



# National Survey of Children's Health

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



The U.S. Census Bureau is conducting the National Survey of Children's Health on behalf of the U.S. Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. The data collected under this agreement are confidential under 13 U.S.C. Section 9. All access to Title 13 data from this survey is restricted to Census Bureau employees and those holding Census Bureau Special Sworn Status pursuant to 13 U.S.C. Section 23(c).

Any information you provide will be shared among a limited number of Census Bureau and HHS staff only for work-related purposes identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-T2**  
(04/13/2016)



## Start Here

Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

These questions will collect more detailed information on various aspects of this child's health including his or her health status, visits to health care providers, health care costs, and health insurance coverage.

We have selected only one child per household in an effort to minimize the amount of time necessary to complete the follow-up questions.

The survey should be completed by an adult who is familiar with this child's health and health care.

Your participation is important. Thank you.

## A. This Child's Health

**A1** In general, how would you describe this child's health (the one named above)?

- Excellent
- Very good
- Good
- Fair
- Poor

**A2** How would you describe the condition of this child's teeth?

- Excellent
- Very good
- Good
- Fair
- Poor

**A3** How well do each of the following phrases describe this child?

	Definitely true	Somewhat true	Not true
a. This child shows interest and curiosity in learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. This child works to finish tasks he or she starts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. This child stays calm and in control when faced with a challenge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. This child cares about doing well in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. This child does all required homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. This child is bullied, picked on, or excluded by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. This child bullies others, picks on them, or excludes them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. This child argues too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A4** DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

	Yes	No
a. Breathing or other respiratory problems (such as wheezing or shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>
b. Eating or swallowing because of a health condition	<input type="checkbox"/>	<input type="checkbox"/>
c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
d. Repeated or chronic physical pain, including headaches or other back or body pain	<input type="checkbox"/>	<input type="checkbox"/>
e. Toothaches	<input type="checkbox"/>	<input type="checkbox"/>
f. Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
g. Decayed teeth or cavities	<input type="checkbox"/>	<input type="checkbox"/>

**A5** Does this child have any of the following?

	Yes	No
a. Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition	<input type="checkbox"/>	<input type="checkbox"/>
b. Serious difficulty walking or climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty dressing or bathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Deafness or problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>
e. Blindness or problems with seeing, even when wearing glasses	<input type="checkbox"/>	<input type="checkbox"/>



**A6** Has a doctor or other health care provider EVER told you that this child has...

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

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A7** Arthritis?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A8** Asthma?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A9** Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A10** Brain Injury, Concussion or Head Injury?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

(Has a doctor or other health care provider EVER told you that this child has...)

**A11** Cerebral Palsy?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A12** Cystic Fibrosis?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A13** Diabetes?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A14** Down Syndrome?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A15** Epilepsy or Seizure Disorder?

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



(Has a doctor or other health care provider EVER told you that this child has...)

**A16 Heart Condition?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A17 Frequent or Severe Headaches, including Migraine?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A18 Tourette Syndrome?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A19 Anxiety Problems?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A20 Depression?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A21 Other Genetic or Inherited Condition?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A22 Has a doctor, other health care provider, or educator EVER told you that this child has...**

*Examples of educators are teachers and school nurses.*

**Behavioral or Conduct Problems?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A23 Substance Abuse Disorder?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A24 Developmental Delay?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A25 Intellectual Disability (also known as Mental Retardation)?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A26 Speech or Other Language Disorder?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A27 Learning Disability?**

Yes  No

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



**A28** Has a doctor or other health care provider EVER told you that this child has...

Any Other Mental Health Condition?

Yes  No

↳ If yes, specify:

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A29** Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Yes  No → **SKIP to question A34**

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A30** How old was this child when a doctor or other health care provider FIRST told you that he or she had Autism, ASD, Asperger's Disorder or PDD?

Age in years  Don't know

**A31** What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD? Mark ONE only.

Primary Care Provider

Specialist

School Psychologist/Counselor

Other Psychologist (Non-School)

Psychiatrist

Other, specify:

Don't know

**A32** Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes  No

**A33** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with his or her behavior?

Yes  No

**A34** Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes  No → **SKIP to question A37**

↳ If yes, does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A35** Is this child CURRENTLY taking medication for ADD or ADHD?

Yes  No

**A36** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with his or her behavior?

Yes  No

**A37** DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected his or her ability to do things other children his or her age do?

