



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 required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the 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. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Any information you provide will be shared for the work-related purposes identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

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.



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:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

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

The survey should be completed by a parent or adult caregiver who lives in this household and 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 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"/> |

A4 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"/> |

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

A5 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

A6 Arthritis?

- 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...

A7 Asthma?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A8 Cerebral Palsy?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A9 Diabetes?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A10 Epilepsy or Seizure Disorder?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A11 Heart Condition?

Yes No

↳ If yes, was this child born with 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...

A12 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

A13 Tourette Syndrome?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A14 Anxiety Problems?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A15 Depression?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A16 Down Syndrome?

Yes No

↳ If yes, is it:

Mild Moderate Severe



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

A17 Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?

Yes No

↳ If yes, is it:

Mild Moderate Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

Yes No

↳ If yes, was this child diagnosed with:

Sickle Cell Disease? Yes No

Thalassemia? Yes No

Hemophilia? Yes No

Other Blood Disorders? Yes No

A18 Cystic Fibrosis?

Yes No

↳ If yes, is it:

Mild Moderate Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

Yes No

A19 Other genetic or inherited condition?

Yes No

↳ If yes, specify:

Is it:

Mild Moderate Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

Yes No

A20 Substance Use Disorder?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

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

Examples of educators are teachers and school nurses.

A21 Behavioral or Conduct Problems?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A22 Developmental Delay?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A23 Intellectual Disability (formerly known as Mental Retardation)?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A24 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

A25 Learning Disability?

Yes No

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

Yes No

↳ If yes, is it:

Mild Moderate Severe



A26 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 A31**

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A27 How old was this child when a doctor or other health care provider FIRST told you that they have Autism, ASD, Asperger's Disorder or PDD?

Age in years Don't know

A28 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 (X) ONE box.

Primary Care Provider

Specialist

School Psychologist/Counselor

Other Psychologist (Non-School)

Psychiatrist

Other, specify:

Don't know

A29 Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes No

A30 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 their behavior?

Yes No

A31 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 A34**

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

Yes No

↳ If yes, is it:

Mild Moderate Severe

A32 Is this child CURRENTLY taking medication for ADD or ADHD?

Yes No

A33 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 their behavior?

Yes No

A34 Do you think this child has EVER had a concussion or brain injury? A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

Yes No → **SKIP to question A35**

↳ If yes, did you seek medical care from a doctor or other health care provider?

Yes No → **SKIP to question A35**

↳ If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?

Yes No

A35 DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected their ability to do things other children their age do?

This child does not have any health conditions → **SKIP to question B1 on page 6**

Never

Sometimes

Usually

Always

A36 To what extent do this child's health conditions or problems affect their 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 their due date?

- Yes
 No

B2 What month and year was this child born?

Birth Month / 4-Digit Birth Year

/

B3 How much did they weigh when born? Answer in pounds and ounces OR kilograms and grams. Your best estimate is fine.

pounds AND ounces
OR

kilograms AND grams

B4 What was the age of the mother when this child was born? Your best estimate is fine.

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 **C5**

C2 If yes, at their LAST medical care visit, did this child have a chance to speak with a doctor or other health care provider privately, without you or another caregiver in the room?

- Yes
 No

C3 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
 1 visit
 2 or more visits

C4 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

C5 What is this child's CURRENT height? Your best estimate is fine.

feet AND inches

OR

meters AND centimeters

C6 How much does this child CURRENTLY weigh? Your best estimate is fine.

pounds

OR

kilograms

C7 Are you concerned about this child's weight?

- Yes, it's too high
 Yes, it's too low
 No, I am not concerned

C8 Has a doctor or other health care provider ever told you that this child is overweight?

- Yes
 No

C9 Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?

- Yes
 No → SKIP to question **C11** on page 7



C10 If yes, where does this child **USUALLY** go first?

Mark (X) *ONE* box.

- 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

C11 Is there a place that this child **USUALLY** goes when they need routine preventive care, such as a physical examination or well-child check-up?

- Yes
- No → **SKIP to question C13**

C12 If yes, is this the same place this child goes when they are sick?

- Yes
- No

C13 **DURING THE PAST 12 MONTHS**, has this child had their vision tested, such as with pictures, shapes, or letters?

- Yes
- No → **SKIP to question C15**

C14 If yes, where was this child's vision tested?

Mark (X) *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:

C15 **DURING THE PAST 12 MONTHS**, did this child see a dentist or other health care provider for any kind of dental or oral health care?

