0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
A. Your Child's General Health				
		To begin, we would like to ask you about your child's general health.		
1		In general, how would you describe your child's health?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
2		How would you describe the condition of your child's teeth?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
3		How well does each of these items describe your child?		
			Definitely true	
			Somewhat true	
			Not true	
	3a	Your child is affectionate and tender with you		
	3b	Your child bounces back quickly when things do not go his or her way		
	3c	Your child shows interest and curiosity in learning new things		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	3d	Your child smiles and laughs a lot		
4		During the past 12 months, has your child had difficulty with or experienced any of the following?		
			Yes	
			No	
	4a	Breathing or other respiratory problems (such as wheezing or shortness of breath)		
	4b	Eating or swallowing because of a health condition		
	4c	Digesting food, including stomach/intestinal problems, constipation, or diarrhea		
	4d	Repeated or chronic physical pain, including headaches or other back or body pain		
	4e	Using his or her hands		
	4f	Coordination or moving around		
	4g	Deafness or problems with hearing		
	4h	Blindness or problems with seeing, even when wearing glasses		
	4i	Toothaches		
	4j	Bleeding gums		
	4k	Decayed teeth or cavities		
5		Chronic Conditions		
		Has a doctor or other health care provider ever told you that your child has…		
	5a1	**Allergies (including food, drug, insect, or other)?**		If Yes, skip to next sub question. Else, skip to next condition.

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Yes	
			No	
	5a2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5a3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5b1	**Arthritis?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5b2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5b3	**If yes**, would you describe it as mild, moderate, or severe?		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Mild	
			Moderate	
			Severe	
	5c1	**Asthma?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5c2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5c3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5d1	**Blood Disorders (such as sickle cell disease, thalassemia, or hemophilia)?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	5d2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5d3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5e1	**Brain injury, concussion or head injury?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5e2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5e3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
	5f1	**Cerebral Palsy?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5f2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5f3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5g1	**Cystic Fibrosis?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	5g2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5g3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5h1	**Diabetes?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5h2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5h3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
	5i1	**Down Syndrome?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5i2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5i3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5j1	**Epilepsy or seizure disorder?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	5j2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5j3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5k1	**Genetic or inherited condition?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5k2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5k3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
	5l1	**Heart condition?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5l2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5l3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5m1	**Frequent or severe headaches, including migraine?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	5m2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	5m3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	5n1	**Tourette Syndrome?**		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	5n2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	5n3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
6		Emotional, Behavioral, and Developmental Conditions/Problems		
		Has a doctor or other health care provider ever told you that your child has…		
	6a1	**Anxiety Problems?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6a2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6a3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6b1	**Depression?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			No	
	6b2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6b3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6c1	**Behavioral or Conduct Problems?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6c2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6c3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Moderate	
			Severe	
	6d1	**Developmental Delay?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6d2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6d3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6e1	**Intellectual Disability (also known as Mental Retardation)?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	6e2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6e3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6f1	**Speech or other language disorder?**		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6f2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6f3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
	6g1	**Learning Disability?**		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	6g2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	6g3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6h1	**Any Other Mental Health Condition? If yes**, please specify.		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	6h2	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6h3	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
7	7a	**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))?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	7b	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to subpart c.
			Yes	
			No	
	7b1	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	7c	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?		
			[AGE]	
			Don't Know	
	7d	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, Specify	
			Don't Know	
	7e	Is your child currently taking medication for Autism, ASD or PDD?		
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	7f	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	
8	8a	**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?**		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	8b	**If yes**, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to subpart c.
			Yes	
			No	
	8b1	**If yes**, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	8b2	Is your child currently taking medication for ADD or ADHD?		
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	8c	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?		
		Please answer the following questions only if your child currently has any health conditions or problems. Otherwise, skip to Section B (Infant Health).		
	9	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?		If Never, skip to next section. Else, skip to Q10.
			Never	
			Sometimes	
			Usually	
			Always	
	10	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				
1		Was your child born more than 3 weeks before his or her due date?		
			Yes	
			No	
2		How much did he or she weigh when born? **Please provide your best estimate**.		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			[POUNDS]	
			[OUNCES]	
			[GRAMS]	
3		Was your child ever breastfed or fed breast milk?		If YES, skip to next subquestion. Else, skip to subpart b.
			Yes	
			No	
	3a	How old was your child when he or she completely stopped breastfeeding or being fed breast milk?		
			[AGE IN MONTHS]	
			Child is still breastfeeding	
	3b	How old was your child when he or she was first fed formula?		
			[AGE IN MONTHS]	
			Child has never been fed formula	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	3c	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.		
			[AGE IN MONTHS]	
			Child has never been fed anything other than breast milk or formula	
C. Health Care Services				
		Next, we would like to ask you about your child's use of health care and services.		
1		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 Q4.

