The Children's Healthy Living (CHL) Program for Remote Underserved Minority Populations in the Pacific Region

CHL DATA COLLECTION FORMS

Vol. 1 Individual-Level Data

for the CHL Community Randomized Trial and FAS Prevalence Study

Developed by the CHL Data Work Group for use in the CHL Pacific Region

For further information, please contact:
Ashley Yamanaka
Children's Healthy Living Program for Remote Underserved Minority Populations in The Pacific Region
Ag Sciences 302M, 1955 East West Road, Honolulu, HI 96822
Phone: 808 956-9832 Fax: 808 956-4024 Email: aby@hawaii.edu
Website: www.chl-pacific.org

This project is supported by the Agriculture and Food Research Initiative Grant no. 2011-68001-30335 from the USDA National Institute of Food and Agricultural Science Enhancement Coordinated Agricultural Program.

United States Department of Agriculture
National Institute of Food and Agriculture

Table of Contents

Screening Form (Only used in time 1) ----------2

Demographic Questionnaire ---------- 3

Acculturation Questionnaire ----------10

Sedentary Behavior Questionnaire ----------11

Sleep Behavior Questionnaire---------- 12

Anthropometry Form ---------- 15

Acanthosis Nigricans Screening Form ----------16

Food and Activity Log (2 day food record) ----------17

Children's Healthy Living (CHL) Program

Screening Questions

1. **Does your child have any problems that keep him/her from being physically active?**

   Yes _____ No _____

   If Yes, what type of problem: _____

2. **If yes, has your child had any problems with her / his**

   ____ heart

   ____ blood pressure

   ____ bones or joints

   ____ nerves

   ____ thyroid

   ____ cancer

   ____ liver

   ____ kidney

   ____ diabetes

3. **Does your child take any medications?**

   Yes _____ No _____

4. **If yes, does he or she take**

   ____ antidepressants,

   ____ lithium

   ____ appetite suppressants

   ____ or any medication that affects appetite or metabolism?

5. **If you answered YES to any of these medications, does your child take them regularly?**

   Yes _____ No _____

Approved by UH IRB 10-19-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

INFORMATION ABOUT YOUR CHILD AND HOUSEHOLD

Parent, Guardian OR Caretaker: Please complete all 6 pages of this form. When completing this form, consider the child who will participate in the Children's Healthy Living Program. Thank you!

SEX (Circle One)	
Boy	Girl

BIRTHDATE		
Month	Day	Year
		20_ _

AGE In Years

GRADE IN SCHOOL (Circle One) Circle Grade in Fall 2012		
Head Start	Day Care	Preschool
Kindergarten	Elementary	None

HOUSEHOLD COMPOSITION

1. What is your relationship to this child? (*Please check which applies to you*:)

☐	Birth mother	☐	Birth father
☐	Step mother	☐	Step father
☐	Adoptive mother	☐	Adoptive father
☐	Legal Guardian, Caregiver, Other: If related, please indicate the relationship: (e.g., grandmother, uncle, sibling)		

2. What is your current Marital Status: (*Please mark ONLY One*)

☐	Married	☐	Widowed
☐	Divorced	☐	Single and NOT living with boyfriend, girlfriend, partner
☐	Separated	☐	Single and living with boyfriend, girlfriend, partner
☐	Other	If Other is checked, please describe:	

3. Who currently lives in the child's household and how are they related to your child? (*Mark ALL that apply*)

Relationship to your child	How Many?	Relationship to your child	How Many?	Relationship to your child	How Many?
Mother		Grandmother		Cousin	
Father		Grandfather		Friend	
Brother		Aunt			
Sister		Uncle			
Other, please specify:					

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

HOUSEHOLD COMPOSITION (CONTINUED)

4. Please tell us about other children (for example; siblings, cousins, friends) who live with your child on a regular basis?

