Millennium Cohort Family Study 2017 Follow-up Survey

Additions to previous survey:

Our records indicate that your name is <participant first and last names>. Is this correct?

- No
- Yes

In what month and year did you marry <spouse>?

MM-YY

Has <spouse> served in the military (Active Duty, Reserve, and/or National Guard) for any portion of the past 3 years?

- Yes
- No

Is <spouse> currently serving in the military?

- Yes
- No

Which of the following best describes <spouse>'s current employment status? (Choose the single best answer)

- Full-time work (greater than or equal to 30 hours per week)
- Part-time work (less than 30 hours per week)
- Homemaker
- Not employed, looking for work
- Not employed, not looking for work
- Not employed, retired
- Not employed, disabled
- Other (please specify):

Does <spouse> currently reside in your household the majority of the time?

- Yes
- No

In the last 12 months, have you taken any of the following regularly (at least once per week)?

Prescription pain medication (e.g., Codeine, OxyContin, Percocet, Vicodin)
Over-the-counter pain medication (e.g., Advil, Tylenol, Bayer, Capsaicin)
Prescription sleep medication (e.g., Ambien, Lunesta, Rozerem)
Over-the-counter sleep medication (e.g., Unisom, Melatonin, Valerian)
Prescription mental health medication (e.g., Prozac, Zoloft, Xanax)
Over-the-counter mental health medication (e.g., B vitamins, St. John's wort, essential oils)

- No or less than once per week
- 1-2
- 3-5
- 6-14
- 15+

During the past 4 weeks, how much have you been bothered by any of the following problems?

Little or no sexual desire or pleasure during sex

- Not bothered
- Bothered a little
- Bothered a lot

In the last 3 years, how much difficulty have you had with conditions related to any of the following health areas? If you have experienced more than one condition in a health area, please mark the severity level for the most severe condition.

Eyes, ears, nose, mouth, throat or head (e.g., visual changes, eye pain/strain, nose bleeds, sinus pain/infections, ringing in the ears, toothache, sore throat, headache)
Cardiovascular (e.g., high blood pressure, high cholesterol, coronary artery disease, heart attack, angina)
Respiratory (e.g., chronic cough, wheezing, shortness of breath, asthma)
Digestive (e.g., ulcers, acid reflux, irritable bowel syndrome)
Reproductive or Urinary (e.g., infections, pain, loss of bladder control)
Musculoskeletal (e.g., pain, stiffness, joint swelling, arthritis)
Skin (e.g., rash, lesions, eczema)
Neurological (e.g., stroke, memory loss, weakness of arm or leg, poor balance, speech problems)
Mental health (e.g., depression, anxiety, psychosis, eating disorder)
Endocrine (gland) (e.g., thyroid, adrenal, hormonal)
Blood or Lymphatic (e.g., anemia, blood transfusions, swelling)
Auto immune or Allergies (e.g., fibromyalgia, lupus, anaphylaxis)
Other (please specify below)

- None
- Slight
- Moderate
- Serious
- Severe

In the past 3 years, were you TRICARE eligible?

- No
- Yes

How old were you when your menstrual periods began?

- 9 or less
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17 or more

Have you ever been pregnant?

- No
- Yes

How many times?

____

How many births (liveborn children or stillbirths) have you had?

____

How old were you when you first gave birth?

____

How many months in total did you breastfeed (total for all children)?

- Less than 1 month

- 1-2 months
- 3-5 months
- 6-11 months
- 12 or more months

Have you ever used oral contraceptives (birth control pills)?
- No
- Yes

Age when first used
____ years old

Age when last used
____ years old

How many years in total have you used birth control pills (exclude time periods when you temporarily stopped)?
- Less than 1 year
- 1-2
- 3-4
- 5-9
- 10-19
- 20 or more

In the last 3 years, has your doctor or other health professional told you that you have any of the following conditions?

Schizophrenia or psychosis
Manic-depressive disorder/bipolar disorder
- No
- Yes
- If yes, in what year were you first diagnosed?
- Mark here if ever hospitalized for the condition

In the past month have you experienced…?

Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)
Blaming yourself or someone else for a stressful experience or what happened after it
Having strong negative feelings such as fear, horror, anger, guilt, or shame
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)
Taking too many risks or doing things that could cause you harm
- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge
Not being able to stop or control worrying
Worrying too much about different things
Trouble relaxing
Being so restless that it is hard to sit still

Becoming easily annoyed or irritable
Feeling afraid as if something awful might happen

- Not at all
- Several days
- More than half the days
- Nearly every day

In the last 3 years, how often have you received counseling/mental health services (including visits for emotional, substance use, or family issues)?

- Never
- Once or twice
- 3-5 times
- 6-10 times
- 11 or more times

You indicated you used counseling/mental health services in the last 3 years. Please specify whether these were military or civilian services.

- Military
- Civilian
- Both

Were any of these visits in the past 12 months?

- No
- Yes

In the past 3 years, about how often have you participated in any of the following community groups or organizations?

Church, synagogue, or other religious/spiritual meetings/gatherings
Professional organizations (e.g., union/guild meetings, professional conferences)
Social clubs or recreational groups (e.g., fraternities/sororities, Audubon society, travel club, etc.)
Sports, hobby or special interest clubs (e.g., athletic teams, book club, community theater, knitting circle)
Service or volunteer organizations/events (e.g., food bank, local shelter, Kiwanis club, activist groups)
Educational events, meetings, or classes

- Never
- Once or twice
- Once a month
- Once a week
- More than once a week

In the past 3 years, have you used any of the following sources of support to help you or your family cope with difficult challenges or solve problems?

Online social networking (e.g., blogs, chat groups, Facebook)
In-person support groups (e.g., family readiness, military spouse, parenting support)
Self-help information (e.g., Combat Operational Stress Control website, WebMD, books, downloadable apps)
Military OneSource
Non-profit agencies (e.g., Red Cross, Goodwill, Navy Marine Corps Relief Society)
Federal or State agencies (e.g., Child and Family Services, WIC)
Religious or spiritual leader (e.g., pastor, chaplain, rabbi)
Military family service center

- Yes
- No

You indicated you used Military OneSource in the past 3 years. Specifically, did you: (Mark all that apply)

Look at information on the website?
Contact the call center?
Receive non-medical counseling through their network?

You indicated you used the following services in the past 3 years. Please specify whether these were military or civilian services.

- Military
- Civilian
- Both

In the last 3 years, have you had any of the following life events happen to you?

You were fired or laid-off
You experienced infidelity or unfaithfulness in a committed relationship
You were stalked
You moved or changed primary residence more than once
You slept in a shelter, on the streets, or in another non-residential setting

- No
- Yes

If YES, did this event occur in the last 12 months?

- No
- Yes

Since you were 18 years old, how often have you had unwanted experiences where a person(s) sexually touched you (e.g., intentional touching of genitalia, breasts, or buttocks), made you sexually touch them, attempted to or actually made you have sexual intercourse/oral or anal sex (or sexual penetration with finger/object) without your consent?

- Never
- Once
- Twice
- A few times
- Many times

How old were you when your most impactful unwanted sexual experience happened?

____ years old

During your most impactful unwanted sexual experience, did the offender(s) do any of the following to you without your consent?

Sexually touch you (e.g., intentional touching of genitalia, breasts, or buttocks) or made you sexually touch them but did not attempt to have intercourse with you?
Attempted to make you have sexual intercourse, but was not successful?
Made you have sexual intercourse?
Attempted to make you perform or receive oral sex, anal sex, or penetration by a finger or object, but was not successful?
Made you perform or receive oral sex, anal sex, or penetration by a finger or object?

- Yes
- No

During this experience, did the offender(s):

Take advantage of you when you couldn't defend yourself (e.g., too drunk/high or asleep)?
Use physical force/violence, or threaten you/someone close to you with physical harm?

- Yes
- No

At the time of this experience, were any of the following true?

