

Attachment 1: ACS Disability & NHIS questions to be cognitively tested

Form Approved
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ACS Questions

Interviewer Instructions: The ACS Instrument is self-administered. Please hand the instrument to the participant and have them complete it. After they have completed the instrument, probe on its questions with particular attention on the disability questions for any of the participant’s children with disabilities (response of “Yes”). Once finished probing on the ACS questions, please continue with the NHIS questions, which are interviewer administered.



THE American Community Survey

This booklet shows the content of the American Community Survey questionnaire.

Start Here

Respond online today at:
<https://respond.census.gov/acs>

OR

Complete this form and mail it back as soon as possible.

This form asks for information about the people who are living or staying at the address on the mailing label and about the house, apartment, or mobile home located at the address on the mailing label.



If you need help or have questions about completing this form, please call **1-800-354-7271**. The telephone call is free.

Telephone Device for the Deaf (TDD):
Call 1-800-582-8330. The telephone call is free.

¿NECESITA AYUDA? Si usted habla español y necesita ayuda para completar su cuestionario, llame sin cargo alguno al **1-877-833-5625**. Usted también puede completar su entrevista por teléfono con un entrevistador que habla español. O puede responder por Internet en: <https://respond.census.gov/acs>

For more information about the American Community Survey, visit our website at: <http://www.census.gov/acs>

➔ Please print today's date.

Month Day Year

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➔ Please print the name and telephone number of the person who is filling out this form. We will only contact you if needed for official Census Bureau business.

Last Name

First Name MI

Area Code + Number

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➔ How many people are living or staying at this address?

- **INCLUDE** everyone who is living or staying here for more than 2 months.
- **INCLUDE** yourself if you are living here for more than 2 months.
- **INCLUDE** anyone else staying here who does not have another place to stay, even if they are here for 2 months or less.
- **DO NOT INCLUDE** anyone who is living somewhere else for more than 2 months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

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➔ Fill out pages 2, 3, and 4 for everyone, including yourself, who is living or staying at this address for more than 2 months. Then complete the rest of the form.

Person 1

(Person 1 is the person living or staying here in whose name this house or apartment is owned, being bought, or rented. If there is no such person, start with the name of any adult living or staying here.)

1 What is Person 1's name?
 Last Name (Please print) _____ First Name _____ MI _____

2 How is this person related to Person 1?
 Person 1

3 What is Person 1's sex? Mark (X) ONE box.
 Male Female

4 What is Person 1's age and what is Person 1's date of birth?
 Please report babies as age 0 when the child is less than 1 year old.
 Age (in years) _____
 Print numbers in boxes.
 Month _____ Day _____ Year of birth _____

→ NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this survey, Hispanic origins are not races.

5 Is Person 1 of Hispanic, Latino, or Spanish origin?
 No, not of Hispanic, Latino, or Spanish origin
 Yes, Mexican, Mexican Am., Chicano
 Yes, Puerto Rican
 Yes, Cuban
 Yes, another Hispanic, Latino, or Spanish origin – Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on. ↴

6 What is Person 1's race? Mark (X) one or more boxes.
 White
 Black or African Am.
 American Indian or Alaska Native – Print name of enrolled or principal tribe. ↴

Asian Indian Japanese Native Hawaiian
 Chinese Korean Guamanian or Chamorro
 Filipino Vietnamese Samoan
 Other Asian – Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on. ↴
 Other Pacific Islander – Print race, for example, Fijian, Tongan, and so on. ↴

Some other race – Print race. ↴

Person 2

1 What is Person 2's name?
 Last Name (Please print) _____ First Name _____ MI _____

2 How is this person related to Person 1? Mark (X) ONE box.
 Opposite-sex husband/wife/spouse Father or mother
 Opposite-sex unmarried partner Grandchild
 Same-sex husband/wife/spouse Parent-in-law
 Same-sex unmarried partner Son-in-law or daughter-in-law
 Biological son or daughter Other relative
 Adopted son or daughter Roommate or housemate
 Stepson or stepdaughter Foster child
 Brother or sister Other nonrelative

3 What is Person 2's sex? Mark (X) ONE box.
 Male Female

4 What is Person 2's age and what is Person 2's date of birth?
 Please report babies as age 0 when the child is less than 1 year old.
 Age (in years) _____
 Print numbers in boxes.
 Month _____ Day _____ Year of birth _____

→ NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this survey, Hispanic origins are not races.

