

National Survey of Children's Health

0 to 5 year old children

A study by the U.S. Department of Health and Human Services to better understand the health issues being faced by children in the United States today.



Your household was chosen at random from all households in the U.S. to participate in this scientific study.

The results will provide vital information used to improve health services—information that is not available anywhere else. The results will help policymakers, researchers, and educators understand the health service needs of our diverse population as health situations throughout the country continue to change.

National Survey of Children's Health

Survey Instructions

Please mark your response with an "X" using blue or black ink, as in the examples below.

Example:

Right Way

98

Wrong Way

98

Example:

Other, specify:

Health Center

Start Here

A while back, you completed a survey that asked about the children living in your household. Thank you for taking the time to complete that survey.

We now have some follow up questions to ask about one of the children you provided information for in the earlier survey. In the cover letter that came with this questionnaire, you will find instructions on which child in your household we would like you to answer these questions for.

Thank you for taking the time to complete this survey.

A. Your Child's General Health

A1

In general, how would you describe your child's health?

- Excellent
- Very Good
- Good
- Fair
- Poor

A2

How would you describe the condition of your child's teeth?

- Excellent
- Very Good
- Good
- Fair
- Poor

A3

How well does each of these items describe your child?

	Definitely true	Somewhat true	Not true
a. Your child is affectionate and tender with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Your child bounces back quickly when things do not go his or her way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Your child shows interest and curiosity in learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your child smiles and laughs a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A4

During the past 12 months, has your child had difficulty with or experienced any of the following?

	Yes	No
a. Breathing or other respiratory problems (such as wheezing or shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>
b. Eating or swallowing because of a health condition	<input type="checkbox"/>	<input type="checkbox"/>
c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
d. Repeated or chronic physical pain, including headaches or other back or body pain	<input type="checkbox"/>	<input type="checkbox"/>
e. Using his or her hands	<input type="checkbox"/>	<input type="checkbox"/>
f. Coordination or moving around	<input type="checkbox"/>	<input type="checkbox"/>
g. Deafness or problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>
h. Blindness or problems with seeing, even when wearing glasses	<input type="checkbox"/>	<input type="checkbox"/>
i. Toothaches	<input type="checkbox"/>	<input type="checkbox"/>
j. Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
k. Decayed teeth or cavities	<input type="checkbox"/>	<input type="checkbox"/>

Chronic Conditions

Has a **doctor** or **other health care provider** ever told you that your child has...

A5

Allergies (including food, drug, insect, or other)?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A6

Arthritis?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A7

Asthma?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A8

Blood Disorders (such as sickle cell disease, thalassemia, or hemophilia)?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A9

Brain injury, concussion or head injury?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A10

Cerebral Palsy?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A11

Cystic Fibrosis?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A12

Diabetes?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A13

Down Syndrome?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A14

Epilepsy or seizure disorder?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A15

Genetic or inherited condition?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A16

Heart Condition?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A17

Frequent or severe headaches, including migraine?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A18

Tourette Syndrome?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

Emotional, Behavioral, and Developmental Conditions/Problems

Has a doctor or other health care provider ever told you that your child has...

A19

Anxiety Problems?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A20

Depression?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A21

Behavioral or Conduct Problems?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A22

Developmental Delay?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A23

Intellectual Disability (also known as Mental Retardation)?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A24

Speech or other language disorder?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A25

Learning Disability?

Yes No

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A26

Any Other Mental Health Condition?

Yes No

↳ If yes, please specify

Does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

A27

Has a doctor or other health care provider ever told you that your child had Autism or Autism Spectrum Disorder (ASD)? Please include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Yes No → [Skip to question A28]

↳ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

↳ How old was your child when a doctor or other health care provider first told you that he or she had Autism, ASD or PDD?

Years Don't know

↳ What type of doctor or other health care provider was the first to tell you that your child had Autism, ASD or PDD? Please check only one

- Primary Care Provider
- Specialist
- School Psychologist/Counselor
- Other Psychologist (Non-School)
- Psychiatrist
- Other, please specify:

↳ Is your child currently taking medication for Autism, ASD or PDD?

Yes No

↳ At any time during the past 12 months, did your child receive behavioral treatment for Autism, ASD or PDD, such as training or an intervention that you or your child received to help with his/her behavior?

Yes No

A28

Has a doctor or other health care provider ever told you that your child had Attention Deficit Disorder or Attention-Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes No

→ If yes, does the child currently have the condition?

