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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-T1
(06/16/2016)

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?**

- ☐ This child does not have any 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 is affectionate and tender with you	☐	☐	☐
b. This child bounces back quickly when things do not go his or her way	☐	☐	☐
c. This child shows interest and curiosity in learning new things	☐	☐	☐
d. This child smiles and laughs a lot	☐	☐	☐

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

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

	Yes	No
a. Deafness or problems with hearing	☐	☐
b. Blindness or problems with seeing, even when wearing glasses	☐	☐

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 **Developmental Delay?**

☐ Yes ☐ No

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

☐ Yes ☐ No

↳ **If yes**, is it:

☐ Mild ☐ Moderate ☐ Severe

A24 **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

A25 **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

A26 **Learning Disability?**

☐ Yes ☐ No

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

☐ Yes ☐ No

↳ **If yes**, is it:

☐ Mild ☐ Moderate ☐ Severe

A27 **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

A28 **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*** **A33**

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

☐ Yes ☐ No

↳ **If yes**, is it:

☐ Mild ☐ Moderate ☐ Severe

A29 **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

A30 **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

A31 **Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?**

☐ Yes ☐ No

A32 **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

A33 **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*** **A36**

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

☐ Yes ☐ No

↳ **If yes**, is it:

☐ Mild ☐ Moderate ☐ Severe

A34 **Is this child CURRENTLY taking medication for ADD or ADHD?**

☐ Yes ☐ No

A35 **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

A36 **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

A37 **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

B4 **Was this child EVER breastfed or fed breast milk?**

☐ Yes

☐ No → ***SKIP to question*** **B6**

B5 **If yes, how old was this child when he or she COMPLETELY stopped breastfeeding or being fed breast milk?**

☐☐☐ days

OR

☐☐ weeks

OR

☐☐ months

OR

☐ *Check this box if child is still breastfeeding*

B6 **How old was this child when he or she was FIRST fed formula?**

☐ At birth

OR

☐☐☐ days

OR

☐☐ weeks

OR

☐☐ months

OR

☐ *Check this box if child has never been fed formula*

B7 **How old was this child when he or she was FIRST fed anything other than breast milk or formula?** *Include juice, cow's milk, sugar water, baby food, or anything else that your child might have been given, even water.*

☐ At birth

OR

☐☐☐ days

OR

☐☐ weeks

OR

☐☐ months

OR

☐ *Check this box if child has never been fed anything other than breast milk or formula*

C. Health Care Services

C1 **DURING THE PAST 12 MONTHS, did 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 AND ☐☐ ounces

OR

☐☐ kilograms AND ☐☐☐ grams

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 **DURING THE PAST 12 MONTHS, did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?**

- ☐ Yes
- ☐ No

C8 **If this child is YOUNGER THAN 9 MONTHS, please SKIP to question C9.**

DURING THE PAST 12 MONTHS, did a doctor or other health care provider have you or another caregiver fill out a questionnaire about specific concerns or observations you may have about this child's development, communication, or social behaviors?
Sometimes a child's doctor or other health care provider will ask a parent to do this at home or during a child's visit.

☐ Yes ☐ No

→ **If yes,** and this child is 9-23 Months:

Did the questionnaire ask about your concerns or observations about: *Mark ALL that apply.*

- ☐ How this child talks or makes speech sounds?
- ☐ How this child interacts with you and others?

→ **If yes,** and this child is 2-5 Years:

Did the questionnaire ask about your concerns or observations about: *Mark ALL that apply.*

- ☐ Words and phrases this child uses and understands?
- ☐ How this child behaves and gets along with you and others?

C9 **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*** **C11**

C10 **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

C11 **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*** **C13**

C12 **If yes, is this the same place this child goes when he or she is sick?**

- ☐ Yes
- ☐ No

C13 **Has this child EVER had his or her vision tested with pictures, shapes, or letters?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **C15**

C14 **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:

C15 **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*** **C18**

C16 **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*** **C18**
- ☐ Yes, 1 visit
- ☐ Yes, 2 or more visits

C17 **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

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**

C19 **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

C20 **DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties with his or her 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 much of a problem was it to get the specialist care that this child needed?**

- ☐ Not a problem
- ☐ Small problem
- ☐ Big problem

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 ALL that apply.*

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

C26 **Which of the following contributed to this child not receiving needed health services:**

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

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?**

- ☐ No visits
- ☐ 1 visit
- ☐ 2 or more visits

C29 **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*** **C32**

C30 **If yes, how old was this child at the time of the FIRST plan?**

☐☐ Years AND ☐☐ Months

C31 **Is this child CURRENTLY receiving services under one of these plans?**

- ☐ Yes
- ☐ No

C32 **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**

C33 **If yes, how old was this child when he or she began receiving these special services?**

☐☐ Years AND ☐☐ Months

C34 **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?	☐	☐	☐	☐
b. Listen carefully to you?	☐	☐	☐	☐
c. Show sensitivity to your family's values and customs?	☐	☐	☐	☐
d. Provide the specific information you needed concerning this child?	☐	☐	☐	☐
e. Help you feel like a partner in this child's care?	☐	☐	☐	☐

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

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

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

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

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 Learning

G1 **Has this child started school?** *Include homeschooling.*

- ☐ This child is younger than 3 years old ➔ ***SKIP to question*** **H1**
- ☐ Yes
- ☐ No

G2 **How well is this child learning to do things for him or herself?**

- ☐ Very well
- ☐ Somewhat
- ☐ Poorly
- ☐ Not at all

G3 **How confident are you that this child will be successful in elementary or primary school?**

- ☐ Very confident
- ☐ Mostly confident
- ☐ Somewhat confident
- ☐ Not confident at all