The offender(s) was your spouse or a romantic/sexual partner you knew well
The offender(s) was/were Active duty or Reserve/Guard military member(s) other than your spouse
The offender(s) was/were in your spouse's – or your own – military chain of command
You were a military dependent or a military member yourself at the time of the experience
You were a military Service member at the time of the experience

- Yes
- No

After this experience, did you ever:

Talk with a friend, family member, or co-worker about what happened?
Report what happened to a civilian authority or advocate (civilian law enforcement, counselor, community support center)?
Report what happened to a military authority or a military advocate (e.g., Sexual Assault Prevention and Response victim advocate, legal advocate, Family Advocacy Program)?

- Yes
- No

In the past year, have you used any of the following tobacco/nicotine products?

Electronic cigarettes or vape

- No
- Yes

Do you now smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all

Do you now smoke e-cigarettes or vape every day, some days, or not at all?

- Every day
- Some days
- Not at all

In a typical week, how much time do you spend participating in… (Please mark both your typical "days per week" and "minutes per day" doing these activities)

Strength training or work that strengthens your muscles (such as lifting/pushing/pulling weights)?
____ days per week you exercise
____ minutes per day on average you exercise

- None
- Cannot physically do

Which best describes the financial condition of you and your family?

- Very comfortable and secure
- Able to make ends meet without much difficulty
- Occasionally have some difficulty making ends meet
- Tough to make ends meet but keeping our heads above water
- In over our heads

Please rate the following statements about your relationship with your spouse:

I have a good marriage
My relationship with my spouse is very stable
I really feel like part of a team with my spouse

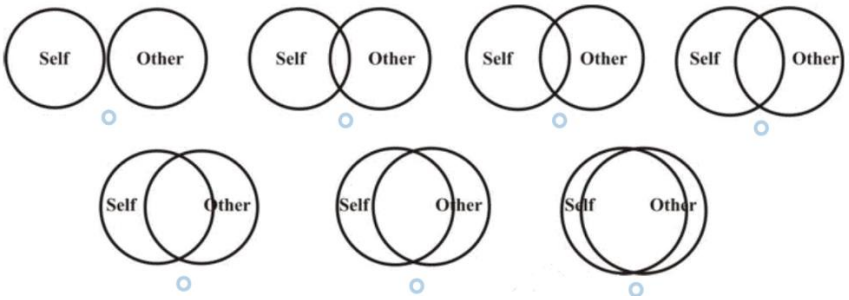
- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

Please rate the following statement about your relationship with <spouse>:

I feel that I can trust my spouse completely.

- Strongly disagree
- Disagree
- Moderately disagree
- Neither agree nor disagree
- Moderately agree
- Agree
- Strongly agree

Please select the picture that best illustrates your current relationship with <spouse>.



In your opinion, does <spouse> consume too much alcohol in a typical week when he/she is at home (or if <spouse> is currently deployed, please refer to the most recent month <spouse> was home)?

- No
- Yes

Over the last 12 months, how often did <spouse>:

Insult you or talk down to you?
Scream or curse at you?
Threaten you with harm?
Physically hurt you?

- 1 Never
- 2
- 3
- 4
- 5 Frequently

Over the last 12 months, how often did you:

Insult or talk down to your spouse?
Scream or curse at your spouse?
Threaten your spouse with harm?
Physically hurt your spouse?

- 1 Never
- 2
- 3
- 4

- 5 Frequently

Please rate how frequently you use each of the following styles to deal with arguments or disagreements with <spouse>.

Launching personal attacks
Focusing on the problem at hand
Remaining silent for long periods of time
Not being willing to stick up for myself
Exploding and getting out of control
Sitting down and discussing differences constructively
Reaching a limit, "shutting down", refusing to talk anymore
Being too compliant
Getting carried away and saying things that aren't meant
Finding alternatives that are acceptable to each of us
Tuning the other person out
Not defending my position
Throwing insults and digs
Negotiating and compromising
Withdrawing, acting distant and not interested
Giving in with little attempt to present my side of the issue

- 1 Never
- 2
- 3
- 4
- 5 Always

Please indicate the extent to which each of the following reasons contributed to your divorce.

