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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 has difficulty with feeling anxious or depressed		
	3b	Your child has difficulty with behavior problems, such as acting out, fighting, or arguing		

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	3c	Your child bullies or is cruel and mean to others		
	3d	Your child argues too much		
	3e	Your child is bullied, picked on, or excluded by other children		
	3f	Your child has difficulty making and keeping friends		
	3g	Your child shows interest and curiosity in learning new things		
	3h	Your child works to finish tasks he or she starts.		
	3i	Your child stays calm and in control when faced with a challenge		
	3j	Your child cares about doing well in school		
	3k	Your child does all required homework		
	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		

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		Concentrating, remembering, or making decisions because of a physical, mental or emotional condition		
		Walking or climbing stairs		
		Dressing or bathing		
	4h	Doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition		
	4i	Deafness or problems with hearing		
	4j	Blindness or problems with seeing, even when wearing glasses		
	4k	Toothaches		
	4l	Bleeding gums		
	4m	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.
			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	

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			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?		
			Mild	
			Moderate	
			Severe	
	5c1	Asthma?		If Yes, skip to next sub question. Else, skip to next condition.

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			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	
	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?		

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			Severe	
	5f1	Cerebral Palsy?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

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	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	
	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	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			Severe	
	5i1	Down Syndrome?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	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	
	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	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			Severe	
	5l1	Heart condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	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	
	5m1	Frequent or severe headaches, including migraine?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	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	

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Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			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	
			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	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			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	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			Moderate	
			Severe	
	6d1	Substance Abuse Disorder?		
			Yes	
			No	
	6d2	If yes, does the child currently have the condition?		
			Yes	
			No	
	6d3	If yes, would you describe it as mild, moderate, or severe?		

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Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			Mild	
			Moderate	
			Severe	
	6e1	Developmental Delay?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	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	Intellectual Disability (also known as Mental Retardation)?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	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	
			Severe	
	6g1	Speech or other language disorder?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6g2	If yes, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6g3	If yes, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			Severe	
	6h1	Learning Disability?		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	6h2	If yes, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next section.
			Yes	
			No	
	6h3	If yes, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
	6i1	Any Other Mental Health Condition? If yes, please specify.		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	

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Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
	6i2	If yes, does the child currently have the condition?		If Yes, skip to next sub question. Else, skip to next condition.
			Yes	
			No	
	6i3	If yes, would you describe it as mild, moderate, or severe?		
			Mild	
			Moderate	
			Severe	
7	7a	Has a <u>doctor</u> or <u>other health care provider</u> 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	

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Section/Q#		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 <u>first</u> 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	

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Section/Q#		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 <u>doctor or other health care provider</u> 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	

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	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.		

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Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			[POUNDS]	
			[OUNCES]	
			[GRAMS]	
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.
	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	
	3	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.		

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			Less than 10 minutes	
			10-20 minutes	
			More than 20 minutes	
	4	At his or her last preventive check-up, did your child have a chance to speak with a doctor or other health provider privately, without you or another adult in the room?		
			Yes	
			No	
	5	What is your child's current height?		
			[FEET]	
			[INCHES]	
			[METERS]	
			[CENTIMETERS]	
	6	How much does your child currently weigh?		
			[POUNDS]	
			[KILOGRAMS]	
	7	Are you concerned about your child's weight?		
			Yes, too high	
			Yes, too low	
			No, I am not concerned	
	7	Is there a place that your child usually goes when he or she is sick or you need advice about his or her health?		

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			Yes, there is a usual place	
			No, there is no usual place	Skip to Q8
	7a	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	

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	Sub #	Question/Intro Text	Response Categories	Skip Instructions
8		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 Q9.
	8a	Is that the same place where your child goes when he or she is sick?		
			Yes	
			No	
9		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 Q10.
	9a	During the past 12 months, how many times did your child see a dentist or other oral health care provider for preventive dental care, such as check-ups and dental cleanings?		
			No preventive visits in past 12 months	Skip to Q10.
			1 visit	
			2 or more visits	
	9b	During the past 12 months, did your child receive any of the following preventive dental services:		
			Checkup	

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			Cleaning	
			Instruction on tooth brushing and oral health care	
			X-Rays	
			Fluoride treatment	
			Sealant (plastic coatings on back teeth)	
			Don't Know	
	10	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	

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			No. My child did not need to see a mental health professional.	Skip to Q11.
	10a	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	
	12	During the past 12 months, has your child taken any medication because of difficulties with his or her emotions, concentration, or behavior?		
			Yes	
			No	
	11	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	

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			No, but my child needed to see a specialist	
			No. My child did not need to see a specialist.	Skip to Q12.
	11a	How much of a problem was it to get the specialist care that your child needed?		
			Big problem	
			Small problem	
			Not a problem	
	13	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	

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14		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 Q16.
	14a	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 (specify) _____ _____	
15		Were these difficulties in getting services for your child because:		
			Yes	
			No	
	15a	Your child was not eligible for the services?		
	15b	The services your child needed were not available in your area?		

