

CASE ID:

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OMB Control Number:

Expiration Date:

### Section A. Screener

**A.1. A1. Are there any children 0-17 years old who usually live or stay at this household?**

<sup>1</sup>  NO [IF NO, STOP HERE. THIS IS THE END OF THE SURVEY]

<sup>2</sup>  YES

**A.2. How many children 0-17 years old usually live or stay at this household?**

NUMBER OF CHILDREN LIVING OR STAYING AT THIS ADDRESS

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**A.3. What is the primary language spoken in the household?**

<sup>1</sup>  ENGLISH

<sup>2</sup>  SPANISH

<sup>3</sup>  ANOTHER LANGUAGE, PLEASE SPECIFY:

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Answer the remaining questions for each of the children 0-17 years old who usually live or stay at this address.

Start with the youngest child, who we will call "Child 1" and continue with the next youngest until you have answered the questions for all children who usually live or stay at this address.

**A.4. CHILD 1**

**What is this child's first name, initials, or nickname?**

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**A.5. Is this child of Hispanic, Latino, or Spanish origin?**

<sup>1</sup>  No, not of Hispanic, Latino, or Spanish origin

<sup>2</sup>  Yes, Mexican, Mexican American, Chicano

<sup>3</sup>  Yes, Puerto Rican

<sup>4</sup>  Yes, Cuban

<sup>5</sup>  Yes, another Hispanic, Latino, or Spanish origin, please specify:

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**A.6. What is this child's race? SELECT ONE OR MORE.**

1  WHITE

2  BLACK OR AFRICAN AMERICAN

3  AMERICAN INDIAN OR ALASKA NATIVE, PLEASE SPECIFY:

4  ASIAN INDIAN

5  CHINESE

6  FILIPINO

7  JAPANESE

8  KOREAN

9  VIETNAMESE

10  OTHER ASIAN, PLEASE SPECIFY:

11  NATIVE HAWAIIAN

12  GUAMANIAN OR CHAMORRO

13  SAMOAN

14  OTHER PACIFIC ISLANDER, PLEASE SPECIFY:

**A.7. What is this child's sex?**

1  MALE

2  FEMALE

**A.8. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)  MONTHS

IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A10.

**A.9. PUERTO RICO: How well does this child speak Spanish?**

**ALL OTHER JURISDICTIONS: How well does this child speak English?**

1  Very well

2  Well

3  Not well

4  Not at all

**A.10. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

1  YES

2  NO [GO TO A11]

**[If YES] is this child's need for prescription medicine because of any medical, behavioral, or other health condition?**

1  YES

2  NO [GO TO A11]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

3  YES

4  NO

**A.11. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A12]

**[If YES] is this child's need for medical care, mental health, or educational services because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A12]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.12. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A13]

**[If YES] is this child's limitation in abilities because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A13]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.13. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A14]

**[If YES] is this because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A14]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.14. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A15]

**[If YES] has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

<sup>3</sup>  YES

<sup>4</sup>  NO

IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A15. ELSE CONTINUE WITH SECTION B.

**A.15. CHILD 2**

What is this child's first name, initials, or nickname?

**A.16. Is this child of Hispanic, Latino, or Spanish origin?**

- 1  No, not of Hispanic, Latino, or Spanish origin
- 2  Yes, Mexican, Mexican American, Chicano
- 3  Yes, Puerto Rican
- 4  Yes, Cuban
- 5  Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

**A.17. What is this child's race? SELECT ONE OR MORE.**

- 1  WHITE
- 2  BLACK OR AFRICAN AMERICAN
- 3  AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*
- 4  ASIAN INDIAN
- 5  CHINESE
- 6  FILIPINO
- 7  JAPANESE
- 8  KOREAN
- 9  VIETNAMESE
- 10  OTHER ASIAN, *PLEASE SPECIFY:*
- 11  NATIVE HAWAIIAN
- 12  GUAMANIAN OR CHAMORRO
- 13  SAMOAN
- 14  OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

**A.18. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A.19. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)  MONTHS

IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A21.