Lack of communication
Too much conflict and arguing
Lack of equality in the relationship
Financial problems
Religious differences
Alcohol or drug abuse
Domestic violence/abuse
Physical or mental health problems
Sexual problems
Infidelity or extramarital affairs
My spouse worked too many hours
How we divided household and/or child care responsibilities
Differences over raising our children
Other:

- Not at all
- Small extent
- Moderate extent
- Large extent
- Very large extent

During the past year, how often have you had any contact with <spouse> by phone, mail, email or by visits?

- Not at all
- About once a year
- Several times a year
- One to three times a month
- About once a week

- More than once a week

How would you describe your current relationship with <spouse>?
- Very unfriendly
- Somewhat unfriendly
- Neither unfriendly nor friendly
- Somewhat friendly
- Very friendly
- Ex-spouse is deceased
- No contact with ex-spouse

In the last 12 months, have you provided unpaid care to any of the following people because of a special medical need (e.g., illness, injury, or emotional/behavioral problem)?

Spouse
Child(ren)
Other relative
Non-relative
- No
- Yes

How physically stressful would you say providing this care is/was for you?
- Not at all stressful
- Slightly stressful
- Moderately stressful
- Very stressful

How emotionally stressful would you say providing this care is/was for you?
- Not at all stressful
- Slightly stressful
- Moderately stressful
- Very stressful

How financially stressful would you say providing this care is/was for you?
- Not at all stressful
- Slightly stressful
- Moderately stressful
- Very stressful

Is/was your spouse's special need a result of a combat-related injury?
- No
- Yes

In general, how well do you feel you are coping with the day-to-day demands of parenthood/raising children?
- Very well
- Somewhat well
- Fair
- Poorly
- Very poorly

In the last year, how often have you done any of the following things for your child(ren)?

Kissed, hugged, or told your child(ren) that you loved them
Paid attention to your child(ren) when they were upset or crying
Done things with your child(ren) that were fun and interesting to them

Helped your child(ren) learn something new, look at books/read, or do schoolwork
Planned and/or monitored what your child(ren) eat to be sure they have a healthy diet
Taken your child(ren) to a medical provider or dentist for regular check-ups
Made sure there was an adult around to supervise or help your child(ren) when needed

- Never
- Sometimes
- Frequently
- Always

How stressful was your spouse's most recent deployment for you?

- Not at all stressful
- Slightly stressful
- Moderately stressful
- Very stressful

How often did you communicate with <spouse> during his/her last completed deployment?

- Almost daily
- Every few days
- About once a week
- About once or twice a month
- Less than once a month

During <spouse>'s last completed deployment, how satisfied were you with the emotional/social support you received from family, friends, and your community?

- Very dissatisfied
- Somewhat dissatisfied
- Generally satisfied
- Very satisfied
- Extremely satisfied

Which best describes your permanent household situation during <spouse>'s last completed deployment?

- Military housing, on base
- Military housing, off base
- Civilian housing

During <spouse>'s last completed deployment, did you voluntarily relocate or have someone relocate to live with you for more than 30 days for any of the following reasons? Mark all that apply.

- No, did not relocate
- Yes, needed child care
- Yes, better job opportunities
- Yes, better educational opportunities
- Yes, financial problems (making ends meet)
- Yes, wanted to be near relatives/friends
- Yes, lack of support at location you moved from
- Yes, personal safety/security
- Yes, for other reasons:

When do you expect <spouse>'s next deployment?

- Does not apply, I do not expect my spouse to be deployed
- Within 3 months
- In 4-6 months
- In 7-9 months
- In 10-12 months

- In 13-18 months
- In 19-24 months
- In more than 24 months

In the past 3 years, have you and your family had any of the following experiences?

Problem in military career (e.g., demotion, poor fitness report, passed over for promotion, etc.)
Unexpected change in military duty station assignment
Potentially dangerous job assignment (not during deployment)
Non-combat injury as result of military duties
Inability to get military support services for you or your family (e.g., family service center program, military installation housing, military child care)
Foreign residence (e.g., OCONUS, overseas) for you and your family
Remote residence (rural CONUS area or location with no local military installation) for you and your family
Unaccompanied tour
Unit leadership raised the possibility of forced downsizing or forced restructuring
For Reserve families only:
Scheduled call to active duty from reserve status
Unscheduled call to active duty from reserve status

- No
- Yes

If YES, did this event occur in the last 12 months?