G4 **How often can this child recognize the beginning sound of a word? For example, can this child tell you that the word "ball" starts with the "buh" sound?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G5 **About how many letters of the alphabet can this child recognize?**

- ☐ All of them
- ☐ Most of them
- ☐ Some of them
- ☐ None of them

G6 **Can this child rhyme words?**

- ☐ Yes
- ☐ No

G7 **How often can this child explain things he or she has seen or done so that you get a very good idea what happened?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G8 **How often can this child write his or her first name, even if some of the letters aren't quite right or are backwards?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G9 **How high can this child count?**

- ☐ Not at all
- ☐ Up to five
- ☐ Up to ten
- ☐ Up to 20
- ☐ Up to 50
- ☐ Up to 100 or more

G10 **How often can this child identify basic shapes such as a triangle, circle, or square?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G11 **How often is this child easily distracted?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G12 **How often does this child keep working at something until he or she is finished?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G13 **When he or she is paying attention, how often can this child follow instructions to complete a simple task?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G14 **When this child holds a pencil, does he or she use fingers to hold, or does he or she grip it in his or her fist?**

- ☐ Uses fingers
- ☐ Grips in fist
- ☐ Cannot hold a pencil

G15 **How often does this child play well with others?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G16 **How often does this child become angry or anxious when going from one activity to another?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G17 **How often does this child show concern when others are hurt or unhappy?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G18 **How often can this child calm down when excited or all wound up?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G19 **How often does this child lose control of his or her temper when things do not go his or her way?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G20 **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

G21 **Compared to other children his or her age, how often is this child able to sit still?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ None of the time

G22 **IN THE PAST 12 MONTHS, were you ever asked to keep your child home from any child care or preschool because of their behavior (things like hitting, kicking, biting, tantrums or disobeying)?** *Mark ONE only.*

- ☐ This child did not attend child care or preschool
- ☐ No
- ☐ Yes, I was told to pick up my child early on 1 or more days
- ☐ Yes, I had to keep my child home for 1 full day or more
- ☐ Yes permanently, I was told my child could no longer attend this child care center or preschool

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 during an average day (count both nighttime sleep and naps)?**

- ☐ Less than 7 hours
- ☐ 7 hours
- ☐ 8 hours
- ☐ 9 hours
- ☐ 10 hours
- ☐ 11 hours
- ☐ 12 or more hours

H6 ***Answer the next question only if this child is LESS THAN 12 MONTHS OLD. Otherwise, SKIP to question H7.***

In which position do you most often lay this baby down to sleep now? *Mark ONE only.*

- ☐ On his or her side
- ☐ On his or her back
- ☐ On his or her stomach

H7 **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

H8 **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

H9 **DURING THE PAST WEEK, how many days did you or other family members read to this child?**

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

H10 **DURING THE PAST WEEK, how many days did you or other family members tell stories or sing songs to this child?**

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

H11 **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

H12 **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?	☐	☐	☐	☐	☐
b. That this child does things that really bother you a lot?	☐	☐	☐	☐	☐
c. Angry with this child?	☐	☐	☐	☐	☐

H13 **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*** **H15**

H14 **If yes, did you receive emotional support from:**

	Yes	No
a. Spouse?	☐	☐
b. Other family member or close friend?	☐	☐
c. Health care provider?	☐	☐
d. Place of worship or religious leader?	☐	☐
e. Support or advocacy group related to specific health condition?	☐	☐
f. Peer support group?	☐	☐
g. Counselor or other mental health professional?	☐	☐
h. Other person, specify:	☐	☐

H15 **Does this child receive care for at least 10 hours per week from someone other than his or her parent or guardian?** *This could be a day care center, preschool, Head Start program, family child care home, nanny, au pair, babysitter or relative.*

- ☐ Yes
- ☐ No

H16 **DURING THE PAST 12 MONTHS, did you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for this child?**

- ☐ Yes
- ☐ No

I. About Your Family and Household

I1 **DURING THE PAST WEEK, on how many days did all the family members who live in the household eat a meal together?**

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

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

- ☐ Yes
- ☐ No ➔ ***SKIP to question*** **I4**

I3 **If yes, does anyone smoke inside your home?**

- ☐ Yes
- ☐ No

I4 **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	☐	☐	☐	☐
b. Work together to solve our problems	☐	☐	☐	☐
c. Know we have strengths to draw on	☐	☐	☐	☐
d. Stay hopeful even in difficult times	☐	☐	☐	☐

I5 **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

I6 **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.

I7 **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?	☐	☐
b. Food Stamps or Supplemental Nutrition Assistance Program benefits (SNAP)?	☐	☐
c. Free or reduced-cost breakfasts or lunches at school?	☐	☐
d. Benefits from the Woman, Infants, and Children (WIC) Program?	☐	☐

I8 **In your neighborhood, is/are there:**

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

I9 **To what extent do you agree with these statements about your neighborhood or community?**

	Definitely agree	Somewhat agree	Somewhat disagree	Definitely disagree
a. People in this neighborhood help each other out	☐	☐	☐	☐
b. We watch out for each other's children in this neighborhood	☐	☐	☐	☐
c. This child is safe in our neighborhood	☐	☐	☐	☐
d. When we encounter difficulties, we know where to go for help in our community	☐	☐	☐	☐

I10 ***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	☐	☐
b. Parent or guardian died	☐	☐
c. Parent or guardian served time in jail	☐	☐
d. Saw or heard parents or adults slap, hit, kick, punch one another in the home	☐	☐
e. Was a victim of violence or witnessed violence in neighborhood	☐	☐
f. Lived with anyone who was mentally ill, suicidal, or severely depressed	☐	☐
g. Lived with anyone who had a problem with alcohol or drugs	☐	☐
h. Treated or judged unfairly because of his or her race or ethnic group	☐	☐

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.