**A.20. PUERTO RICO: How well does this child speak Spanish?**

**ALL OTHER JURISDICTIONS: How well does this child speak English?**

- 1  Very well
- 2  Well
- 3  Not well
- 4  Not at all

**A.21. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A22]

**[If YES] is this child's need for prescription medicine because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A22]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.22. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A23]

**[If YES] is this child's need for medical care, mental health, or educational services because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A23]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.23. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A24]

**[If YES] is this child's limitation in abilities because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A24]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.24. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A25]

**[If YES] is this because of any medical, behavioral, or other health condition?**

<sup>3</sup>  YES

<sup>4</sup>  NO [GO TO A25]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

<sup>5</sup>  YES

<sup>6</sup>  NO

**A.25. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

<sup>1</sup>  YES

<sup>2</sup>  NO [GO TO A26]

**[If YES] has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

<sup>3</sup>  YES

<sup>4</sup>  NO

*IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A26. ELSE CONTINUE WITH SECTION B.*

**A.26. CHILD 3**

**What is this child's first name, initials, or nickname?**

**A.27. Is this child of Hispanic, Latino, or Spanish origin?**

<sup>1</sup>  No, not of Hispanic, Latino, or Spanish origin

<sup>2</sup>  Yes, Mexican, Mexican American, Chicano

<sup>3</sup>  Yes, Puerto Rican

<sup>4</sup>  Yes, Cuban

<sup>5</sup>  Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

**A.28. What is this child's race? *SELECT ONE OR MORE.***

<sup>1</sup>  WHITE

<sup>2</sup>  BLACK OR AFRICAN  
AMERICAN

<sup>3</sup>  AMERICAN INDIAN OR  
ALASKA NATIVE, *PLEASE  
SPECIFY:*

<sup>4</sup>  ASIAN INDIAN

<sup>5</sup>  CHINESE

<sup>6</sup>  FILIPINO

<sup>7</sup>  JAPANESE

<sup>8</sup>  KOREAN

<sup>9</sup>  VIETNAMESE

<sup>10</sup>  OTHER ASIAN, *PLEASE  
SPECIFY:*

<sup>11</sup>  NATIVE HAWAIIAN

<sup>12</sup>  GUAMANIAN OR CHAMORRO

<sup>13</sup>  SAMOAN

<sup>14</sup>  OTHER PACIFIC ISLANDER,  
*PLEASE SPECIFY:*





**A.29. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A.30. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)   MONTHS

*IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A32.*

**A.31. PUERTO RICO: How well does this child speak Spanish?**

**ALL OTHER JURISDICTIONS: How well does this child speak English?**

- 1  Very well
- 2  Well
- 3  Not well
- 4  Not at all

**A.32. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES
- 2  NO [GO TO A33]

**[If YES] is this child's need for prescription medicine because of any medical, behavioral, or other health condition?**

- 3  YES
- 4  NO [GO TO A33]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES
- 6  NO

**A.33. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A34]

**[If YES] is this child's need for medical care, mental health, or educational services because of any medical, behavioral, or other health condition?**

- 3  YES
- 4  NO [GO TO A34]

**[If YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES
- 6  NO

**A.34. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES  
2  NO [GO TO A35]

**[IF YES] is this child's limitation in abilities because of any medical, behavioral, or other health condition?**

- 3  YES  
4  NO [GO TO A35]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES  
6  NO

**A.35. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES  
2  NO [GO TO A36]

**[IF YES] is this because of any medical, behavioral, or other health condition?**

- 3  YES  
4  NO [GO TO A36]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES  
6  NO

**A.36. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES  
2  NO [GO TO A37]

**[IF YES] has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

- 3  YES  
4  NO

*IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A37. ELSE CONTINUE WITH SECTION B.*

**A.37. CHILD 4**

**What is this child's first name, initials, or nickname?**

**A.38. Is this child of Hispanic, Latino, or Spanish origin?**

- 1  No, not of Hispanic, Latino, or Spanish origin  
2  Yes, Mexican, Mexican American, Chicano  
3  Yes, Puerto Rican  
4  Yes, Cuban  
5  Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