- No
- Yes

In the past 3 years, have you experienced any of the following due to conflicts between military duties and civilian employment?

Financial difficulties
Employment problems
Disruption in healthcare coverage

- Yes
- No

Do you think <spouse> should stay in or leave the military?

- I strongly favor staying
- I somewhat favor staying
- I have no opinion one way or the other
- I somewhat favor leaving
- I strongly favor leaving

How did you feel about <spouse> leaving the military?

- I strongly favored staying
- I somewhat favored staying
- I had no opinion one way or the other
- I somewhat favored leaving
- I strongly favored leaving

Please indicate to what extent you feel being a military spouse has impacted the following aspects of your life:

Career development
Education development
Access to health care for self and family
Access to child care
Overall financial stability
Recreation, travel and entertainment activities

- Very positive impact
- Positive impact
- Neither negative nor positive impact
- Negative impact
- Very negative impact
- Not applicable

Has this child ever lived in the same household as <spouse>?
- No
- Yes

How many years has this child lived in the same household as <spouse> for the majority of the year?
- Less than 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17

Please provide the date of birth for this child.

MM-DD-YY

Please provide the gender of this child.
- Male
- Female

How often do you use each of the following types of child services/programs in a typical week?

Military child care program (e.g., Child Development Center – CDC, Family Child Care – FCC)
Civilian school-based program (e.g., after-school program)
Civilian child care center or other certified program (e.g., YMCA, certified home-based provider)
Informal care (e.g., babysitter, relatives, friends)
Character development and leadership development programs
Education support and career development programs
Health and life skills programs
Art programs
Sports, fitness and recreation programs
- None
- Once a week
- Twice a week
- 3 to 4 days a week
- 5 or more days a week

Which of the following describes your overall experience with obtaining child care?

- Not applicable, I do not use child care
- Very easy
- Somewhat easy
- Neither difficult nor easy
- Somewhat difficult
- Very difficult

During the past month, how often have you felt:

Your ##-year old is much harder to care for than most children his/her age?
He/she does things that really bother you a lot?
Angry with him/her?

- Never
- Rarely
- Sometimes
- Usually
- Always

Earlier in the survey, you reported that you were providing care for a child with special needs. Is this child your XX-year old?

- No
- Yes

Has your ##-year old ever received any of these services or been placed in any of the following:

Outpatient or in-home counseling for a mental, emotional, or behavioral health problem
Inpatient or residential treatment for a mental, emotional or behavioral health problem
Self-help/social support groups for a mental, emotional, or behavioral problem
Special education services or school counseling for a mental, emotional, or behavioral problem
Special education services for a learning disability or delayed academic progress
Foster care or other child welfare services
Legal services (e.g., court counselor, juvenile detention, probation)
State-sponsored case management

- Yes, within past 3 years
- Yes, prior to past 3 years
- No

In general, how would you describe your XX-year old's health?

- Excellent
- Very good
- Good
- Fair
- Poor

Deletions from previous survey:

As you begin, please write in today's date. Be sure to use a blue or black pen.

MM-DD-YY

How many years have you been married to your spouse?

____ years

Is English your primary language?

- No
- Yes

How much did you weigh a year ago? (If you were pregnant a year ago, please indicate your weight before pregnancy.)

___ pounds

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports
Lifting or carrying groceries
Climbing one flight of stairs
Bending, kneeling, or stooping
Walking more than a mile
Walking several blocks
Walking one block
Bathing or dressing yourself

- No, not limited at all
- Yes, limited a little
- Yes, limited a lot

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities
Had difficulty performing the work or other activities (for example, it took extra effort)

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

In the past 12 months, did you use prescription-strength pain relievers (e.g. codeine, OxyContin, Percocet)?

- Never
- Once a month or less
- Few days per month
- Few days per week
- Daily

During the past 4 weeks, how much have you been bothered by any of the following problems?

Feeling tired or having low energy
Trouble sleeping

- Not bothered
- Bothered a little

- Bothered a lot

Are you currently taking any medicine for anxiety, depression, or stress?

- No
- Yes

In the last 3 years, has your doctor or other health professional told you that you have any of the following conditions?