	Please, specify below whether the child is a boy or a girl and the age of the child.		
	Boy	Girl	Age
Child 1	☐	☐	
Child 2	☐	☐	
Child 3	☐	☐	
Child 4	☐	☐	
Child 5	☐	☐	
Child 6	☐	☐	
Child 7	☐	☐	
Child 8	☐	☐	
Child 9	☐	☐	
Child 10	☐	☐	

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ __ MM DD YEAR **Checked by:** _____

HOUSEHOLD INFORMATION (OTHER)

5. What is the highest grade or year of school you completed?

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 up to 8 (Elementary to middle school)
- ☐ Grades 9 up to 11 (Some high school)
- ☐ Grade 12 or GED (High school graduate)
- ☐ College or technical school 1 year to 3 years
- ☐ College 4 years or more (College graduate)

6. Your current employment status? (*Please select all that apply.*)

- ☐ Employed for wages/salary (full-time/part-time/seasonal)
- ☐ Self-employed
- ☐ Out of work for more than 1 year
- ☐ Out of work for less than 1 year
- ☐ A Homemaker
- ☐ A Student
- ☐ Retired
- ☐ Unable to work

7. Do you currently have more than one job at this time?

- ☐ Yes
- ☐ No

8. Based on everyone that lives under one roof or house, what is the annual household income from all sources over the past 12 months?

- ☐ Under $10,000
- ☐ From $10,000 to less than $20,000
- ☐ From $20,000 to less than $35,000
- ☐ From $35,000 to less than $60,000
- ☐ From $60,000 to less than $75,000
- ☐ $75,000 or more
- ☐ No Response

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

CHILD INFORMATION

1.	**Do you consider your child to be of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish cultural heritage?**		
☐	Yes	☐	No

Which category(s) below best describes your child?

2. You may check (✓) <u>more than one box</u>.

☐ **Black or African American-** A person having origins of any of the original peoples of Africa.

☐ **White** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **American Indian or Alaska Native -** A person having origin in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.

Please specify the one(s) you most identify with (*check all that apply*):

☐ Athabascan	☐ Siberian
☐ Cup'ik	☐ Yup'ik
☐ Inupiaq	☐ Other *(please describe)*_____

☐ **Asian**

Please specify the one(s) you most identify with (*check all that apply*):

☐ Cambodian	☐ Japanese	☐ Pakistani
☐ Chinese	☐ Korean	☐ Thai
☐ Filipino	☐ Malaysian	☐ Vietnamese
☐ Indian	☐ Other *(please describe)* _____	

☐ **Native Hawaiian or other Pacific Islander:**

Please specify the one(s) you most identify with: (*check all that apply*):

☐ Chamorro	☐ Kosraean	☐ Pohnpeian	☐ Tokelaun
☐ Carolinian	☐ Marshallese	☐ Samoan	☐ Tahitian
☐ Chuukese	☐ Native Hawaiian	☐ Tongan	☐ Yapese
☐ Kiribati	☐ Palauan	☐ Other *(please describe)* _____	

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

CHILD INFORMATION (CONTINUED)

3.	**What language(s) does your child speak?** _____
4.	**What language does your child most often speak at home?** _____
5.	**In what city or country was your child born?** _____
6.	**How many years has your child lived here?** **(*Enter the number of years in the space provided*)** _____

EARLY LIFE OF YOUR CHILD

1. Child's Birth Weight: _____ lb. and _____ oz. **OR** ___ . __ kilograms ☐ Unknown

2. Child's Birth Length: _____ inches **OR** ____ . __ cm ☐ Unknown

3. Was your child ever breastfed or fed breastmilk?

☐ Yes ☐ No (skip to question 4) ☐ Unknown ☐ Other *(please describe)* _____

If yes, how old was your child when he/she completely stopped breastfeeding or being fed breastmilk?

_____ Months of age ☐ Still Breastfeeding ☐ Unknown

4. Was your child ever fed formula?

☐ Yes ☐ No (skip to question 5) ☐ Unknown ☐ Other (please describe) _____

If yes, how old was the child when he/she was first fed formula?

_____ Months of age ☐ Since Birth ☐ Unknown

If your child was fed formula, how old was your child when he/she completely stopped drinking formula?