5 Is Person 2 of Hispanic, Latino, or Spanish origin?
 No, not of Hispanic, Latino, or Spanish origin
 Yes, Mexican, Mexican Am., Chicano
 Yes, Puerto Rican
 Yes, Cuban
 Yes, another Hispanic, Latino, or Spanish origin – Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on. ↴

6 What is Person 2's race? Mark (X) one or more boxes.
 White
 Black or African Am.
 American Indian or Alaska Native – Print name of enrolled or principal tribe. ↴

Asian Indian Japanese Native Hawaiian
 Chinese Korean Guamanian or Chamorro
 Filipino Vietnamese Samoan
 Other Asian – Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on. ↴
 Other Pacific Islander – Print race, for example, Fijian, Tongan, and so on. ↴

Some other race – Print race. ↴

Person 3

1 What is Person 3's name?
 Last Name (Please print) _____ First Name _____ MI _____

- 2 How is this person related to Person 1? Mark (X) ONE box.**
- | | |
|---|--|
| <input type="checkbox"/> Opposite-sex husband/wife/spouse | <input type="checkbox"/> Father or mother |
| <input type="checkbox"/> Opposite-sex unmarried partner | <input type="checkbox"/> Grandchild |
| <input type="checkbox"/> Same-sex husband/wife/spouse | <input type="checkbox"/> Parent-in-law |
| <input type="checkbox"/> Same-sex unmarried partner | <input type="checkbox"/> Son-in-law or daughter-in-law |
| <input type="checkbox"/> Biological son or daughter | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Adopted son or daughter | <input type="checkbox"/> Roommate or housemate |
| <input type="checkbox"/> Stepson or stepdaughter | <input type="checkbox"/> Foster child |
| <input type="checkbox"/> Brother or sister | <input type="checkbox"/> Other nonrelative |

3 What is Person 3's sex? Mark (X) ONE box.
 Male Female

4 What is Person 3's age and what is Person 3's date of birth?
 Please report babies as age 0 when the child is less than 1 year old.

Age (in years) _____

Print numbers in boxes.
 Month _____ Day _____ Year of birth _____

→ **NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this survey, Hispanic origins are not races.**

- 5 Is Person 3 of Hispanic, Latino, or Spanish origin?**
- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican Am., Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin – Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on. ↴

- 6 What is Person 3's race? Mark (X) one or more boxes.**
- White
- Black or African Am.
- American Indian or Alaska Native – Print name of enrolled or principal tribe. ↴

- | | | |
|--|---|--|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Other Asian – Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on. ↴ | <input type="checkbox"/> Other Pacific Islander – Print race, for example, Fijian, Tongan, and so on. ↴ | |

Some other race – Print race. ↴

Person 4

1 What is Person 4's name?
 Last Name (Please print) _____ First Name _____ MI _____

- 2 How is this person related to Person 1? Mark (X) ONE box.**
- | | |
|---|--|
| <input type="checkbox"/> Opposite-sex husband/wife/spouse | <input type="checkbox"/> Father or mother |
| <input type="checkbox"/> Opposite-sex unmarried partner | <input type="checkbox"/> Grandchild |
| <input type="checkbox"/> Same-sex husband/wife/spouse | <input type="checkbox"/> Parent-in-law |
| <input type="checkbox"/> Same-sex unmarried partner | <input type="checkbox"/> Son-in-law or daughter-in-law |
| <input type="checkbox"/> Biological son or daughter | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Adopted son or daughter | <input type="checkbox"/> Roommate or housemate |
| <input type="checkbox"/> Stepson or stepdaughter | <input type="checkbox"/> Foster child |
| <input type="checkbox"/> Brother or sister | <input type="checkbox"/> Other nonrelative |

3 What is Person 4's sex? Mark (X) ONE box.
 Male Female

4 What is Person 4's age and what is Person 4's date of birth?
 Please report babies as age 0 when the child is less than 1 year old.