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
2		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 Q4.
			1 visit	
			2 or more visits	
4		What is your child's current height?		
			[FEET]	
			[INCHES]	
			[METERS]	
			[CENTIMETERS]	
5		How much does your child currently weigh?		
			[POUNDS]	
			[OUNCES]	
			[KILOGRAMS]	
			[GRAMS]	
		Please answer the following question if your child is age 9 months or older. Otherwise, please skip to Question 9.		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
8		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	Skip to Q9
9		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, there is a usual place	
			No, there is no usual place	Skip to Q10
	9a	Where does your child usually go? Please check <u>one</u> box below:		
			Doctor's Office	
			Hospital Emergency Department	
			Hospital Outpatient Department	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Clinic or Health Center	
			Retail Store Clinic or "Minute Clinic"	
			School (Nurse's Office, Athletic Trainer's Office)	
			Some other place	
10		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 Q11.
	10a	Is that the same place where your child goes when he or she is sick?		
			Yes	
			No	
		Please answer the following questions if your child is 6 months of age or older. Otherwise, please skip to Question 12.		
11		During the past 12 months, did your child see a dentist or other oral health care provider for *any kind* of dental care?		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Yes	
			No	Skip to Q12.
12		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 Q13.
	12a	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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
16		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 Q18.
20		Does your child receive Special Educational Services? Children receiving these services often have an Individualized Family Service Plan or Individualized Education Plan.		
			Yes	
			No	
21		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 next section.
	21a	How old was your child when he/she began receiving these therapy services?		
			[YEARS OF AGE]	
			Don't Know	
D. Experience with Your Child's Health Care Providers				

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
		Next we would like to ask you about your child's health care providers and experiences with receiving health care services.		
1		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	
2		During the past 12 months, did your child need a referral to see any doctors or receive any services?		
			Yes	
			No	Skip to Q3.
	2a	Was getting referrals a big problem, a small problem, or not a problem?		
			Big problem	
			Small problem	
			Not a problem	
		Please answer the following questions only if your child had a health care visit in the past 12 months. Otherwise, skip to Section E (Your Child's Health Insurance Coverage).		
3		During the past 12 months, how often did your child's doctors or other health care providers:		
			Never	
			Sometimes	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Usually	
			Always	
	3a	Spend enough time with your child?		
	3b	Listen carefully to you?		
	3c	Show sensitivity to your family's values and customs?		
	3d	Provide the specific information you needed concerning your child?		
	3e	Help you feel like a partner in your child's care?		
6		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 Q8.
	6a	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 Q7.

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	6b	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	
7		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	
8		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 next section.
	8a	Overall, how satisfied are you with that communication?		
			Very satisfied	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Somewhat satisfied	
			Somewhat dissatisfied	
			Very dissatisfied	
E. Your Child's Health Insurance Coverage				
1		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 Q3.
			Yes, *but* my child had a gap in coverage	
			No	
2		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	
	2a	Change in employer or employment status		
	2b	Cancellation due to overdue premiums		
	2c	Dropped coverage because it was unaffordable		
	2d	Dropped coverage because benefits were inadequate		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
	2e	Dropped coverage because choice of health care providers was inadequate		
	2f	Problems with application or renewal process		
	2g	Other (specify)_____		
3		Is your child CURRENTLY covered by ANY kind of health insurance or health coverage plan?		
			Yes	
			No	Skip to next section.
4		Is your child covered by any of the following types of health insurance or health coverage plans?		
			Yes	
			No	
		Insurance through a current or former employer or union		
		Insurance purchased directly from an insurance company		
		Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability		
		TRICARE or other military health care		
		Indian Health Service		
		Other (specify) _____		
5		How often does your child's health insurance offer benefits or cover services that meet your child's needs?		
			Never	
			Sometimes	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Usually	
			Always	
6		How often does your child's health insurance allow him/her to see the health care providers he/she needs?		
			Never	
			Sometimes	
			Usually	
			Always	
7		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 Q8.
	7a	How often are these costs reasonable?		
			Never	
			Sometimes	
			Usually	
			Always	
		Please answer the next question only if your child uses mental or behavioral health services. Otherwise, skip to Section F (Providing for your child's health).		
8		Finally, 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?		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			No, it never covers these services	
			Yes, it sometimes covers these services	
			Yes, it usually covers these services	
			Yes, it always covers these services	
F. Providing for Your Child's Health				
		Now we would like to ask you if your child's health has any impact on your family.		
1		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 Q3.
			$1-$249	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			$250-$499	
			$500-$999	
			$1,000-$5,000	
			More than $5,000	
2		During the past 12 months, did your family have problems paying for any of your child's medical or health care bills?		
			Yes	
			No	
G. School Readiness				
		This next set of questions asks about your child's readiness to start school. **Please answer these questions only <u>if your child is age 4 or older</u>. Otherwise, please skip to Section H (About your child).**		
1		How concerned are you about your child's readiness to start school?		
			A lot	
			A little	
			Not at all	
2		How concerned are you about how your child is learning to do things for him or herself?		
			A lot	
			A little	
			Not at all	
3		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?		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Yes	
			No	
4		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	
5		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	
6		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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Some of the time	
			None of the time	
7		Can your child count to 20?		
			All of the time	
			Most of the time	
			Some of the time	
			None of the time	
8		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	
9		How often is your child easily distracted?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
10		How often does your child keep working at something until he/she is finished?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
11		When he or she is paying attention, how often is your child able to carry out a simple instruction?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
12		Can your child use a pencil or crayon?		
			Very well	
			Somewhat	
			Poorly	
			Not at all	
13		Does your child play well with others?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
14		Compared to other children his/her age, how much difficulty does your child have making or keeping friends?		