Yes No

↳ If yes, would you describe it as mild, moderate, or severe?

Mild Moderate Severe

→ Is your child currently taking medication for ADD or ADHD?

Yes No

→ At any time during the past 12 months, did your child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or your child received to help with his/her behavior?

Yes No

A29

Please answer the following question only if you answered YES to any of the health conditions or problems listed in A1 through A28. Otherwise, skip to the next section.

During the past 12 months, how often have your child's health conditions or problems affected his or her ability to do things other children his/her age do?

Never → [Skip to Section B]

Sometimes

Usually

Always

→ To what extent do your child's health conditions or problems affect his/her ability to do things?

A great deal

Some

Very little

B. Infant Health

B1

Was your child born more than 3 weeks before his or her due date?

Yes No

B2

How much did he or she weigh when born?

Please provide your best estimate.

pounds ounces

OR

kilograms grams

B3

Was your child ever breastfed or fed breast milk?

Yes No

→ How old was your child when he or she completely stopped breastfeeding or being fed breast milk?

Month(s) Check this box if child is still breastfeeding

→ How old was your child when he or she was first fed formula?

Month(s) Check this box if child has never been fed formula

B4

How old was your child when he or she was first fed anything other than breast milk or formula?

Please include juice, cow's milk, sugar water, baby food, or anything else that your child might have been given, even water.

Month(s) Check this box if child has never been fed anything other than breast milk or formula

C. Health Care Services

C1

During the past 12 months, did your child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

Yes No → [Skip to Question C4]

C2

During the past 12 months, how many times did your child visit a doctor, nurse, or other health care professional to receive a preventive check-up? A preventive check-up is when your child was not sick or injured, such as an annual or sports physical, or well-child visit.

0 visits → [Skip to Question C4]
 1 visit
 2 or more visits

C3

Thinking about the last time you took your child for a preventive check-up, about how long was the doctor or healthcare provider who examined your child in the room with you? Your best estimate is fine.

Less than 10 minutes
 10-20 minutes
 More than 20 minutes

C4

What is your child's current height?

feet inches

OR

meters centimeters

C5

How much does your child currently weigh?

pounds ounces

OR

kilograms grams

C6

Are you concerned about your child's weight?

Yes, too high
 Yes, too low
 No, I am not concerned

C7

During the past 12 months, did your child's doctors or other health care providers ask if you have concerns about your child's learning, development, or behavior?

Yes No

C8

Answer C8 if your child is 9 months of age or older. Otherwise go to Question C9.

Sometimes a child's doctor or other health care provider will ask a parent to fill out a questionnaire at home or during their child's visit.

During the past 12 months, or since your child's birth, did a doctor or other health care provider have you fill out a questionnaire about specific concerns or observations you may have about your child's development, communication, or social behaviors?

Yes No

→ If your child is 9-23 Months:

↳ Did the questionnaire ask about your concerns or observations about: Check all that apply.

How your child talks or makes speech sounds?
 How your child interacts with you and others?

→ If your child is 2-5 Years:

↳ Did the questionnaire ask about your concerns or observations about: Check all that apply.

Words and phrases your child uses and understands?
 How your child behaves and gets along with you and others?

C9

Is there a place that your child usually goes when he or she is sick or you need advice about his or her health?

Yes No → [Skip to Question C11]

↳ Where does your child usually go? Please check one box below

Doctor's Office
 Hospital Emergency Department
 Hospital Outpatient Department
 Clinic or Health Center
 Retail Store Clinic or "Minute Clinic"
 School (Nurse's Office, Athletic Trainer's Office)
 Some other place

C10

Is there a place that your child usually goes when he or she needs routine preventive care, such as a physical examination or well-child check-up?

Yes No → [Skip to Question C11]

↳ Is that the same place where your child goes when he or she is sick?

Yes No

C11

Please answer C11 if your child is 6 months of age or older. Otherwise, please skip to Question C12.

During the past 12 months, did your child see a dentist or other oral health care provider for any kind of dental care?

- Yes
- No → [Skip to Question C12]

During the past 12 months, how many times did your child visit a dentist or other oral health care provider for preventive dental care, such as check-ups and dental cleanings?

- 1 visit
- 2 or more visits
- No preventive visits in past 12 months → [Skip to Question C12]

During the past 12 months, what preventive dental services did your child receive? Check all that apply.