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	15c	There were problems getting an appointment when your child needed one?		
	15d	There were problems with getting transportation or child care?		
	15e	The (clinic/doctor's) office wasn't open when your child needed care?		
	15f	There were issues related to cost?		
16		During the past 12 months, how often were you frustrated in your efforts to get services for your child?		
			Never	
			Sometimes	
			Usually	
			Always	
17		During the past 12 months, how many times did your child visit a hospital emergency department?		
			1 visit	
			2 or more visits	
			No visits	
18		Does your child receive Special Educational Services? Children receiving these services often have an Individualized Family Service Plan or Individualized Education Plan.		
			Yes	
			No	

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19		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.
19a		How old was your child when he/she began receiving these therapy services?		
			[YEARS OF AGE]	
			Don't Know	
19b		Is your child currently receiving these therapy services?		
			Yes	
			No	
D. Experience with Your Child's Health Care Providers				
		Next we would like to ask you about your child's health care providers and experiences with receiving health care services.		
		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	
		During the past 12 months, did your child need a referral to see any doctors or receive any services?		

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			Yes	
			No	Skip to Q3.
		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 Question 9.		
	3	During the past 12 months, how often did your child's doctors or other health care providers:		
			Never	
			Sometimes	
			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?		

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	4	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 next section.
	5	During the past 12 months, how often did your child's doctors or other healthcare providers:		
			Never	
			Sometimes	
			Usually	
			Always	
	5a	Discuss with you the range of options to consider for his or her health care or treatment?		
	5b	Make it easy for you to raise concerns or disagree with recommendations for your child's health care?		
	5c	Work with you to decide together which health care and treatment choices would be best for your child?		
	6	Does anyone help you arrange or coordinate your child's care among the different doctors or services that your child uses?		

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			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.
	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	

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			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	
			Somewhat satisfied	
			Somewhat dissatisfied	
			Very dissatisfied	
		The next questions are about preparing for your child's health care needs as he or she becomes an adult.		
	9	Do any of your child's doctors or other health care providers treat only children?		
			Yes	
			No	Skip to Q10.

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	9a	If yes, have they talked with you about having your child eventually see doctors or other health care providers who treat adults?		
			Yes	
			No	
10		Has your child's doctor or other health care provider actively worked with your child to:		
			Yes	
			No	
			Don't know	
	10a	Think about and plan for his/her future. For example, by taking time to discuss future plans about education, work, relationships, and development of independent living skills.		
	10b	Make positive choices about his/her health For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity.		
	10c	Gain skills to manage his/her health and health care. For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications he/she may need.		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	10d	Understand the changes in health care that happen at age 18. For example, by understanding changes in privacy, consent, access to information, or decision-making.		
	11	Has your child's doctors or other health care providers worked with you and your child to create a written plan to meet his/her health goals and needs?		
			Yes	
			No	Skip to Q12
	11a	Does this plan identify specific health goals for your child and any health needs or problems your child may have and how to get these needs met?		
			Yes	
			No	
	11b	Did you and your child receive a written copy of this plan of care?		
			Yes	
			No	
	11c	Is this plan currently up-to-date for your child?		
			Yes	
			No	
	12	Eligibility for health insurance often changes in young adulthood. Do you know how your child will be insured as he/she becomes an adult?		
			Yes	Skip to next section

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			No	
	12a	If no, has anyone discussed with you how to obtain or keep some type of health insurance coverage as your child becomes an adult?		
			Yes	
			No	
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, <i>but</i> 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		

12-17 LONG

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	

12-17 LONG

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?		

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
	Sub #			
			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	