Hypertension (high blood pressure)
High cholesterol requiring medication
Coronary heart disease
Heart attack
Angina (chest pain)
Any other heart condition (please specify)
Asthma
Diabetes or sugar diabetes
Fibromyalgia
Rheumatoid arthritis
Lupus
Stomach, duodenal, or peptic ulcer
Acid reflux / gastroesophageal reflux disease requiring medication
Migraine headaches
Stroke
Sleep apnea
Thyroid condition other than cancer
Cancer (please specify)
Chronic fatigue syndrome
Depression
Posttraumatic stress disorder
Infertility
Anxiety
Memory loss or memory impairment
Eating disorder
Irritable bowel syndrome
Other (please specify below)

- No
- Yes
- If yes, in what year were you first diagnosed?
- Mark here if ever hospitalized for the condition

Please choose the answer that best describes how true or false each of the following statements is for you.

I seem to get sick a little easier than other people
I am as healthy as anybody I know
I expect my health to get worse
My health is excellent

- Definitely true
- Mostly true
- Not sure
- Mostly false
- Definitely false

Compared to 3 years ago, how would you rate your physical health in general now?

- Much better
- Somewhat better

- About the same
- Somewhat worse
- Much worse

Compared to one year ago, how would you rate your emotional health or well-being (such as feeling anxious, depressed, or irritable) now?

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

In the last 3 years, have you and your spouse tried to get pregnant?

- No
- Not applicable
- Yes

In the last 3 years, have you and your spouse been unsuccessful getting pregnant for a year or more (not including time spent apart, such as deployment)?

- No
- Yes

In the last 3 years, if you and your spouse got pregnant, did you have a miscarriage?

- Does not apply (no pregnancy)
- No miscarriage
- Yes, 1 miscarriage → Year ____
- Yes, 2 miscarriages → Years ____ ____
- Yes, 3 miscarriages → Years ____ ____ ____

In the last 3 years, have you been diagnosed with gestational diabetes by a glucose tolerance test during pregnancy?

- No
- Yes

In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?

- No
- Yes

Has this ever happened to you before?

- No
- Yes

Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?

- No
- Yes

Do these attacks bother you a lot, or are you worried about having another attack?

- No
- Yes

Think about your last bad anxiety attack.

Were you short of breath?

Did your heart race, pound, or skip?
Did you have chest pain or pressure?
Did you sweat?
Did you feel as if you were choking?
Did you have hot flashes or chills?
Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?
Did you feel dizzy, unsteady, or faint?
Did you have tingling or numbness in parts of your body?
Did you tremble or shake?
Were you afraid you were dying?

- No
- Yes

Over the last 4 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious, on edge, or worrying a lot about different things
Feeling restless so that it is hard to sit still
Getting tired very easily
Muscle tension, aches, or soreness
Trouble falling asleep or staying asleep
Trouble concentrating on things, such as reading a book or watching TV
Becoming easily annoyed or irritable

- Not at all
- Several days
- More than half the days

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

During the past 4 weeks, how much of the time: (Select the single best answer for each question.)

Did you feel full of pep?
Have you been a very nervous person?
Have you felt so down in the dumps that nothing could cheer you up?
Did you feel worn out?
Have you been a happy person?
Did you feel tired?

- None of the time
- A little of the time
- Some of the time
- A good bit of the time
- Most of the time
- All of the time

How often in the past month did you…

Threaten someone with physical violence
Cry persistently or uncontrollably
Sulk or refuse to talk about an issue

- Never

- One time
- Two times
- Three or four times
- Five or more times

During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

Rate each item from 0 (not at all) to 8 (exactly so) to indicate the degree to which each statement describes your feelings or behavior:

When I get angry, I get really mad
When I get angry, I stay angry
When I get angry at someone, I want to clobber the person

- 0 Not at all
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8 Exactly so

Do you often feel that you can't control what or how much you eat?

- No
- Yes

Do you often eat, within any 2 hour period, what most people would regard as an unusually large amount of food?

- No
- Yes

If you marked yes to either of the above, has this been as often, on average, as twice a week for the last 3 months?

