

## Appendix 2: Questions to be cognitively tested

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### ACS Questions

1. What is Person [1-5]'s name?

Last name \_\_\_\_\_

First Name \_\_\_\_\_

2. How is this person related to Person 1?

Person 1

Opposite-sex husband/wife/spouse

Opposite-sex unmarried partner

Same-sex husband/wife/spouse

Same-sex unmarried partner

Biological son or daughter

Adopted son or daughter

Stepson or stepdaughter

Brother or sister

Father or mother

Grandchild

Parent-in-law

Son-in-law or daughter-in-law

Other relative

Roommate or housemate

Foster child

Other nonrelative

3. What is Person [1-5]'s sex? *Mark X ONE box*

Male

Female

4. What is Person 2's age and what is Person 2's date of birth? *For babies less than 1 year old, do not write the age in months. Write 0 as the age.*

Age (in years) \_\_\_\_\_  
Month\_\_  
Day\_\_  
Year of birth\_\_\_\_\_

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

Is Person [1-5] 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, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc. \_\_\_\_\_

6. What is Person 2's race? Mark (X) one or more boxes AND print origins

White – Print, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc. \_\_\_\_\_  
Black or African Am. – Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc. \_\_\_\_\_  
American Indian or Alaska Native – Print name of enrolled or principal tribe(s), for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc. \_\_\_\_\_  
Chinese  
Filipino  
Asian Indian  
Vietnamese  
Korean  
Japanese  
Other Asian – Print, for example, Pakistani, Cambodian, Hmong, etc. \_\_\_\_\_  
Native Hawaiian  
Samoan  
Chamorro  
Other Pacific Islander – Print, for example, Tongan, Fijian, Marshallese, etc. \_\_\_\_\_  
Some other race – Print race or origin. \_\_\_\_\_

7. Where was this person born?

In the United States—*Print name of state.* \_\_\_\_\_  
Outside the United States—*Print name of foreign country, or Puerto Rico, Guam, etc.-*  
\_\_\_\_\_

**8.** Is this person a citizen of the United States?

Yes, born in the United States (*SKIP to question 10a*)

Yes, born in Puerto Rico, Guam, the U.S. Virgin Islands, or Northern Marianas

Yes, born abroad of U.S. citizen parent or parents

Yes, U.S. citizen by naturalization—*Print year of naturalization* \_\_\_\_\_

No, not a U.S. citizen

**9.** When did this person come to live in the United States? *If this person came to live in the United States more than once, print elates year.*

Year \_\_\_\_\_

**10a.** At any time in the last 3 months, has this person attended school or college? *Include only nursery or preschool, kindergarten, elementary school, home school, and schooling which leads to a high school diploma or a college degree.*

No, has not attended in the last 3 months (*SKIP to question 11*)

Yes, public school, public college

Yes, private school, private college, home school

**10b.** What grade or level was this person attending? *Mark (X) ONE box.*

Nursery school, preschool

Kindergarten

Grade 1 through 12—*Specify grade 1-12* \_\_\_\_\_

College undergraduate

Graduate or professional school beyond a bachelor's degree (*for example: MA or PhD program, or medical or law school*)

**11.** What is the highest grade of school or degree this person has completed? *If currently enrolled, select the previous grade or highest degree received. Mark (X) ONE box.*

Less than grade 1

Grade 1 through 11—*Specify grade 1-11* \_\_\_\_\_

12<sup>th</sup> grade—NO DIPLOMA

Regular high school diploma

GED or alternative credential

Some college credit, but less than 1 year or college credit

11 or more years of college credit, no degree

Associate's degree (*for example: AA, AS*)

Bachelor's degree (*for example: BA, BS*)

Master's degree (*for example: MA, MS, MEng, Med, MSW, MBA*)

Professional degree beyond a bachelor's degree (*for example: PhD, EdD*)

**12.** This question focuses on the person's BACHELOR'S DEGREE. Please print below the specific major(s) of any BACHELOR'S DEGREES this person has received. (*For example: chemical engineering, elementary teacher education, organizational psychology*)

\_\_\_\_\_

**13.** What is this person’s ancestry or ethnic origin? (For example: Italian, Jamaican, African Am., Cambodia, Cape Verdean, Norwegian, Dominican, French Canadian, Haitian, Korean, Lebanese, Polish, Nigerian, Mexican, Taiwanese, Ukrainian, and so on.)