Age (in years) _____

Print numbers in boxes.
 Month _____ Day _____ Year of birth _____

→ **NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this survey, Hispanic origins are not races.**

- 5 Is Person 4 of Hispanic, Latino, or Spanish origin?**
- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican Am., Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin – Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on. ↴

- 6 What is Person 4's race? Mark (X) one or more boxes.**
- White
- Black or African Am.
- American Indian or Alaska Native – Print name of enrolled or principal tribe. ↴

- | | | |
|--|---|--|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Other Asian – Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on. ↴ | <input type="checkbox"/> Other Pacific Islander – Print race, for example, Fijian, Tongan, and so on. ↴ | |

Some other race – Print race. ↴

Person 5

1 What is Person 5's name?

Last Name (Please print) _____ First Name _____ MI _____

2 How is this person related to Person 1? Mark (X) ONE box.

- | | |
|---|--|
| <input type="checkbox"/> Opposite-sex husband/wife/spouse | <input type="checkbox"/> Father or mother |
| <input type="checkbox"/> Opposite-sex unmarried partner | <input type="checkbox"/> Grandchild |
| <input type="checkbox"/> Same-sex husband/wife/spouse | <input type="checkbox"/> Parent-in-law |
| <input type="checkbox"/> Same-sex unmarried partner | <input type="checkbox"/> Son-in-law or daughter-in-law |
| <input type="checkbox"/> Biological son or daughter | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Adopted son or daughter | <input type="checkbox"/> Roommate or housemate |
| <input type="checkbox"/> Stepson or stepdaughter | <input type="checkbox"/> Foster child |
| <input type="checkbox"/> Brother or sister | <input type="checkbox"/> Other nonrelative |

3 What is Person 5's sex? Mark (X) ONE box.

- Male Female

4 What is Person 5's age and what is Person 5's date of birth?

Please report babies as age 0 when the child is less than 1 year old.
 Print numbers in boxes.
 Age (in years) _____ Month _____ Day _____ Year of birth _____

→ **NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this survey, Hispanic origins are not races.**

5 Is Person 5 of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
 Yes, Mexican, Mexican Am., Chicano
 Yes, Puerto Rican
 Yes, Cuban
 Yes, another Hispanic, Latino, or Spanish origin – Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.

6 What is Person 5's race? Mark (X) one or more boxes.

- White
 Black or African Am.
 American Indian or Alaska Native – Print name of enrolled or principal tribe.
- | | | |
|--|---|--|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Other Asian – Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on. | <input type="checkbox"/> Other Pacific Islander – Print race, for example, Fijian, Tongan, and so on. | |
- Some other race – Print race.

→ **If there are more than five people living or staying here, print their names in the spaces for Person 6 through Person 12. We may call you for more information about them.**

Person 6

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 7

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 8

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 9

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 10

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 11

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 12

Last Name (Please print) _____ First Name _____ MI _____

Sex Male Female Age (in years) _____

Person 1

A Answer questions 1a-b if this person is 2 years old or older. Otherwise SKIP to the questions for Person 2 on next page.

- ① a. Does this person have difficulty seeing, even if wearing glasses? Would you say:**
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all
- b. Does this person have difficulty hearing, even if using a hearing aid? Would you say:**
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

B Answer questions 2a if this person is 5 years old or older. Otherwise SKIP to the questions for Person 2 on next page.