- No
- Yes

In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

- Never
- Rarely
- Monthly
- Weekly
- Daily

How much time did you spend growing up in a military family?

- None of my childhood
- Very little of my childhood
- Some of my childhood
- Most of my childhood
- All of my childhood

Please indicate your level of agreement with each item.

In most ways my life is close to my ideal
The conditions of my life are excellent
So far I have gotten the important things I want in life
If I could live my life over, I would change almost nothing

- Strongly disagree
- Disagree
- Slightly disagree
- Neither agree or disagree
- Agree
- Strongly agree

In the past year, on those days that you drank alcoholic beverages, on average, how many drinks did you have?

____ drinks

In a typical week, how many drinks of each type of alcoholic beverage do you have?

____ beer(s)
____ wine
____ liquor

In the past year, how often did you typically get drunk (intoxicated)?

- Never
- Monthly or less
- 2-4 times per month
- >4 times per month

At what age did you start smoking?

____ years old

During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

In the last 3 years, how often have you experienced the following during deployment?

Being exposed to smoke from burning trash and/or feces

- Never
- Yes, 1 time
- Yes, more than 1 time
- If yes, list most recent year of exposure → _____

Do you feel that being a military spouse has hindered your career development (In other words, that you have not achieved in your career as much as you would have if you were not a military spouse)?

- 1 Not at all hindered
- 2
- 3
- 4
- 5
- 6
- 7 Extremely hindered

How many years have you been married to your spouse?

____ years

On average, during the past year, how many days of leave from work did your spouse take? Please round to nearest whole number and do not use dashes or decimals.

____ days in the past year

Many situations experienced by military families can be stressful for them. For each of the following possible stressful situations you and your family personally experienced in the past 12 months, please indicate how stressful you felt it was for you and your family.

A combat-related deployment or duty assignment for your spouse
A non-combat-related deployment or duty assignment requiring your spouse to be away from home
Uncertainty about future deployments or duty assignments
Combat-related injury to your spouse
A non-combat injury to your spouse from carrying out his/her military duties
Caring for your ill, injured, or disabled spouse
Intensified training schedule for your spouse
Increased time spouse spent away from family, or missed family celebrations, while performing military duties
Family conflict over whether spouse should remain in the military or reserves
Difficulty balancing demands of family life and your spouse's military duties
A permanent change of station (PCS)
For Reserve families only:
Unpredictability of when reservists will be activated for duty
Changes in your family's financial situation due to your spouse's active duty
Concern over your spouse's employment when de-activated
Concern over continuity of access to healthcare for your family

- Very stressful
- Moderately stressful
- Not at all stressful
- Have not experienced in the past 12 months

The questions listed below concern what happens between you and <Spouse's name>. While you may not find an answer which exactly describes what you think, please mark the answer that comes closest to what you think. Your first reaction should be your first answer.

<Spouse's name> enjoys being alone with our child
During pregnancy, <Spouse's name> expressed confidence in my ability to be a good parent
When there is a problem with our child, we work out a good solution together
<Spouse's name> and I communicate well about our child
Talking to <Spouse's name> about our child is something I look forward to
<Spouse's name> and I agree on what our child should and should not be permitted to do
I feel close to <Spouse's name> when I see him/her play with our child
<Spouse's name> believes I am a good parent
I believe <Spouse's name> is a good parent
<Spouse's name> sees our child in the same way I do
<Spouse's name> and I would basically describe our child in the same way
If our child needs to be punished, <Spouse's name> and I usually agree on the type of punishment
I feel good about <Spouse's name>'s judgment about what is right for our child
<Spouse's name> tells me I am a good parent
<Spouse's name> and I have the same goals for our child

- Strongly agree
- Agree
- Not sure

- Disagree
- Strongly disagree

What was the main cause of your spouse's death?
- Combat
- Accident (on-duty)
- Accident (off-duty)
- Illness/Disease
- Homicide
- Suicide
- Unknown
- Other:

