pregnancy.)

- I wanted to be pregnant sooner
- I wanted to be pregnant later
- I wanted to be pregnant at that time
- It didn't matter when I became pregnant
- I didn't want to be pregnant then or at any time in the future
- I don't know

41. Are you now using any birth control [contraception] to prevent pregnancy?

- No
- Yes ► Go to Question 43

42. What is the most important reason for not using any birth control to prevent pregnancy? Check only one response.

- I am currently pregnant
- I am not having sex
- I do not mind if I get pregnant
- I am trying to get pregnant
- I had side effects from the birth control method I was using
- I had problems getting birth control when I needed it
- I had a tubal ligation (tubes tied) or I had a hysterectomy
- My husband or partner had a vasectomy
- Other ► Please tell us:

If you are not using birth control
► Go to Question 44

43. What kind of birth control are you or your husband or partner now using to prevent pregnancy? Check all that apply.

- Tubal ligation (tubes tied) / hysterectomy / vasectomy
- Pill (Birth Control Pill)
- Condoms
- Contraceptive Implants (Jadelle or Implanon)
- Shot once a month (Lunelle)
- Shots once every 3 months (Depo-Provera)
- The Patch (Ortho Evra)
- Diaphragm, Cervical ring or cap (Nuvaring or others)
- IUD (including Mirena)
- Other ► Please tell us:

44. This question is about things that may have happened to you in the past 12 months.

- a. A close family member or friend was very sick or diedNo Yes
- b. I was very sickNo Yes
- c. I was separated or divorced from my husband/partnerNo Yes
- d. I was involved in a physical fight.....No Yes
- e. My husband/partner was sent to jail.....No Yes
- f. I had a lot of bills I couldn't pay ...No Yes
- g. I lost my jobNo Yes
- h. My husband/partner lost his job ...No Yes
- i. Someone close to me had a problem with drinking or drugs ...No Yes
- j. I was without a telephoneNo Yes
- k. My child or I did not have enough foodNo Yes

45. Over the past 12 months, have you had two or more weeks in a row when you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed?

- No
- Yes

46. Over the past 12 months, how often have you felt overwhelmed by the demands of your child or children?

- Never
- Rarely
- Sometimes
- Usually
- Always

47. Over the past 12 months, has a doctor, nurse, or other health care worker diagnosed you with depression?

- No ➤ *Go to Question 50*
- Yes

48. Over the past 12 months, did you take prescription medication for your depression?

- No
- Yes

49. Over the past 12 months, did you receive counseling for your depression?

- No
- Yes

50. Over the past 12 months, how many alcoholic drinks did you have in an average week? (A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.)

- I did not drink
- Less than 1 drink a week
- 1 to 3 drinks a week
- 4 to 6 drinks a week
- 7 drinks or more a week
- I don't know

51. Over the last 12 months did you mostly...? Check one.

- Stay at home
 - Work part-time
 - Work full time
 - Go to School (Part-time or Full-time)
 - Other ➤ *Please tell us:*
-

52. How many times have you moved since your child was born?

_____ Times

53. Overall, how satisfied are you with the house or apartment in which you currently live?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

54. In the past two years, have you ever needed help in getting housing, food, or money in an emergency?

- No ➤ *Go to Question 56*
- Yes

55. Do you know of a specific place or program in your community where a family can go for help in getting housing, food, or money in an emergency?

- No
- Yes

56. What is your current marital status?

- Married to my child's father
- Married to a different person
- Widowed
- Divorced
- Separated
- Never married

57. What is the highest grade/ level of school you completed?

- 8th grade or less
- Some high school (1-3 years)
- High school graduate or GED (General Education Development, no college)
- Some college
- College graduate or higher
- Trade/technical school graduate

58. Including your two year old, how many children under the age of 18 live in your household?

_____ Children under 18

Date you completed this survey:

Month

Day

Year

COMMENTS:

Please use this space to tell us about the major issues that affect your child's health and wellness. What services would you like for your family but cannot afford?