This child does not have any conditions → **SKIP to question B1**

Never

Sometimes

Usually

Always

**A38** To what extent do this child's health conditions or problems affect his or her ability to do things?

Very little

Somewhat

A great deal



## B. This Child as an Infant

**B1** Was this child born more than 3 weeks before his or her due date?

Yes

No

**B2** How much did he or she weigh when born?  
Answer in pounds and ounces OR kilograms and grams.  
Provide your best estimate.

pounds AND   ounces

OR

kilograms AND    grams

**B3** What was the age of the mother when this child was born?

Age in years

## C. Health Care Services

**C1** DURING THE PAST 12 MONTHS, did this 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** If yes, DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up?

A preventive check-up is when this 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 this child for a preventive check-up, about how long was the doctor or health care provider who examined this 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 this child's CURRENT height?

feet AND   inches

OR

meters AND    centimeters

**C5** How much does this child CURRENTLY weigh?

pounds

OR

kilograms

**C6** Are you concerned about this child's weight?

Yes, it's too high

Yes, it's too low

No, I am not concerned



**C7** Is there a place that this child **USUALLY** goes when he or she is sick or you or another caregiver needs advice about his or her health?

- Yes
- No → **SKIP to question C9**

**C8** If yes, where does this child **USUALLY** go?  
Mark **ONE** only.

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

**C9** Is there a place that this 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**

**C10** If yes, is this the same place this child goes when he or she is sick?

- Yes
- No

**C11** **DURING THE PAST 2 YEARS**, has this child had his or her vision tested with pictures, shapes, or letters?

- Yes
- No → **SKIP to question C13**

**C12** If yes, what kind of place or places did this child have his or her vision tested? Mark **ALL** that apply.

- Eye doctor or eye specialist (ophthalmologist, optometrist) office
- Pediatrician or other general doctor's office
- Clinic or health center
- School
- Other, specify:

**C13** **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for any kind of dental or oral health care?

- Yes, saw a dentist
- Yes, saw other oral health care provider
- No → **SKIP to question C16**

**C14** If yes, **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for preventive dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?

- No preventive visits in the past 12 months → **SKIP to question C16**
- Yes, 1 visit
- Yes, 2 or more visits

**C15** If yes, **DURING THE PAST 12 MONTHS**, what preventive dental services did this child receive? Mark **ALL** that apply.

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

**C16** **DURING THE PAST 12 MONTHS**, has this 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 this child needed to see a mental health professional
- No, this child did not need to see a mental health professional → **SKIP to question C18**

**C17** How much of a problem was it to get the mental health treatment or counseling that this child needed?

- Not a problem
- Small problem
- Big problem





**C18** DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties with his or her emotions, concentration, or behavior?

- Yes  
 No

**C19** DURING THE PAST 12 MONTHS, did this 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 this child needed to see a specialist  
 No, this child did not need to see a specialist → **SKIP to question C21**

**C20** How much of a problem was it to get the specialist care that this child needed?

- Not a problem  
 Small problem  
 Big problem

**C21** DURING THE PAST 12 MONTHS, did this 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

**C22** DURING THE PAST 12 MONTHS, was there any time when this 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 C25**

**C23** If yes, which types of care were not received? *Mark ALL that apply.*

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

**C24** Which of the following contributed to this child not receiving needed health services:

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

**C25** DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?

- Never  
 Sometimes  
 Usually  
 Always

**C26** DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?

- No visits  
 1 visit  
 2 or more visits

**C27** Has this child EVER had a special education or early intervention plan? *Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).*

- Yes  
 No → **SKIP to question C30**

**C28** If yes, how old was this child at the time of the FIRST plan?

Years AND  Months

**C29** Is this child CURRENTLY receiving services under one of these plans?

- Yes  
 No





**C30** Has this child **EVER** received special services to meet his or her developmental needs such as speech, occupational, or behavioral therapy?

Yes

No → **SKIP to question D1**

**C31** If yes, how old was this child when he or she began receiving these special services?

Years AND   Months

**C32** Is this child **CURRENTLY** receiving these special services?

Yes

No

## D. Experience with This Child's Health Care Providers

**D1** Do you have one or more persons you think of as this child's personal doctor or nurse? A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.

Yes, one person

Yes, more than one person

No

**D2** **DURING THE PAST 12 MONTHS**, did this child need a referral to see any doctors or receive any services?

Yes

No → **SKIP to question D4**

**D3** If yes, how much of a problem was it to get referrals?

Not a problem

Small problem

Big problem

**D4** Answer the following questions only if this child had a health care visit **IN THE PAST 12 MONTHS**. Otherwise, **SKIP to question E1**.