When did your spouse leave for deployment?
MM-YYYY

When did your spouse return from his/her last completed deployment?
MM-YYYY

During the last completed deployment or active duty assignment, how much support did you feel you received from the following?
Your extended family
Your friends
Your co-workers
Your neighbors
Your clergyman or chaplain
Support group of those in a situation similar to yours
Family and community support services
Your mental health provider (e.g. psychiatrist or psychologist)
Your primary care provider (e.g. family practice doctor or nurse practitioner)
Other military resources
- A lot
- Moderate amount
- Only a little
- None at all
- Does not apply

Following your spouse's last completed deployment, did you personally participate in any deployment transition programs such as Return and Reunion? (For instance, programs on how to prevent or manage the stress related to your spouse returning from a deployment or active duty assignment.)
- No
- Yes

Indicate which of the following are reasons why you did not participate in a deployment transition program.
No such program was available to me
I was not able to take the time to participate in the program
I had no child care available
I was unable to get off work to attend the program
I had previously received this training and did not need it again
I did not think such training would help me
I was not aware these programs were available
My spouse was not supportive of the program
- No

- Yes

Please choose the best answer regarding your spouse's return from the last completed deployment.

How long did it take for your relationship to return to the way it was before he/she left home?

- Less than one month
- 1-2 months
- 3-5 months
- 6 or more months
- Not yet adjusted

Please indicate how you feel about each statement: Generally, on a day-to-day basis, I am proud to be a military spouse

- Very strongly disagree
- Strongly disagree
- Mildly disagree
- Neutral
- Mildly agree
- Strongly agree
- Very strongly agree

How long have you lived at your current location?

- Less than a year
- 1 to 2 years
- 3 to 5 years
- 6 or more years

Do you currently live with extended family (for example, your parents, your in-laws, your siblings)?

- Yes, in your home
- Yes, in their home
- No

Are you currently living near family (for example, you moved to your hometown)?

- Yes
- No

Do you have any children with your spouse or from prior relationship(s)?

- No
- Yes

Please indicate if you are currently interested in your child(ren) receiving mental health services/counseling?

If yes, please indicate which children.

Please indicate if your child(ren) is overweight.

If yes, please indicate which child(ren).

In the last 3 years, have any of your children 17 or younger, received any of these services or been placed in any of the following: (If you have more than one child, please mark all that apply for any of your children.)

Inpatient psychiatric unit or a hospital for mental health problems

Residential treatment center (A self-contained treatment facility where the child lives and goes to school)

Detention center, training school, jail, or prison

Group home (A group residence in a community setting)

Treatment foster care (Placement with foster parents who receive special training and supervision to help children with problems

Probation officer or court counselor
Day treatment program (A day program that includes a focus on therapy and may also provide education while the child is there)
Case management or care coordination (Someone who helps the child get the kinds of services he/she needs)
In-home counseling (Services, therapy, or treatment provided in the child's home)
Outpatient counseling/therapy (From psychologist, social worker, therapist, or other counselor)
Outpatient treatment from a psychiatrist
Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems. (Excluding emergency room)
School counselor, school psychologist, or school social worker (For behavioral or emotional problems.)
Special class or special school (For all or part of the day)
Child Welfare or Department of Social Services (Include any type of contact)
Foster care (Placement in kinship or non-relative foster care)
Therapeutic recreation services or mentor
Hospital emergency room (For problems related to trauma or emotional or behavioral problems)
Self-help groups (such as Alcoholics Anonymous, Narcotics Anonymous)

- No
- Yes

In the last 3 years, has a doctor or health professional told you that any of your children 17 or younger, has any of the following conditions? (If you have more than one child, and more than one child has the condition, please mark the severity level for the child that is most affected by the condition.)

Food allergies
Non-food allergies
Stuttering, stammering, or other speech problems
Eating disorder
Tourette syndrome
Cystic fibrosis
Cerebral palsy
Muscular dystrophy
Epilepsy or other seizure disorder
Migraine or frequent headaches
Arthritis or other joint problems
A brain injury or concussion
Blood problems such as anemia or sickle cell disease

- No
- Yes

If yes:

- Mild
- Moderate
- Severe

A great deal has been learned from this study and as a consequence we've been asked to consider other research possibilities. If other related research studies become available, is it ok to contact you to let you know about these opportunities?

- No
- Yes