- Checkup
- Cleaning
- Instruction on tooth brushing and oral health care
- X-Rays
- Fluoride treatment
- Sealant (plastic coatings on back teeth)
- Don't know

C12

During the past 12 months, has your child received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

- Yes
- No, but my child needed to see a mental health professional
- No. My child did not need to see a mental health professional. → [Skip to Question C13]

How much of a problem was it to get the mental health treatment or counseling that your child needed?

- Big problem
- Small problem
- Not a problem

C13

During the past 12 months, has your child taken any medication because of difficulties with his or her emotions, concentration, or behavior?

- Yes
- No

C14

During the past 12 months, did your child see a specialist other than a mental health professional?

Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.

- Yes
- No, but my child needed to see a specialist
- No. My child did not need to see a specialist. → [Skip to Question C15]

How much of a problem was it to get the specialist care that your child needed?

- Big problem
- Small problem
- Not a problem

C15

During the past 12 months, did your child use any type of alternative health care or treatment? Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.

- Yes
- No

C16

Sometimes people have difficulty getting health care when they need it. During the past 12 months, was there any time when your child needed health care but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.

- Yes
- No → [Skip to Question C18]

If yes, which type of care was not received. Check all that apply.

- Medical Care
- Dental Care
- Vision Care
- Hearing Care
- Mental Health Services
- Other, please specify:

C17

Were these difficulties in getting services for your child because:

	Yes	No
a. Your child was not eligible for the services?	<input type="checkbox"/>	<input type="checkbox"/>
b. The services your child needed were not available in your area?	<input type="checkbox"/>	<input type="checkbox"/>
c. There were problems getting an appointment when your child needed one?	<input type="checkbox"/>	<input type="checkbox"/>
d. There were problems with getting transportation or child care?	<input type="checkbox"/>	<input type="checkbox"/>
e. The (clinic/doctor's) office wasn't open when your child needed care?	<input type="checkbox"/>	<input type="checkbox"/>
f. There were issues related to cost?	<input type="checkbox"/>	<input type="checkbox"/>

C18 During the past 12 months, how often were you frustrated in your efforts to get services for your child?
 Never
 Sometimes
 Usually
 Always

C19 During the past 12 months, how many times did your child visit a hospital emergency department?
 1 visit
 2 or more visits
 No visits

C20 Does your child receive Special Educational Services? Children receiving these services often have an Individualized Family Service Plan or Individualized Education Plan.
 Yes No

C21 Has your child ever received therapy services to meet his/her developmental needs, such as occupational therapy, speech therapy, or behavioral therapy?
 Yes No → [Skip to Section D]
 → How old was your child when he/she began receiving these therapy services? Age in years
 Years
 → Is your child currently receiving these therapy services?
 Yes No

D. Experience with Your Child's Health Care Providers

D1 Does your child have a primary doctor or nurse? A primary doctor or nurse is the one your child would see if he or she needs a check-up or gets sick or hurt.
 Yes No

D2 During the past 12 months, did your child need a referral to see any doctors or receive any services?
 Yes No → [Skip to Question D3]
 ↳ Was getting referrals a big problem, a small problem, or not a problem?
 Big problem
 Small problem
 Not a problem

D3 Please answer the following questions only if your child had a health care visit in the past 12 months. Otherwise, skip to section E.

During the past 12 months, how often did your child's doctors or other health care providers:

	Never	Sometimes	Usually	Always
a. Spend enough time with your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Listen carefully to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Show sensitivity to your family's values and customs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Provide the specific information you needed concerning your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Help you feel like a partner in your child's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D4 During the past 12 months, were any decisions needed about your child's health care services or treatment, such as whether to start or stop a prescription or therapy services, get a referral to a specialist, or have a medical procedure?
 Yes
 No, no health care decisions were needed → [Skip to Section E]

D5 During the past 12 months, how often did your child's doctors or other healthcare providers:

	Never	Sometimes	Usually	Always
a. Discuss with you the range of options to consider for his or her health care or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Make it easy for you to raise concerns or disagree with recommendations for your child's health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Work with you to decide together which health care and treatment choices would be best for your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- D6** Does anyone help you arrange or coordinate your child's care among the different doctors or services that your child uses?
- Yes No
- Did not see more than one health care provider in past 12 months → [Skip to Question D9]
- D7** During the past 12 months, have you felt that you could have used extra help arranging or coordinating your child's care among the different health care providers or services?
- Yes No → [Skip to Question D8]
- ↳ During the past 12 months, how often did you get as much help as you wanted with arranging or coordinating your child's health care?
- Never
- Sometimes
- Usually
- Always