**DURING THE PAST 12 MONTHS**, how often did this child's doctors or other health care providers:

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



**D5** DURING THE PAST 12 MONTHS, were any decisions needed about this 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 → *SKIP to question D7*

**D6** If yes, DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers:

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

**D7** Does anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?

Yes

No

Did not see more than one health care provider in PAST 12 MONTHS → *SKIP to question D11*

**D8** DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?

Yes

No → *SKIP to question D10*

**D9** If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?

Usually

Sometimes

Never

**D10** Overall, how satisfied are you with the communication among this child's doctors and other health care providers?

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied

**D11** DURING THE PAST 12 MONTHS, did this child's health care provider communicate with the child's school, child care provider, or special education program?

Yes

No → *SKIP to question E1*

Did not need health care provider to communicate with these providers → *SKIP to question E1*

**D12** If yes, overall, how satisfied are you with the health care provider's communication with the school, child care provider, or special education program?

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied



## E. This Child's Health Insurance Coverage

**E1** DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, this child was covered all 12 months → **SKIP to question E4**
- Yes, but this child had a gap in coverage
- No

**E2** Indicate whether any of the following is a reason this child was not covered by health insurance DURING THE PAST 12 MONTHS:

	Yes	No
a. Change in employer or employment status	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancellation due to overdue premiums	<input type="checkbox"/>	<input type="checkbox"/>
c. Dropped coverage because it was unaffordable	<input type="checkbox"/>	<input type="checkbox"/>
d. Dropped coverage because benefits were inadequate	<input type="checkbox"/>	<input type="checkbox"/>
e. Dropped coverage because choice of health care providers was inadequate	<input type="checkbox"/>	<input type="checkbox"/>
f. Problems with application or renewal process	<input type="checkbox"/>	<input type="checkbox"/>
g. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>

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

- Yes
- No → **SKIP to question F1**

**E4** Is this child covered by any of the following types of health insurance or health coverage plans?

	Yes	No
a. Insurance through a current or former employer or union	<input type="checkbox"/>	<input type="checkbox"/>
b. Insurance purchased directly from an insurance company	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability	<input type="checkbox"/>	<input type="checkbox"/>
d. TRICARE or other military health care	<input type="checkbox"/>	<input type="checkbox"/>
e. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
f. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>

**E5** How often does this child's health insurance offer benefits or cover services that meet this child's needs?

- Always
- Usually
- Sometimes
- Never

**E6** How often does this child's health insurance allow him or her to see the health care providers he or she needs?

- Always
- Usually
- Sometimes
- Never

**E7** Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs?

- This child does not use mental or behavioral health services
- Always
- Usually
- Sometimes
- Never



## F. Providing for This Child's Health

**F1** Including co-pays and amounts from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS? 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 F4**
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5,000

**F2** How often are these costs reasonable?

- Always
- Usually
- Sometimes
- Never

**F3** DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child's medical or health care bills?

- Yes
- No

**F4** DURING THE PAST 12 MONTHS, have you or other family members:

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

**F5** IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.

- This child does not need health care provided on a weekly basis
- No at home care was provided by me or other family members
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

**F6** IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?

- This child does not need health care coordinated on a weekly basis
- No health or medical care was arranged or coordinated by me or other family members
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

## G. This Child's Schooling and Activities

**G1** DURING THE PAST 12 MONTHS, about how many days did this 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

**G2** DURING THE PAST 12 MONTHS, how many times has this child's school contacted you or another adult in your household about any problems he or she is having with school?

- No times
- 1 time
- 2 or more times



**G3** SINCE STARTING KINDERGARTEN, has this child repeated any grades?

Yes

No

**G4** DURING THE PAST 12 MONTHS, did this child participate in:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. A sports team or did he or she take sports lessons after school or on weekends?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Any clubs or organizations after school or on weekends?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other organized activities or lessons, such as music, dance, language, or other arts?              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any type of community service or volunteer work at school, church, or in the community?                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any paid work, including regular jobs as well as babysitting, cutting grass, or other occasional work? | <input type="checkbox"/> | <input type="checkbox"/> |

**G5** DURING THE PAST 12 MONTHS, how often did you attend events or activities that this child participated in?

Always

Usually

Sometimes

Rarely

Never

**G6** DURING THE PAST WEEK, on how many days did this 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

**G7** Compared to other children his or her age, how much difficulty does this child have making or keeping friends?

No difficulty

A little difficulty

A lot of difficulty

## H. About You and This Child

**H1** Was this child born in the United States?

Yes → *SKIP to question H3*

No

**H2** If no, how long has this child been living in the United States?

Years AND   Months

**H3** How many times has this child moved to a new address since he or she was born?

Number of times

**H4** How often does this child go to bed at about the same time on weeknights?

Always

Usually

Sometimes

Rarely

Never

**H5** DURING THE PAST WEEK, how many hours of sleep did this child get on an average weeknight?

Less than 6 hours

6 hours

7 hours

8 hours

9 hours

10 hours

11 or more hours



**H6** ON AN AVERAGE WEEKDAY, about how much time does this child usually spend in front of a TV watching TV programs, videos, or playing video games?