12-17 LONG

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	
	3	During the past 12 months, have you or other family members:		
			Yes	
			No	
	3a	Stopped working because of your child's health status?		
	3b	Cut down on the hours you work because of your child's health or health conditions?		
	3c	Avoided changing jobs because of concerns about maintaining health insurance for your child?		
	4	In an average week, how many hours do you or other family members spend <u>providing health care at home</u> for your child? Care might include changing bandages, or giving medication and therapies when needed.		
			Less than 1 hour per week	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			1-4 hours per week	
			5-10 hours per week	
			11 or more hours per week	
	5	In an average week, how many hours do you or other family members spend <u>arranging or coordinating health or medical care</u> 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. Your Child's Schooling and Activities				
		This next set of questions asks about your child's schooling and extracurricular activities.		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	1	During the past 12 months, about how many days did your child miss school because of illness or injury?		
			No missed school days	
			1-3 days	
			4-6 days	
			7-10 days	
			11 or more days	
	2	During the past 12 months, how many times has your child's school contacted you or another adult in your household about any problems he/she is having with school?		
			No calls home	
			1 time	
			2 or more times	
	3	Since starting kindergarten, has your child repeated any grades?		
			Yes	
			No	
	4	During the past 12 months, did your child participate in:		
			Yes	
			No	
	4a	A sports team or did he/she take sports lessons after school or on weekends?		
	4b	Any clubs or organizations after school or on weekends?		
	4c	Any other organized activities or lessons, such as music, dance, language, or other arts?		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	4d	Any type of community service or volunteer work at school, church, or in the community?		
	4e	Any paid work, including regular jobs as well as babysitting, cutting grass, or other occasional work?		
	5	During the past 12 months, how often did you attend events or activities that your child participated in?		
			Never	
			Sometimes	
			Usually	
			Always	
	6	During the past week, on how many days did your child exercise, play a sport, or participate in physical activity for at least 60 minutes?		
			0 days	
			1-3 days	
			4-6 days	
			Every day	
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?		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			[NUMBER OF TIMES]	
		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	
	5	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 1hour	
			1-2 hours	
			3-4 hours	

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			More than 4 hours	
	6	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 1hour	
			1-2 hours	
			3-4 hours	
			More than 4 hours	
	7	How well can you and your child share ideas or talk about things that really matter?		
			Very well	
			Somewhat well	
			Not very well	
			Not very well at all	
	8	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	

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
9		During the past month, how often have you felt:		
			Never	
			Rarely	
			Sometimes	
			Usually	
			Always	
	9a	That your child is much harder to care for than most children his/her age?		
	9b	That your child does things that really bother you a lot?		
	9c	Angry with your child?		
10		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	Go to next section.
11		<i>If yes, did you receive this emotional support from:</i>		
			Yes	
			No	
	11a	Healthcare provider?		
	11b	Family member or close friend?		
	11c	Place of worship or religious leader?		
	11d	Support or advocacy group related to specific health condition?		
	11e	Peer support group?		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	11f	Counselor or other mental health professional?		
	11g	Other (specify)		
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.
	1a	Does anyone smoke inside your home?		
			Yes	
			No	
	3	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	
	3a	Talk together about what to do		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	3b	Work together to solve our problems		
	3c	Know we have strengths to draw on		
	3d	Stay hopeful even in difficult times		
4		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	
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	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			Sometimes we could not afford enough to eat	
			Often we could not afford enough to eat	
	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?		
	7	In your neighborhood, are there:		
			Yes	
			No	
	7a	Sidewalks or walking paths?		
	7b	A park or playground?		
	7c	A recreation center, community center, or boys' and girls' club?		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
	7d	A library or bookmobile?		
	7e	Litter or garbage on the street or sidewalk?		
	7f	Poorly kept or rundown housing?		
	7g	Vandalism such as broken windows or graffiti?		
	8	To what extent do you agree with these statements about your neighborhood or community:		
			Definitely agree	
			Somewhat agree	
			Somewhat disagree	
			Definitely disagree	
	8a	People in this neighborhood help each other out.		
	8b	We watch out for each other's children in this neighborhood.		
	8c	My child is safe in our neighborhood.		
	8d	When we encounter difficulties, we know where to go for help in our community.		
	8e	My child is safe at school.		
	9	Other than you or other adults in your home, is there at least one other adult in your child's school, neighborhood, or community who knows your child well and who he/she can rely on for advice or guidance?		
			Yes	

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			No	
		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.		
	10	To the best of your knowledge, has your child ever experienced any of the following?		
			Yes	
			No	
	10a	Parent/guardian divorced or separated		
	10b	Parent/guardian died		
	10c	Parent/guardian served time in jail		
	10d	Saw or heard parents or adults slap, hit, kick, punch one another in the home		
	10e	Was a victim of violence or witnessed violence in neighborhood		
	10f	Lived with anyone who was mentally ill, suicidal, or severely depressed		
	10g	Lived with anyone who had a problem with alcohol or drugs		
	10h	Was ever discriminated against		
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.		

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
		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	
			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?		

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			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)	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)	
	6	What is your marital status?		
			Married	
			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	

12-17 LONG

Section/Q#	Sub #	Question/Intro Text	Response Categories	Skip Instructions
			Poor	
		ADULT 2		
	1	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	
	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]	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
5	Sub #	Question/Intro Text		
		What is the highest grade or year 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)	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
			Master's Degree (MA, MS, MSW, MBA)	
			Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)	
	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	

12-17 LONG

Section/Q#		Question/Intro Text	Response Categories	Skip Instructions
2		<p>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?</p> <p>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.</p>		
			[INCOME AMOUNT]	
			Don't Know/Don't Remember	
3		<p>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.</p> <p>To the best of your knowledge, please select the range that best applies to your household.</p>		
			No income	
			Less than \$20,000	

12-17 LONG

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
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	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