- D8** Overall, how satisfied are you with the communication among your child's doctors and other health care providers?
- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied
- D9** During the past 12 months, did your child's health care provider communicate with the child's school, child care provider, or special education program?
- Yes No → [Skip to Section E]
- ↳ Overall, how satisfied are you with that communication?
- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

E. Your Child's Health Insurance Coverage

- E1** During the past 12 months, was your child EVER covered by ANY kind of health insurance or health coverage plan?
- Yes, my child was covered all 12 months → [Skip to Question E3]
- Yes, *but* my child had a gap in coverage
- No
- E2** Please indicate whether any of the following is a reason your child was not covered by health insurance during the past 12 months:
- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Change in employer or employment status | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cancellation due to overdue premiums | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dropped coverage because it was unaffordable | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Dropped coverage because benefits were inadequate | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Dropped coverage because choice of health care providers was inadequate | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Problems with application or renewal process | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other, <i>please specify</i> : | <input type="checkbox"/> | <input type="checkbox"/> |
-

- E4** Is your child covered by any of the following types of health insurance or health coverage plans?
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Insurance through a current or former employer or union | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Insurance purchased directly from an insurance company | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability | <input type="checkbox"/> | <input type="checkbox"/> |
| d. TRICARE or other military health care | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Indian Health Service | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other, <i>please specify</i> : | <input type="checkbox"/> | <input type="checkbox"/> |
-

- E3** Is your child CURRENTLY covered by ANY kind of health insurance or health coverage plan?
- Yes No → [Skip to Section F]

- E5** How often does your child's health insurance offer benefits or cover services that meet your child's needs?
- Never
- Sometimes
- Usually
- Always
- E6** How often does your child's health insurance allow him/her to see the health care providers he/she needs?
- Never
- Sometimes
- Usually
- Always

E7

Not including health insurance premiums or costs that are covered by insurance, do you pay any money for your child's health care?

Yes No → [Skip to Question E8]

↳ How often are these costs reasonable?

- Never
- Sometimes
- Usually
- Always

E8

Please answer this question only if your child uses mental or behavioral health services. Otherwise, skip to section F. Thinking specifically about your child's mental or behavioral health needs, does your child's health insurance offer benefits or cover services that meet these needs?

- Yes, it sometimes covers these services
- Yes, it usually covers these services.
- Yes, it always covers these services.
- No, it never covers these services.

F. Providing for Your Child's Health

F1

How much money did you pay for this child's medical and health care during the past 12 months? Please do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- \$0 (No medical or health-related expenses) → [Skip to Question F3]
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5,000

F2

During the past 12 months, did your family have problems paying for any of your child's medical or health care bills?

- Yes
- No

F3

During the past 12 months, have you or other family members:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Stopped working because of your child's health status? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cut down on the hours you work because of your child's health or health conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Avoided changing jobs because of concerns about maintaining health insurance for your child? | <input type="checkbox"/> | <input type="checkbox"/> |

F4

In an average week, how many hours do you or other family members spend providing health care at home for your child? Care might include changing bandages, or giving medication and therapies when needed.

- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

F5

In an average week, how many hours do you or other family members spend arranging or coordinating health or medical care for your child, such as making appointments or locating services?

- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

G. School Readiness

Please answer Section G only if your child is age 4 or older. Otherwise, please skip to the next section.

G1 How concerned are you about your child's readiness to start school?

- A lot
- A little
- Not at all

G2 How concerned are you about how your child is learning to do things for him or herself?

- A lot
- A little
- Not at all

G3 Can your child recognize the beginning sound of a word? For example, can he/she tell you that the word "ball" starts with the "buh" sound?

- Yes
- No

G4 Can your child recognize the letters of the alphabet?

- All of the letters of the alphabet
- Most of them
- Some of them
- None of them

G5 Can your child clearly explain things he or she has seen or done so that you get a very good idea what happened?

- All of the time
- Most of the time
- Some of the time
- None of the time

G6 Can your child write his/her first name, even if some of the letters aren't quite right or are backwards?

- All of the time
- Most of the time
- Some of the time
- None of the time

G7 Can your child count to 20?

- All of the time
- Most of the time
- Some of the time
- None of the time

G8 Can your child recognize basic shapes [e.g., triangle, circle, square]?

- All of the time
- Most of the time
- Some of the time
- None of the time

G9 How often is your child easily distracted?

