1. Do you smoke?

☐No

☐Yes (→ cigarettes per day)

2. Does your child's father smoke?

☐No

☐Yes (→ cigarettes per day)

3. Does your child's father rear your child?

☐Often ☐Sometime

☐Rarely ☐Difficult to say

4. Do you devise a way to prevent your child from opening the bathroom door alone?

☐Yes ☐No ☐No applicable

5. How about your recent physical and mental condition?

☐Good ☐Fair ☐Neither good or bad

☐Moderate poor ☐Poor

6. Do you have time to spend with your child in a relaxed mood?

☐Yes ☐No ☐Difficult to say

7. Do you find difficult to raise your child?

☐Always ☐Sometime (→No.8)

☐No (→No.9)

8. When you find difficult to raise your child, do you have any measures to take?
(e.g.: know where to consult)

☐Yes ☐No

9. Do you have anyone who can support you to raise your child?
(Check all that applies)

☐Spouse ☐Parents (parents in low) ☐Neighbors

☐Friends ☐A family doctor ☐PHN in your region

☐Nursery ☐Telephone consultation

☐Internet ☐Others ☐None

10. Have you experienced any of the following at home in the past few months?

☐Discipline children too much
☐Hitting children emotionally
☐Leaving children at home without adult attendance
☐Not feeding children for a long time
☐Scolding children emotionally
☐Not applicable

11. Do you know that many children aged around 1 and a half to 2 try to point at them when they are interested?

☐Yes ☐No

12. Do you know “Child rearing support center” or ” Child rearing circle” in your region?

☐Yes ☐No

13. Do you intend to raise your child in the community where you are now?

☐Yes ☐If I had to choose, yes
☐If I had to choose, no ☐No

14. How about do you feel your financially?

☐Very stable ☐Stable
☐Average ☐Difficult ☐Rather difficult

15. What are you worrying about?
(Check all that applies)

☐Your child ☐Relationship with spouse
☐Relationship with parents (parents in low) ☐Friends of child rearing
☐Others ☐There is nothing

16. Has your child received DPT-IPV immunization 3 times for the first time in the 1 turm?
(Diphtheria/Pertussis/Tetanus/Polio)

☐Yes ☐No

17. Has your child received measles-rubella immunization?

☐Yes ☐No

18. Does your child speak any meaningful words? (e.g. mama,vroom-vroom )

☐Yes ☐No

19. Does your child imitate the gestures of the people around him/her?

☐Yes ☐No

20. When your child is interested in something, does your child try to communicate it by pointing?

☐Yes ☐No

21. Does your child turn around when you call child's name from behind?

☐Yes ☐No

22. Does your child use a baby bottle?

☐Yes ☐No

23. Do you have a set time for your child's meals and snacks?

☐Yes ☐No

24. What time does your child usually get up?

☐Before 5 AM ☐5 AM ☐6 AM ☐7 AM

☐8 AM ☐9 AM ☐10 AM ☐After 11 AM

25. What time does your child usually go to bed?

☐Before 6 PM ☐6 PM ☐7 PM ☐8 PM

☐9 PM ☐10 PM ☐11 PM

☐After 12 PM

26. Does your child often drink sweet beverages?

☐Yes ☐No

27. Has your child ever been to the hospital for an accident?

☐Yes ☐No

28. Do you have any concerns about your child's food allergy?

☐Yes ☐No

29. Do you brush your child's teeth daily?

☐Yes ☐No