- ② a. Does this person have difficulty walking or climbing steps [stairs]? Would you say:**
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all
- b. Does this person have difficulty remembering or concentrating? Would you say:**
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

c. Does this person have difficulty with self-care such as washing all over or dressing? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

d. Using their usual language, does this person have difficulty communicating, for example understanding or being understood? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

Ⓢ Continue with the questions for Person 2 on the next page. If no one is listed as Person 2 on page 2, END ACS Questionnaire.

Person 2

Ⓐ Answer questions 1a-b if this person is 2 years old or older. Otherwise SKIP to the questions for Person 3 on next page.

- ① a. Does this person have difficulty seeing, even if wearing glasses? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all
- b. Does this person have difficulty hearing, even if using a hearing aid? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

Ⓑ Answer questions 2a if this person is 5 years old or older. Otherwise SKIP to the questions for Person 3 on next page.

- ② a. Does this person have difficulty walking or climbing steps [stairs]? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all
- b. Does this person have difficulty remembering or concentrating? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

- c. Does this person have difficulty with self-care such as washing all over or dressing? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

- d. Using their usual language, does this person have difficulty communicating, for example understanding or being understood? Would you say:
- No, no difficulty
 - Yes, some difficulty
 - Yes, a lot of difficulty
 - Cannot do at all

Ⓒ Continue with the questions for Person 3 on the next page. If no one is listed as Person 3 on page 2, END ACS Questionnaire.

Person 3

A Answer questions 1a-b if this person is 2 years old or older. Otherwise SKIP to the questions for Person 4 on next page.

① a. Does this person have difficulty seeing, even if wearing glasses? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have difficulty hearing, even if using a hearing aid? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

B Answer questions 2a if this person is 5 years old or older. Otherwise SKIP to the questions for Person 4 on next page.

② a. Does this person have difficulty walking or climbing steps [stairs]? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have difficulty remembering or concentrating? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

c. Does this person have difficulty with self-care such as washing all over or dressing? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

d. Using their usual language, does this person have difficulty communicating, for example understanding or being understood? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

C Continue with the questions for Person 4 on the next page. If no one is listed as Person 4 on page 2, END ACS Questionnaire.

Person 4

A Answer questions 1a-b if this person is 2 years old or older. Otherwise SKIP to the questions for Person 5 on next page.

① a. Does this person have difficulty seeing, even if wearing glasses? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have difficulty hearing, even if using a hearing aid? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

B Answer questions 2a if this person is 5 years old or older. Otherwise SKIP to the questions for Person 5 on next page.

② a. Does this person have difficulty walking or climbing steps [stairs]? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have difficulty remembering or concentrating? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

c. Does this person have difficulty with self-care such as washing all over or dressing? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

d. Using their usual language, does this person have difficulty communicating, for example understanding or being understood? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

C Continue with the questions for Person 5 on the next page. If no one is listed as Person 5 on page 2, END ACS Questionnaire.

Person 5

A Answer questions 1a-b if this person is 2 years old or older. Otherwise, END ACS Questionnaire.

① a. Does this person have

difficulty seeing, even if wearing glasses? Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have **difficulty hearing, even if using a hearing aid?**

Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

B Answer questions 2a if this person is 5 years old or older. Otherwise, END ACS Questionnaire.

② a. Does this person have

difficulty walking or climbing steps [stairs]?

Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

b. Does this person have **difficulty remembering or concentrating? Would you say:**

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

c. Does this person have **difficulty with self-care such as washing all over or dressing? Would you say:**

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

d. Using their usual language, does this person have **difficulty communicating, for example understanding or being understood?**

Would you say:

- No, no difficulty
- Yes, some difficulty
- Yes, a lot of difficulty
- Cannot do at all

END ACS Questionnaire.

NHIS Questions

CHILD SLEEP

SLEEP1. In a typical week during the school year, how often does [CHILD'S NAME] wake up well-rested? Would you say every day, most days, some days, few days, or no days? Would you say never, some days, most days, or every day?