_____ Months of age ☐ Still Formula fed ☐ Unknown

5. How old was the child when he/she was first fed anything other than breast milk or formula?

(This includes juice, cow's milk, sugar water, baby food, or anything else that the child might have been given, even water)

_____ Months of age ☐ Unknown

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

OTHER INFORMATION

FOOD SECURITY/AVAILABILITY

1. In the past 12 months, how often does your money for food run out before the end of the month?

☐ Never ☐ Seldom ☐ Sometimes ☐ Most times ☐ Always ☐ Don't know ☐ No Response

2. In the past 12 months, how often does your money for household utilities (e.g., water, fuel oil, electricity) run out before the end of the month? (*Please check which applies to you.*)

☐ Never ☐ Seldom ☐ Sometimes ☐ Most times ☐ Always ☐ Don't know ☐ No Response

3. In the past 12 months, do you receive assistance to pay for food (e.g., food stamps, WIC coupons)?

☐ Yes ☐ No ☐ No Response

4. If yes, which benefits does this household receive? (*Check all that apply*)

☐ EBT/ SNAP/ NAP (formerly called Food Stamps) ☐ Food Assistance (Food Bank/Food Pantries or Commodity foods) ☐ WIC benefits ☐ Free or reduced-cost breakfasts or lunches at school ☐ Don't know ☐ Not applicable

Approved by UH IRB 10-25-2012

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

MEDICAL

1. How many hours of sleep on average does your child get in a 24-hour period (at night and in naps)? (*Please choose one*, ☑; h= hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7h	7.5h	8h	8.5h	9h.	9.5h	10h	10.5h	11h	11.5h	12h	12.5h	13h	>13h
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. Does your child have any current medical conditions diagnosed by a doctor?

☐ Yes ☐ No

If yes, please specify: _____

_____

3. Has a doctor or nurse ever told you that the child has asthma?

☐ Yes ☐ No ☐ Don't Know/Not Sure

RELIGION

1. What is <u>your</u> religious affiliation?

☐ Baptist
☐ Buddhist
☐ Catholic
☐ Episcopalian
☐ Evangelical Covenant
☐ Mormon/ Latter-day Saints
☐ Moravian
☐ Muslim
☐ Pentecostal
☐ Protestant
☐ Russian Orthodox
☐ Other *(please describe)* _____
☐ None
☐ No Response

2. How often do <u>you</u> engage in religious activities or events with your religious community?

☐ _____ per Week ☐ _____ per Month ☐ Do not attend ☐ No Response

Approved by UH IRB 10-25-2012

FORM 23-03	**Children's Healthy Living Program Culture**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

Below are questions about your attitude and beliefs on **your group's** culture and lifestyle. Please read each question carefully and circle the response that best describes you.

Your Group's Heritage and Lifestyle

1) How knowledgeable are you of **your group's** traditional culture and lifestyle?	Very Knowledgeable	Somewhat knowledgeable	Neutral or no response	Somewhat not knowledgeable	Not at all knowledgeable
2) How involved are you in **your group's** traditional culture and lifestyle?	Very involved	Somewhat involved	Neutral or no response	Somewhat not involved	Not at all involved
3) How do you feel toward **your group's** traditional culture and lifestyle?	Very positive	Somewhat positive	Neutral or no response	Somewhat negative	Very Negative
4) How often do you associate with people of **your group's** traditional culture and lifestyle?	Most of the time	Somewhat often	Neutral or no response	Very little of the time	Not at all

Below are questions about your attitude and beliefs on **U.S. Mainland** culture and lifestyle. Please read each question carefully and circle the response that best describes you.

U.S. Mainland Heritage and Lifestyle

1) How knowledgeable are you of **U.S. Mainland** culture and lifestyle?	Very Knowledgeable	Somewhat knowledgeable	Neutral or no response	Somewhat not knowledgeable	Not at all knowledgeable
2) How involved are you in **U.S. Mainland** culture and lifestyle?	Very involved	Somewhat involved	Neutral or no response	Somewhat not involved	Not at all involved
3) How do you feel toward the **U.S. Mainland** culture and lifestyle?	Very positive	Somewhat positive	Neutral or no response	Somewhat negative	Very Negative
4) How often do you associate with people of **U.S. Mainland** culture and lifestyle?	Most of the time	Somewhat often	Neutral or no response	Very little of the time	Not at all

Approved by UH IRB 10-19-2012

FORM 23-04	**Children's Healthy Living Program** **Lifestyle Behavior**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ___/___/20__ MM DD YEAR **Checked by:** _____

Please complete the following questions about your child.