- Yes, saw a dentist or other oral health care provider
- Yes, saw another kind of health care provider
- No → **SKIP to question C18**

C16 If yes, **DURING THE PAST 12 MONTHS**, did this child see a dentist or other 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 C18**
- Yes, 1 visit
- Yes, 2 or more visits

C17 If yes, **DURING THE PAST 12 MONTHS**, what preventive dental service(s) did this child receive? Mark (X) *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

C18 **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 C20 on page 8**

C19 How difficult was it to get the mental health treatment or counseling that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care



C20 DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties with their emotions, concentration, or behavior?

- Yes
- No

C21 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 C23**

C22 How difficult was it to get the specialist care that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

C23 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

C24 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 C27**

C25 If yes, which types of care were not received? *Mark (X) ALL that apply.*

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

C26 Did any of the following reasons contribute to this child not receiving needed health services? *Mark (X) Yes or No for each item.*

	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 or 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"/>

C27 DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?

- Never
- Sometimes
- Usually
- Always

C28 DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

C29 DURING THE PAST 12 MONTHS, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

C30 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 C33 on page 9**

C31 If yes, how old was this child at the time of the FIRST plan?

Years AND Months



C32 Is this child **CURRENTLY** receiving services under one of these plans?

- Yes
- No

C33 Has this child **EVER** received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes
- No → **SKIP to question D1**

C34 If yes, how old was this child when they began receiving these special services?

Years **AND** Months

C35 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 How difficult was it to get referrals?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to get a referral

D4 Answer the following questions only if this child had a health care visit **IN THE PAST 12 MONTHS**. Otherwise skip to question **D13** on page 10.

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**, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?

- 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 their 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 **DURING THE PAST 12 MONTHS**, did 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 the **PAST 12 MONTHS** → **SKIP to question D11 on page 10**



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 DURING THE PAST 12 MONTHS, how satisfied were you with the communication between 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 D13*
- Did not need health care provider to communicate with these providers → *SKIP to question D13*

D12 If yes, during this time, how satisfied were 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

D13 Do any of this child's doctors or other health care providers treat only children?

- Yes
- No → *SKIP to question D15*

D14 If yes, have they talked with you about when this child will need to see doctors or other health care providers who treat adults?

- Yes
- No

D15 Has this child's doctor or other health care provider actively worked with this child to:

- | | Yes | No | Don't know |
|---|--------------------------|--------------------------|--------------------------|
| a. Make positive choices about their health. For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Gain skills to manage their health and health care. For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications they may need? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

D16 Did you and this child receive a summary of your child's medical history (for example, medical conditions, allergies, medications, immunizations)?

- Yes
- No

D17 Have this child's doctors or other health care providers worked with you and this child to create a plan of care to meet their health goals and needs?

- Yes
- No → *SKIP to question D20 on page 11*

D18 If yes, do you and this child have access to this plan of care?

- Yes
- No

D19 Does this plan of care address transition to doctors and other health care providers who treat adults?

- Yes
- No
- No, child already sees providers who treat adults



D20 Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as they become an adult?

- Yes → **SKIP to question E1**
- No

D21 If no, has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?

- Yes
- No

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 at any time 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 on page 12**

E4 Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark (X) Yes or No for EACH item.

	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 them to see the health care providers they need?

- 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 reimbursed 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. Left a job or taken a leave of absence 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 at home on a weekly basis
- 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
- 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? Include days missed from any formal home schooling.

- No missed school days
- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days
- This child was not enrolled in school

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 they are having with school?

- None
- 1 time
- 2 or more times



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

- Yes
 No

G4 DURING THE PAST 12 MONTHS, how often did you attend events or activities that this child participated in?

- Always
 Usually
 Sometimes
 Rarely
 Never

G5 DURING THE PAST 12 MONTHS, did this child participate in...

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. A sports team or did they 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, place of worship, 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"/> |

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 their age, how much difficulty does this child have making or keeping friends?

- No difficulty
 A little difficulty
 A lot of difficulty

G8 DURING THE PAST 12 MONTHS, how often was this child bullied, picked on, or excluded by other children? *If the frequency changed throughout the year, report the highest frequency.*

- 1-2 times (in the past 12 months)
 Never (in the past 12 months)
 1-2 times per week
 1-2 times per month
 Almost every day

G9 DURING THE PAST 12 MONTHS, how often did this child bully others, pick on them, or exclude them? *If the frequency changed throughout the year, report the highest frequency.*

- 1-2 times (in the past 12 months)
 Never (in the past 12 months)
 1-2 times per week
 1-2 times per month
 Almost every day

G10 How often does this child...

- | | Always | Usually | Sometimes | Never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Show interest and curiosity in learning new things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Work to finish tasks they start? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stay calm and in control when faced with a challenge? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Care about doing well in school? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Do all required homework? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Argue too much? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

H. About You and This Child

H1 Was this child born in the United States?