- None
- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

**H7** ON AN AVERAGE WEEKDAY, about how much time does this 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 hour
- 2 hours
- 3 hours
- 4 or more hours

**H8** How well can you and this child share ideas or talk about things that really matter?

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

**H9** How well do you think you are handling the day-to-day demands of raising children?

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

**H10** DURING THE PAST MONTH, how often have you felt:

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

**H11** 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 question 11**

**H12** If yes, did you receive emotional support from:

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



## I. About Your Family and Household

**11** DURING THE PAST WEEK, on how many days did all the family members who live in the household eat a meal together?

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

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

- Yes
- No → **SKIP to question 14**

**13** If yes, does anyone smoke inside your home?

- Yes
- No

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

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

**15** SINCE THIS 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?

- Never
- Rarely
- Somewhat often
- Very often

**16** 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 PAST 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.

**17** At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive:

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

**18** In your neighborhood, is/are there:

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





**19** To what extent do you agree with these statements about your neighborhood or community?

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

**110** Other than you or other adults in your home, is there at least one other adult in this child's school, neighborhood, or community who knows this child well and who he or she can rely on for advice or guidance?

- Yes
- No

**111** The next questions are about events that may have happened during this child's life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

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

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



## J. About You

→ Complete the questions for each of the two adults in the household who are this child's primary caregivers. If there is just one adult, provide answers for that adult.

### ADULT 1 (Respondent)

**J1** How are you related to this 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?

Age in years

**J4** Where were you born?

- In the United States → *SKIP to question J6*
- Outside of the United States

**J5** When did you come to live in the United States?

Year

**J6** What is the highest grade or year of school you have completed? *Mark ONE only.*

- 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)

**J7** What is your marital status?

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

**J8** In general, how is your physical health?

- Excellent
- Very Good
- Good
- Fair
- Poor

**J9** In general, how is your mental or emotional health?

- Excellent
- Very Good
- Good
- Fair
- Poor

**J10** Were you employed at least 50 out of the past 52 weeks?

- Yes
- No



## ADULT 2

**J11** How is Adult 2 related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Aunt or Uncle
- Other: Relative
- Other: Non-Relative
- There is only one primary adult caregiver for this child → **SKIP to question K1**

**J12** What is Adult 2's sex?

- Male
- Female

**J13** What is Adult 2's age?

Age in years

**J14** Where was Adult 2 born?

- In the United States → **SKIP to question J16**
- Outside of the United States

**J15** When did Adult 2 come to live in the United States?

Year

**J16** What is the highest grade or year of school Adult 2 has completed? *Mark ONE only.*

- 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)

**J17** What is Adult 2's marital status?

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

**J18** In general, how is Adult 2's physical health?

- Excellent
- Very Good
- Good
- Fair
- Poor

**J19** In general, how is Adult 2's mental or emotional health?

- Excellent
- Very Good
- Good
- Fair
- Poor

**J20** Was Adult 2 employed at least 50 out of the past 52 weeks?

- Yes
- No

## K. Household Information

**K1** How many people are living or staying at this address?

*Include everyone who usually lives or stays at this address. 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

**K2** How many of these people in your household are family members? *Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.*

Number of people



**K3 Income IN THE LAST CALENDAR YEAR  
(January 1 - December 31, 2015)**

Mark (X) the "Yes" box for each type of income this child's family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the "No" box to show types of income NOT received.

a. Wages, salary, commissions, bonuses, or tips from all jobs?

Yes  No

\$           Total Amount

b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships?

Yes  No

\$           Total Amount

c. Interest, dividends, net rental income, royalty income, or income from estates and trusts?

Yes  No

\$           Total Amount

d. Social security or railroad retirement; retirement, survivor, or disability pensions?

Yes  No

\$           Total Amount

e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office?

Yes  No

\$           Total Amount

f. Any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony?

Yes  No

\$           Total Amount

**K4** The following question is about your income and is very important. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is 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.

\$           Total Amount



## Mailing Instructions

### Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

**Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:**

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

You may also call **1-800-845-8241** to request a replacement envelope.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Paperwork Project, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to [DEMO\\_Paperwork@census.gov](mailto:DEMO_Paperwork@census.gov); use "Paperwork Project" as the subject.