Never
Some days
Most days
Every day
Refused
Don't know

SLEEP2. In a typical week during the school year, how often does [CHILD'S NAME] have difficulty getting out of bed in the morning? Would you say never, some days, most days, or every day?

Never
Some days
Most days
Every day
Refused
Don't know

SLEEP3. In a typical week during the school year, how often does [CHILD'S NAME] complain about being tired during the day? Would you say never, some days, most days, or every day?

Never
Some days
Most days
Every day
Refused
Don't know

SLEEP4. In a typical week during the school year, how often does [CHILD'S NAME] nap or fall asleep during the day, such as in school, watching TV, or riding in a car? Would you say never, some days, most days, or every day?

Never
Some days
Most days
Every day
Refused
Don't know

SLEEP5. In a typical week during the school year, on nights [CHILD'S NAME] had school the next day, how often did he/she go to bed at the same time? Would you say never, some days, most days, or every day?

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

SLEEP6. In a typical week during the school year, on school days, how often did [CHILD'S NAME] wake up at the same time? Would you say never, some days, most days, or every day?

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

CHILD SCREEN TIME

SCREENTIME1. "In a typical week during the school year, how often does [CHILD'S NAME] spend at least 60 minutes a day in front of a TV, computer, cellphone or other electronic device watching programs, playing games, or accessing the internet or using social media? Would you say never, some days, most days, or every day? *Read-if-necessary: Do not include time spent doing schoolwork.*

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

CHILD PHYSICAL EDUCATION

PHYSED1. In the past 12 months, did [CHILD'S NAME] take a Physical Education, PE, or gym class?

- Yes
- No
- Don't know
- Refused

WALK1. In a typical week during the school year, how often does [CHILD'S NAME] walk for at least 10 minutes at a time? Would you say never, some days, most days, or every day?

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

BIKE1. In a typical week during the school year, how often does [CHILD'S NAME] bike for at least 10 minutes at a time? Would you say never, some days, most days, or every day?

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

STRENGTH1. In a typical week during the school year, how often does [CHILD'S NAME] lift weights or use weights while they play or exercise? Would you say never, some days, most days, or every day?

- Never
- Some days
- Most days
- Every day
- Refused
- Don't know

CHILD INJURY

INJURY_INTRO: The next set of questions asks about injuries. People can be injured accidentally, or on purpose. They may hurt themselves or others may cause them to be hurt.

INJURY1. DURING THE PAST 3 MONTHS, did [CHILD'S NAME] have an accident or an injury where any part of his/her body was hurt?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

Skip Instructions: If Yes: go to INJURY2
 If No, DK, or Refused: End Questionnaire

INJURY2. Did any of these injuries limit [CHILD'S NAME]'s usual activities for at least 24 hours after the injury occurred?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY3. Did any of these injuries cause [CHILD'S NAME] to miss at least one day of [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare]?

1. Yes
2. No
7. Don't know
9. Refused

Skip Instructions: If Yes to INJURY2 or INJURY3 and Child's age is 3 or older: go to INJURY4.
If Yes to INJURY2 or INJURY3 and Child's age <3; go to INJURY7
If No, DK, or Refused to INJURY2 and INJURY3: End Questionnaire.

INJURY4. [age 3-17] Please think only about the injuries that occurred IN THE PAST 3 MONTHS that caused [child's name] to miss at least one day of [FILL (if age 5-17): school; (if age 3-4): school or daycare], or that made it difficult for him/her to do things that he/she usually does for one day or more.

Did any of these injuries occur while [CHILD'S NAME] was playing sports or exercising, including walking, biking, or running, playing baseball, basketball, football or doing any other physical activity?
Read if necessary: Include recreational sports such as skating, skiing, tennis, golf, bowling, or fishing.

1. Yes
2. No
7. Don't know
9. Refused

INJURY5. [age 3-17] Did any of these injuries occur while [CHILD'S NAME] was doing household activities, such as housework, cooking, chores, or yardwork?