- Yes → **SKIP to question H3 on page 14**
 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 they were 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 most weeknights?

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

H6 ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media? Do not include time spent doing schoolwork.

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

H7 How well can you and this child share ideas or talk about things that really matter?

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

H8 How well do you think you are handling the day-to-day demands of raising children?

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

H9 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 their 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"/>

H10 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 **I1** on page 15

H11 If yes, did you receive emotional support from...

	Yes	No
a. Spouse or domestic partner?	<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

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 → **SKIP to question I4**

I3 If yes, does anyone smoke inside your home?

- Yes
- No

I4 DURING THE PAST 12 MONTHS, how often were pesticides used inside your residence to control for insects? If the frequency changed throughout the year, report the highest frequency.

- More than once a week
- Once a week
- Once a month
- Once every 2-5 months
- Once every 6 months
- Once during the past 12 months
- Never
- Don't know

I5 DURING THE PAST 12 MONTHS, other than in a shower or bathtub, have you seen any mold, mildew or other signs of water damage on walls or other surfaces inside your home?

- Yes
- No

I6 SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?

- Never
- Rarely
- Somewhat often
- Very often

I7 Which of these statements best describes your household's ability to afford the food you need DURING 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.

I8 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 (SNAP) benefits?	<input type="checkbox"/>	<input type="checkbox"/>
c. Free or reduced-cost breakfasts or lunches at school?	<input type="checkbox"/>	<input type="checkbox"/>
d. Benefits from the Woman, Infants, and Children (WIC) Program?	<input type="checkbox"/>	<input type="checkbox"/>



19 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"/> |

110 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"/> |

111 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 they can rely on for advice or guidance?

- Yes
- No

112 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 their 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 their race or ethnic group | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Treated or judged unfairly because of their sexual orientation or gender identity? | <input type="checkbox"/> | <input type="checkbox"/> |

113 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"/> |



J. Child's Caregivers

→ Complete the questions for UP TO TWO ADULTS in the household who are this child's primary caregivers.

CAREGIVER 1 (You)

J1 How are you related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- 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?

Indicate the 4-digit year in which you came to live in the United States.

4-Digit Year

J6 What is the highest grade or level of school you have completed? Mark (X) ONE box.

- 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

J11 Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard? Mark (X) ONE box.

- Never served in the military → **SKIP to question J13**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question J13**
- Now on active duty
- On active duty in the past, but not now

J12 Were you deployed at any time during this child's life?

- Yes
- No

J13 Does this child have another primary adult caregiver who lives in this household?

- Yes - Complete Questions **J14 - J25**
- No - SKIP to Question **K1** on page 19

CAREGIVER 2

J14 How is Caregiver 2 related to this child?

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

J15 What is Caregiver 2's sex?

- Male
- Female

J16 What is Caregiver 2's age?

Age in years

J17 Where was Caregiver 2 born?

- In the United States → **SKIP to question J19**
- Outside of the United States

J18 When did Caregiver 2 come to live in the United States? Indicate the 4-digit year in which Caregiver 2 came to live in the United States.

4-Digit Year

J19 What is the highest grade or level of school Caregiver 2 has completed? Mark (X) ONE box.

- 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)

J20 What is Caregiver 2's marital status?

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

J21 In general, how is Caregiver 2's physical health?

- Excellent
- Very good
- Good
- Fair
- Poor



J22 In general, how is Caregiver 2's mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

J23 Was Caregiver 2 employed at least 50 out of the past 52 weeks?

- Yes
- No

J24 Has Caregiver 2 ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard? Mark (X) ONE box.

- Never served in the military → **SKIP to question K1**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question K1**
- Now on active duty
- On active duty in the past, but not now

J25 Was Caregiver 2 deployed at any time during this child's life?

- 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 2019

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 for all jobs.

- Yes → \$.00
- No TOTAL AMOUNT in the last calendar year

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

- Yes → \$.00 Loss
- No TOTAL AMOUNT in the last calendar year

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

- Yes → \$.00 Loss
- No TOTAL AMOUNT in the last calendar year

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

- Yes → \$.00
- No TOTAL AMOUNT in the last calendar year

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

- Yes → \$.00
- No TOTAL AMOUNT in the last calendar year

f. Any other sources of income received such as Veterans' (VA) payments, unemployment compensation, child support, alimony, gifts, prize winnings, etc.

- Yes → \$.00
- No TOTAL AMOUNT in the last calendar year

K4 The following question is about your 2019 income. 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 businesses, farm or rent, and any other money income received.

\$.00

TOTAL AMOUNT in the last calendar year



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.

We estimate that completing the National Survey of Children's Health will take 33 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to DEMO.Paperwork@census.gov; use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.