\_\_\_\_\_

**14a.** Does this person speak a language other than English at home?

Yes

No (SKIP to question 15a)

**14b.** What is this language?

\_\_\_\_\_

**14c.** How well does this person speak English?

Very well

Well

Not well

Not at all

**15a.** Did this person live in this house or apartment 1 year ago?

Person is under 1 year old → SKIP to question 16

Yes, this house → SKIP to question 16

No, outside the United States and Puerto Rico – Print name of foreign country, or U.S. Virgin Islands, Guam, etc., below; then SKIP to question 16\_\_\_\_\_

No, different house in the United States or Puerto Rico

**15b.** Where did this person live 1 year ago?

Address (number and street name)\_\_\_\_\_

Name of city, town, or post office \_\_\_\_\_

Name of U.S. country or municipio in Puerto Rico\_\_\_\_\_

Name of U.S. state or Puerto Rico\_\_\_\_\_

ZIP code\_\_\_\_\_

**16.** Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? Do NOT include plans that cover only one type of service, such as dental, drug, or vision plans.

Mark "Yes" or "No" for EACH type of coverage in items a – h.

a. Insurance through a current or former employer or union (of this person or another family member)

b. Medicare, for people 65 and older, or people with certain disabilities

c. Medicaid, Children’s Health Insurance Program (CHIP), or any kind of government-assistance plan for those with low incomes or a disability

- d. Insurance purchased directly from an insurance company or through a State or Federal Marketplace, HealthCare.gov, or a similar website (by this person or another family member)
- e. TRICARE or other military health care
- f. VA (enrolled for VA health care)
- g. Indian Health Service
- h. Any other type of health insurance or health coverage plan – Specify \_\_\_\_\_

**17a.** Is there a premium for this plan? *A premium is a fixed amount of money paid on a regular basis for health coverage. It does not include copays, deductibles, or other expenses such as prescription costs.*

Yes

No (*SKIP to question 18a*)

**17b.** Does this person or another family member receive a tax credit or subsidy based on family income to help pay the premium?

Yes

No

**18a.** Does this person have difficulty seeing, even if wearing glasses?

No difficulty

Some difficulty

A lot of difficulty

Cannot do at all

**18b.** Does this person have difficulty hearing, even if using a hearing aid?

No difficulty

Some difficulty

A lot of difficulty

Cannot do at all

Skip Instructions: Answer questions 19-20 if this person is 5 years or over.  
Otherwise, SKIP to the questions for Person -2-5] on the next page.

**19a.** Does this person have difficulty walking or climbing stairs?

No difficulty

Some difficulty

A lot of difficulty

Cannot do at all

**19b.** Does this person have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

**19c.** Does this person have difficulty with self-care such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

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

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

### **NHIS Questions**

**AGEOFONSET.** You said that [YOU or NAME if proxy] have difficulty with [fill: seeing, hearing, walking or climbing steps, remembering or concentrating, self-care, communicating]. Did [if one: this difficulty / if more than one: any of these difficulties] begin before age 18?

- Yes
- No
- Don't know
- Refused

### **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?

*Read if necessary: Motor vehicles include cars, trucks, vans, buses, motorcycles, motorized scooters, motorized carts, tractors, ATVs, snowmobiles, dune buggies, and other motorized vehicles.*

- 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?

*Read if necessary: Motor vehicles include cars, trucks, vans, buses, motorcycles, motorized scooters, motorized carts, tractors, ATVs, snowmobiles, dune buggies, and other motorized vehicles.*

(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

**CONCINTRO\_C:** *The next questions are about head injuries that may have occurred anytime in [CHILD'S NAME]'s life. Please think about all head injuries, for example, from playing sports, car accidents, falls, or being hit by something or someone.*

**INJLOSTCON\_C.** As a result of a blow or jolt to the head, has [CHILD'S NAME] ever been knocked out or lost consciousness?

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

Skip Instructions: If Yes: go to INJCHKCONC\_C

If No, DK, or Refused; go to INJDAZED\_C

**INJDAZED\_C.** As a result of a blow or jolt to the head, has [CHILD'S NAME] ever been dazed or had a gap in his/her memory?

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

**INJHEADSYM\_C.** As a result of a blow or jolt to the head, has [CHILD'S NAME] ever had headaches, vomiting, blurred vision, or changes in mood or behavior?

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

**INJCHKCONC\_C.** Has [CHILD'S NAME] ever been checked for a concussion or brain injury by a doctor, nurse, athletic trainer, or other health care professional?

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

Skip Instructions:    If Yes: go to INJDRCONC\_C  
                              If No, DK, or Refused; End Questionnaire

**INJDRCONC\_C.** Did a doctor, nurse, athletic trainer, or other health care provider ever say that [CHILD'S NAME] had a concussion or brain injury?

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