- Never
- Rarely
- Sometimes
- Usually
- Always

G10 How often does your child keep working at something until he/she is finished?

- Never
- Rarely
- Sometimes
- Usually
- Always

G11 When he or she is paying attention, how often is your child able to carry out a simple instruction?

- Never
- Rarely
- Sometimes
- Usually
- Always

G12 Can your child use a pencil or crayon?

- Never
- Rarely
- Sometimes
- Usually
- Always

G13 Does your child play well with others?

- Never
- Rarely
- Sometimes
- Usually
- Always

G14 Compared to other children his/her age, how much difficulty does your child have making or keeping friends?

- A lot of difficulty
- A little difficulty
- No difficulty

G15 Compared to other children his/her age, how often is your child unable to sit still?

- Never
- Rarely
- Sometimes
- Usually
- Always

G16 Does your child seem nervous or afraid?

- Yes
- No

G17 Does your child fight with other children?

- Yes
- No

H. About Your Child

H1

Was your child born in the United States?

Yes → [Skip to Question H2]

No

↳ How long has your child been in the United States?

Years

Months

H2

How many times has your child moved to a new address since he or she was born?

Number of times

H3

How often does your child go to bed at about the same time on weeknights?

- Never
- Rarely
- Sometimes
- Usually
- Always

H4

During the past week, how many hours of sleep did your child get on an average weeknight?

- Less than 6 hours
- 6-7 hours
- 8-9 hours
- 10 or more hours

H5

Please answer this question only if your child is less than 12 months old. Otherwise, please skip to Question H6. In which one position do you most often lay your baby down to sleep now? Check only one

- On his or her side
- On his or her back
- On his or her stomach

H6

On an average weekday, about how much time does your child usually spend in front of a TV watching TV programs, videos, or playing video games?

- None
- Less than 1 hour
- 1-2 hours
- 3-4 hours
- More than 4 hours

H7

On an average weekday, about how much time does your child usually spend with computers, cell phones, handheld video games, and other electronic devices, doing things other than schoolwork?

- None
- Less than 1 hour
- 1-2 hours
- 3-4 hours
- More than 4 hours

H8

During the past week, how many days did you or other family members read to your child?

- 0 days
- 1-3 days
- 4-6 days
- Every day

H9

During the past week, how many days did you or other family members tell stories or sing songs to your child?

- 0 days
- 1-3 days
- 4-6 days
- Every day

H10

In general, how well do you feel that you are coping with the day-to-day demands of raising children?

- Very well
- Somewhat well
- Not very well
- Not very well at all

H11

During the past month, how often have you felt:

Never Rarely Sometimes Usually Always

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. That your child is much harder to care for than most children his/her age? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. That your child does things that really bother you a lot? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Angry with your child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

H12 During the past 12 months, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?

Yes No → [Skip to Section I]

H13 If yes, did you receive emotional support from:

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Healthcare provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Family member or close friend? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Place of worship or religious leader? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Support or advocacy group related to specific health condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Peer support group? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Counselor or other mental health professional? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other, <i>please specify</i> : | <input type="checkbox"/> | <input type="checkbox"/> |

H14 Does your child receive care for at least 10 hours per week from someone other than his/her parent or guardian? This could be a day care center, preschool, Head Start program, family child care home, nanny, au pair, babysitter or relative.

Yes No

H15 During the past 12 months, did you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for your child?

Yes No

I. About Your Family and Household

11 During the past week, on how many days did all the family members who live in the household eat a meal together?

- 0 days
 1-3 days
 4-6 days
 Every day

12 Does anyone living in your household use cigarettes, cigars, or pipe tobacco?

Yes No

↳ Does anyone smoke inside your home?

- Yes
 No

13 When your family faces problems, how often are you likely to do each of the following?

- | | None of the time | Some of the time | Most of the time | All of the time |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Talk together about what to do | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Work together to solve our problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Know we have strengths to draw on | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Stay hopeful even in difficult times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14 Since your child was born, how often has it been very hard to get by on your family's income – hard to cover the basics like food or housing?

- Very often
 Somewhat often
 Rarely
 Never

15 The next question is about whether you were able to afford the food you need. Which of these statements best describes the food situation in your household in the last 12 months?