1. Yes
2. No
7. Don't know
9. Refused

INJURY6. [If age 3-17] Did any of these injuries occur while [CHILD'S NAME] was engaged in leisure activities, such as playing, hanging out with friends, doing a hobby, or just relaxing?

1. Yes
2. No
7. Don't know
9. Refused

INJURY7. The next two questions are about where [CHILD'S NAME] was when s/he was injured. Please continue to only consider those injuries that happened IN THE PAST 3 MONTHS that caused him/her to miss at least one day of [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare], or that made it difficult for him/her to do things that he/she usually does for one day or more.

Did any injury occur while [CHILD'S NAME] was at his/her home?
Read if necessary: Include the yards, garage, basement, and other places on the home property.

1. Yes
2. No
7. Don't know

9. Refused

INJURY8. Did any injury occur while [CHILD'S NAME] was at [FILL (if age 5-17): school; (if age 3-4): school or a daycare center; (if age 0-2): a daycare center]?

Read if necessary: Include classrooms, playgrounds, sports fields, swimming pools, parking lots and other places on school or daycare property.

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY9. The next questions are about two ways that [CHILD'S NAME] might have been injured.

Did [CHILD'S NAME] have any injury as a result of a fall or falling?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

Skip Instructions: If Yes to INJURY7: go to INJURY10
 Else If Yes to INJURY8; go to INJURY11
 Else; go to INJURY12

INJURY10. Did any fall occur while [CHILD'S NAME] was at his/her HOME?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY11. Did any fall occur while [CHILD'S NAME] was at [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare]?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY12. Did [CHILD'S NAME] have any injury as a result of being in a motor vehicle crash or being hit by a motor vehicle, while not in a vehicle, such as while walking or biking?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY13. Was [CHILD'S NAME] a [if age>=6: a driver,] passenger, bicyclist, a pedestrian, or doing something else when this occurred?

(MARK ALL THAT APPLY)

- 1. Driver
- 2. Passenger
- 3. Bicyclist
- 4. Pedestrian
- 5. Something else
- 7. Don't know
- 9. Refused

INJURY14. Did any of [CHILD'S NAME's] injuries result in broken bones?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY15. Did any of [CHILD'S NAME's] injuries require stitches or staples?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY16. Were any of [CHILD'S NAME's] injuries a sprain or strain?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY17. The next questions are about the impact of [CHILD'S NAME]'s injuries. Please continue to only consider those injuries that happened **IN THE PAST 3 MONTHS** that caused him/her to miss at least one day of [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare], or that made it difficult for him/her to do things that he/she usually does for one day or more.

DURING THE PAST 3 MONTHS, how many days of [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare], did [child's name] miss because of injuries?

_____ Number of days

Skip Instructions: If 0: go to INJURY19
 If 1-90; go to INJURY18

INJURY18. Do you expect [CHILD'S NAME] to miss any more days of [FILL (if age 5-17): school; (if age 3-4): school or daycare; (if age 0-2): daycare], because of injuries that occurred DURING THE PAST 3 MONTHS?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY19. Did [CHILD'S NAME] see a doctor or other health professional about any of these injuries?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

Skip Instructions: If Yes: go to INJURY20.
 If No, DK, or Refused; go to INJURY22

INJURY20. Did [CHILD'S NAME] go to an emergency room for any of these injuries?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY21. Was [CHILD'S NAME] hospitalized overnight for any of these injuries?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

INJURY22. In his/her lifetime, has [CHILD'S NAME] ever had a significant head injury or concussion?

- 1. Yes
- 2. No
- 7. Don't know
- 9. Refused

Skip Instruction: If yes: go to INJURY23
 If no: End Questionnaire

INJURY23. How many times has [child's name] have a significant head injury or concussion?

Enter number of times _____

INJURY24. Did [CHILD'S NAME] have a significant head injury or concussion in the past three months?

1. Yes
2. No
7. Don't know
9. Refused