Monday to Friday

1. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend watching television and/or videos/DVD? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend playing **INACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.)? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend playing **ACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.) that incorporate movement or exercise? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Saturday to Sunday

4. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend watching television and/or videos/DVD? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend playing **INACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.)? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend playing **ACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.) that incorporate movement or exercise? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

FORM 23-05	Children's Healthy Living Program Sleep Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ___/___/20__ MM DD YEAR Checked by: _____

Please complete the questions below in regard to your child's sleep behavior.

1.	**How long after going to bed does your child usually fall asleep?**
☐	0 to less than 15 minutes
☐	15 to less than 30 minutes
☐	30 to less than 45 minutes
☐	45 to less than 60 minutes
☐	More than 60 minutes
2.	**Your child goes to bed reluctantly, (hesitant, slowly, involuntary)…**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
3.	**The child has difficulty getting to sleep at night (and may require a parent to be present)**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
4.	**The child does not fall asleep in his or her own bed**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

FORM 23-05	**Children's Healthy Living Program** **Sleep Behavior**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ___/___/20__ MM DD YEAR **Checked by:** _____

5.	**The child wakes up two or more times in the night**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
6.	**After waking up in the night the child has difficulty falling asleep again by himself or herself**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
7.	**The child sleeps in the parent's bed at some time during the night**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
8.	**If the child wakes, he or she uses a comforter (e.g. pacifier or binky) and requires a parent to replace it**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

FORM 23-05	**Children's Healthy Living Program** **Sleep Behavior**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ___/___/20__ MM DD YEAR **Checked by:** _____

9.	**The child wants a drink during the night (including breast or bottle-feed)**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

10. Do you think your child has sleeping difficulties?

☐ Yes ☐ No

Please explain:

Questions above were modified from the Tayside Children's Sleep Questionnaire (McGreavy et al. *Child: Care, Health & Development* 31(5); 539–544, 2005).

FORM 59-01 – Time 3	**Children's Healthy Living Center of Excellence** **Anthropometric Measurements**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/_____/____ MM DD YEAR **Measured by:** _____ **Checked by:** _____

Instructions:
Record all measurements using a black/blue pen.
Each measurement must be taken 3 times for each child.
Two of the 3 measures must be within 0.2 units. If two of the three measures are not within 0.2 units or the measurement team is uncertain about any of the three measurements, take an additional measure and write the result in the comments section below the initial three measures.
Continue to take additional measures until there are two within 0.2 units and the measurement team is satisfied with the quality of the measures.

Measurement:	**1st Reading:**	**2nd Reading:**	**3rd Reading:**
Weight Scale # _____	☐☐☐.☐ kg **Comments:** _____	☐☐☐.☐ kg _____	☐☐☐.☐ kg _____
Height Stadiometer # _____	☐☐☐.☐ cm **Comments:** _____	☐☐☐.☐ cm _____	☐☐☐.☐ cm _____
Waist Circumference Tape # _____	☐☐☐.☐ cm **Comments:** _____	☐☐☐.☐ cm _____	☐☐☐.☐ cm _____

Child Refused: ☐ Weight ☐ Height ☐ Waist

Instructions: Rate and circle using a black/blue pen the severity of acanthosis nigricans on the back of the neck using the screening scale below.

Neck Severity Rating:	0	1	2	3	4
Comments:					

Acanthosis Nigricans Screening Scale

(Burke JP, Hale DE, Hazuda HP, Stern MP. 1999. A quantitative scale of acanthosis nigricans. Diabetes Care 22:1655–1659.)

Neck Severity Rating	Neck Severity	Description
0	Absent	Not detectable on close inspection.
1	Present	Clearly present on close visual inspection, not visible to the casual observer, extent not measurable
2	Mild	Limited to the base of the skull, does not extend to the lateral margins of the neck (usually <3 inches in breadth).
3	Moderate	Extending to the lateral margins of the neck (posterior border of the sternocleidomastoid) (usually 3-6 inches), should not be visible when the participant is viewed from the front.
4	Severe	Extending anteriorly (>6 inches), visible when the participant is viewed from the front.