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

Wrong Way

Example:

Other, specify:

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	☐	☐	☐
b. Your child bounces back quickly when things do not go his or her way	☐	☐	☐
c. Your child shows interest and curiosity in learning new things	☐	☐	☐
d. Your child smiles and laughs a lot	☐	☐	☐

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)	☐	☐
b. Eating or swallowing because of a health condition	☐	☐
c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea	☐	☐
d. Repeated or chronic physical pain, including headaches or other back or body pain	☐	☐
e. Using his or her hands	☐	☐
f. Coordination or moving around	☐	☐
g. Deafness or problems with hearing	☐	☐
h. Blindness or problems with seeing, even when wearing glasses	☐	☐
i. Toothaches	☐	☐
j. Bleeding gums	☐	☐
k. Decayed teeth or cavities	☐	☐

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 <u>9 months of age or older</u>. 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 <u>one</u> 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?	☐	☐
b. The services your child needed were not available in your area?	☐	☐
c. There were problems getting an appointment when your child needed one?	☐	☐
d. There were problems with getting transportation or child care?	☐	☐
e. The (clinic/doctor's) office wasn't open when your child needed care?	☐	☐
f. There were issues related to cost?	☐	☐

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?	☐	☐	☐	☐
b. Listen carefully to you?	☐	☐	☐	☐
c. Show sensitivity to your family's values and customs?	☐	☐	☐	☐
d. Provide the specific information you needed concerning your child?	☐	☐	☐	☐
e. Help you feel like a partner in your child's care?	☐	☐	☐	☐

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?	☐	☐	☐	☐
b. Make it easy for you to raise concerns or disagree with recommendations for your child's health care?	☐	☐	☐	☐
c. Work with you to decide together which health care and treatment choices would be best for your child?	☐	☐	☐	☐

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	☐	☐
b. Cancellation due to overdue premiums	☐	☐
c. Dropped coverage because it was unaffordable	☐	☐
d. Dropped coverage because benefits were inadequate	☐	☐
e. Dropped coverage because choice of health care providers was inadequate	☐	☐
f. Problems with application or renewal process	☐	☐
g. Other, *please specify:*	☐	☐

E3 **Is your child CURRENTLY covered by ANY kind of health insurance or health coverage plan?**

☐ Yes ☐ No → ***[Skip to Section F]***

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	☐	☐
b. Insurance purchased directly from an insurance company	☐	☐
c. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability	☐	☐
d. TRICARE or other military health care	☐	☐
e. Indian Health Service	☐	☐
f. Other, *please specify:*	☐	☐

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?	☐	☐
b. Cut down on the hours you work because of your child's health or health conditions?	☐	☐
c. Avoided changing jobs because of concerns about maintaining health insurance for your child?	☐	☐

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 <u>one</u>*

☐ 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
a. That your child is much harder to care for than most children his/her age?	☐	☐	☐	☐	☐
b. That your child does things that really bother you a lot?	☐	☐	☐	☐	☐
c. Angry with your child?	☐	☐	☐	☐	☐

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?	☐	☐
b. Family member or close friend?	☐	☐
c. Place of worship or religious leader?	☐	☐
d. Support or advocacy group related to specific health condition?	☐	☐
e. Peer support group?	☐	☐
f. Counselor or other mental health professional?	☐	☐
g. Other, *please specify:*	☐	☐

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

I1 **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

I2 **Does anyone living in your household use cigarettes, cigars, or pipe tobacco?**

☐ Yes ☐ No

→ **Does anyone smoke inside your home?**

☐ Yes
☐ No

I3 **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	☐	☐	☐	☐
b. Work together to solve our problems	☐	☐	☐	☐
c. Know we have strengths to draw on	☐	☐	☐	☐
d. Stay hopeful even in difficult times	☐	☐	☐	☐

I4 **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

I5 **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

I6 **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?	☐	☐
b. Food Stamps or Supplemental Nutrition Assistance Program benefits?	☐	☐
c. Free or reduced-cost breakfasts or lunches at school?	☐	☐
d. Benefits from the Women, Infants, and Children (WIC) Program?	☐	☐

I7 **In your neighborhood, are there:**

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

I8 **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.	☐	☐	☐	☐
b. We watch out for each other's children in this neighborhood.	☐	☐	☐	☐
c. My child is safe in our neighborhood.	☐	☐	☐	☐
d. When we encounter difficulties, we know where to go for help in our community.	☐	☐	☐	☐

I9 **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	☐	☐
b. Parent/guardian died	☐	☐
c. Parent/guardian served time in jail	☐	☐
d. Saw or heard parents or adults slap, hit, kick, punch one another in the home	☐	☐
e. Was a victim of violence or witnessed violence in neighborhood	☐	☐
f. Lived with anyone who was mentally ill, suicidal, or severely depressed	☐	☐
g. Lived with anyone who had a problem with alcohol or drugs	☐	☐
h 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.

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.