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			A lot of difficulty	
			A little difficulty	
			No difficulty	
15		Compared to other children his/her age, how often is your child unable to sit still?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
16		Does your child seem nervous or afraid?		
			Yes	
			No	
17		Does your child fight with other children?		
			Yes	
			No	
H. About Your Child				
1		Was your child born in the United States?		
			Yes	Skip to Q2.
			No	
	1a	How long has your child been in the United States?		
			[YEARS]	
			[MONTHS]	
2		How many times has your child moved to a new address since he or she was born?		
			[NUMBER OF TIMES]	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
		We would now like to ask some questions about your child's sleeping behaviors.		
3		How often does your child go to bed at about the same time on weeknights?		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
4		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	
		Please answer the next question only if your child is less than 12 months old. Otherwise, please skip to Question 6.		
5		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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
8		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	
16		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				
1		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	
2		Does anyone living in your household use cigarettes, cigars, or pipe tobacco?		
			Yes	
			No	Skip to Q3.
	2a	Does anyone smoke inside your home?		
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
5		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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
6		At any time during the past 12 months, even for one month, did anyone in this household receive:		
			Yes	
			No	
	6a	Cash assistance from a government welfare program?		
	6b	Food Stamps or Supplemental Nutrition Assistance Program benefits?		
	6c	Free or reduced-cost breakfasts or lunches at school?		
	6d	Benefits from the Women, Infants, and Children (WIC) Program?		
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)		
1		How are you related to the selected child?		
			Biological or Adoptive Parent	
			Step-parent	
			Grandparent	
			Foster Parent	
			Aunt or Uncle	
			Other: Relative	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Other: Non-Relative	
2		What is your sex?		
			Male	
			Female	
3		What is your age?		
			[AGE IN YEARS]	
4		Where were you born?		
			In the United States	Go to Q5.
			Outside of the United States	
	4a	When did you come to the United States?		
			[YEAR]	
5		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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			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)	
6		What is your marital status?		
			Married	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Not married, but living with a partner	
			Never Married	
			Divorced	
			Separated	
			Widowed	
7		In general, what is your physical health status?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
8		In general, what is your mental or emotional health status?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
		ADULT 2		
1		How is Adult 2 related to the selected child?		
			Biological or Adoptive Parent	
			Step-parent	
			Grandparent	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			Foster Parent	
			Aunt or Uncle	
			Other: Relative	
			Other: Non-Relative	
2		What is Adult 2's sex?		
			Male	
			Female	
3		What is Adult 2's age?		
			[AGE IN YEARS]	
4		Where was Adult 2 born?		
			In the United States	Go to Q5.
			Outside of the United States	
	4a	When did Adult 2 come to the United States?		
			[YEAR]	
5		What is the highest grade or year of school Adult 2 has completed?		
			8th grade or less	
			9th-12th grade; No diploma	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			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)	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
6		In general, what is Adult 2's physical health status?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
7		In general, what is Adult 2's mental or emotional health status?		
			Excellent	
			Very Good	
			Good	
			Fair	
			Poor	
1		Was anyone in the household employed at least 50 weeks out of the past 52 weeks?		
			Yes	
			No	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
2		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.		
			[INCOME AMOUNT]	
			Don't Know/Don't Remember	
3		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	

0-5 SHORT				
Section/Q#				
	Sub#	Question/Intro Text	Response Categories	Skip Instructions
			$20,000 - $29,999	
			$30,000 - $49,999	
			$50,000 - $69,999	
			$70,000 - $99,999	
			$100,000 - $124,999	
			$125,000 - $149,999	
			$150,000 or more	
4		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]	
END QUESTIONNAIRE				

Color	Code

	All age groups (0-5, 6-11, 12-17)
	0-5 Only
	6-11 Only
	12-17 Only
	Older age groups (6-11, 12-17)
	Not Applicable
RED	Test/Retest Item
GRAY	Item excluded from Short version