- We could always afford to eat good nutritious meals
 We could always afford enough to eat but not always the kinds of food we should eat
 Sometimes we could not afford enough to eat
 Often we could not afford enough to eat

16 At any time during the past 12 months, even for one month, did anyone in this household receive:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Cash assistance from a government welfare program? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Food Stamps or Supplemental Nutrition Assistance Program benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Free or reduced-cost breakfasts or lunches at school? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Benefits from the Women, Infants, and Children (WIC) Program? | <input type="checkbox"/> | <input type="checkbox"/> |

17

In your neighborhood, are there:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Sidewalks or walking paths? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A park or playground? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A recreation center, community center, or boys' and girls' club? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A library or bookmobile? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Litter or garbage on the street or sidewalk? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Poorly kept or rundown housing? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Vandalism such as broken windows or graffiti? | <input type="checkbox"/> | <input type="checkbox"/> |

18

To what extent do you agree with these statements about your neighborhood or community:

- | | Definitely agree | Somewhat agree | Somewhat disagree | Definitely disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. People in this neighborhood help each other out. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. We watch out for each other's children in this neighborhood. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My child is safe in our neighborhood. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. When we encounter difficulties, we know where to go for help in our community. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

19

Families must sometimes face hardships such as divorce or separation, the loss of a loved one, or drug and alcohol addiction. The next question asks about experiences and events that may have occurred during your child's life. We understand the sensitive nature of this question, so we ask that you answer to the best of your ability.

To the best of your knowledge, has your child ever experienced any of the following?

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Parent/guardian divorced or separated | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Parent/guardian died | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Parent/guardian served time in jail | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Saw or heard parents or adults slap, hit, kick, punch one another in the home | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Was a victim of violence or witnessed violence in neighborhood | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lived with anyone who was mentally ill, suicidal, or severely depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lived with anyone who had a problem with alcohol or drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Was ever discriminated against | <input type="checkbox"/> | <input type="checkbox"/> |

J. Adult Demographics

Please fill out a column for each of the two adults in the household who are the child's primary caregivers. If there is just one adult, please provide answer for that adult.

ADULT 1 (Respondent)

J1

How are you related to the selected child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Aunt or Uncle
- Other: Relative
- Other: Non-Relative

J2

What is your sex?

- Male
- Female

J3

What is your age?

(Print numbers in boxes)

J4

Where were you born?

- In the United States
- Outside of the United States

↳ **When did you come to the United States?**

YEAR (Print numbers in boxes)

J5

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

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but No Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

J6

What is your marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

J7

In general, what is your physical health status?

- Excellent
- Very Good
- Good
- Fair
- Poor

J8

In general, what is your mental or emotional health status?

- Excellent
- Very Good
- Good
- Fair
- Poor

ADULT 2

J9

How is Adult 2 related to the selected child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Aunt or Uncle
- Other: Relative
- Other: Non-Relative

J10

What is Adult 2's sex?

- Male
- Female

J11

What is Adult 2's age?

(Print numbers in boxes)

J12

Where was Adult 2 born?

- In the United States
- Outside of the United States

↳ **When did Adult 2 come to the United States?**

YEAR (Print numbers in boxes)

J13

What is the highest degree or level of school Adult 2 has completed?

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but No Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

J14

What is Adult 2's marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

J15

In general, what is Adult 2's physical health status?

- Excellent
- Very Good
- Good
- Fair
- Poor

J16

In general, what is Adult 2's mental or emotional health status?

- Excellent
- Very Good
- Good
- Fair
- Poor

J17

Was anyone in the household employed at least 50 weeks out of the past 52 weeks?

- Yes
- No

J18

The following question is about your income and is very important for our research. Think about your total combined family income during last year for all members of the family. Can you please tell us that amount before taxes?

Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from business, farm, or rent, and any other money income received.

\$

Don't know/Don't remember

→ For the purposes of this survey, it is important to get at least a range for the total income received by all members of your household last year. **To the best of your knowledge, please select the range that best applies to your household.**

- No income
- Less than \$20,000
- \$20,000 up to 29,999
- \$30,000 up to 49,999
- \$50,000 up to 69,999
- \$70,000 up to 99,999
- \$100,000 up to 124,999
- \$125,000 up to 149,999
- \$150,000 or more

J19

How many people are living or staying at this address?

Please include everyone who is living or staying here for more than two months. Include yourself if you are living here for more than two months. Include anyone else staying here how does not have another place to stay, even if they are here for two months or less. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

Mailing Instructions

Please place the completed questionnaire into the postage-paid return envelope. If the envelope has been misplaced, please mail the questionnaire to:

NORC at the University of Chicago
P.O. Box 123456, Chicago, IL

Thank you for your participation.