**A.39. What is this child's race? *SELECT ONE OR MORE.***

1  WHITE

2  BLACK OR AFRICAN  
AMERICAN

3  AMERICAN INDIAN OR  
ALASKA NATIVE, *PLEASE*  
*SPECIFY:*

4  ASIAN INDIAN

5  CHINESE

6  FILIPINO

7  JAPANESE

8  KOREAN

9  VIETNAMESE

10  OTHER ASIAN, *PLEASE*  
*SPECIFY:*

11  NATIVE HAWAIIAN

12  GUAMANIAN OR CHAMORRO

13  SAMOAN

14  OTHER PACIFIC ISLANDER,  
*PLEASE SPECIFY:*

**A.40. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A.41. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)  MONTHS

*IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A43*

**A.42. PUERTO RICO: How well does this child speak Spanish?**

**ALL OTHER JURISDICTIONS: How well does this child speak English?**

- 1  Very well
- 2  Well
- 3  Not well
- 4  Not at all

**A.43. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES
- 2  NO [GO TO A44]

**[IF YES] is this child's need for prescription medicine because of any medical, behavioral, or other health condition?**

- 3  YES
- 4  NO [GO TO A44]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES
- 6  NO

**A.44. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A45]

**[IF YES] is this child's need for medical care, mental health, or educational services because of any medical, behavioral, or other health condition?**

- 3  YES
- 4  NO [GO TO A45]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES
- 6  NO

**A.45. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES  
2  NO [GO TO A46]

**[IF YES] is this child's limitation in abilities because of any medical, behavioral, or other health condition?**

- 3  YES  
4  NO [GO TO A46]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES  
6  NO

**A.46. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES  
2  NO [GO TO A47]

**[IF YES] is this because of any medical, behavioral, or other health condition?**

- 3  YES  
4  NO [GO TO A47]

**[IF YES] is this a condition that has lasted or is expected to last 12 months or longer?**

- 5  YES  
6  NO

**A.47. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES  
2  NO [GO TO A48]

**[IF YES] has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

- 3  YES  
4  NO

*IF THERE ARE NO OTHER CHILDREN, CONTINUE TO SECTION B.*

*IF THERE ARE MORE THAN FOUR CHILDREN 0-17 YEARS OLD WHO USUALLY LIVE OR STAY AT THIS ADDRESS, LIST THE AGE AND SEX FOR EACH. DO NOT REPEAT INFORMATION FOR CHILDREN ALREADY INCLUDED FOR CHILD 1 THROUGH CHILD 4.*

**A.48. CHILD 5**

**What is this child's first name, initials, or nickname?**

**A.49. How old is this child?**

YEARS (OR)  MONTHS

**A.50. What is this child's sex?**

- <sup>1</sup>  MALE  
<sup>2</sup>  FEMALE

**A.51. CHILD 6**

**What is this child's first name, initials, or nickname?**

**A.52. How old is this child?**

YEARS (OR)  MONTHS

**A.53. What is this child's sex?**

- <sup>1</sup>  MALE  
<sup>2</sup>  FEMALE

**A.54. CHILD 7**

**What is this child's first name, initials, or nickname?**

**A.55. How old is this child?**

YEARS (OR)  MONTHS

**A.56. What is this child's sex?**

- <sup>1</sup>  MALE  
<sup>2</sup>  FEMALE

**A.57. CHILD 8**

**What is this child's first name, initials, or nickname?**

**A.58. How old is this child?**

YEARS (OR)  MONTHS

**A.59. What is this child's sex?**

- <sup>1</sup>  MALE  
<sup>2</sup>  FEMALE

**A.60. CHILD 9**

**What is this child's first name, initials, or nickname?**

**A.61. How old is this child?**

YEARS (OR)  MONTHS

**A.62. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A.63. CHILD 10**

What is this child's first name, initials, or nickname?

**A.64. How old is this child?**

YEARS (OR)  MONTHS

**A.65. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**Section B. This Child's Health**

*We now have some follow up questions to ask about [SPECIFY CHILD]. 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.*

**A.66. In general, how would you describe this child's health?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.67. How would you describe the condition of this child's teeth?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 6  CHILD DOES NOT HAVE TEETH
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

A.68. During the past 12 months, has this child had frequent or chronic difficulty with any of the following?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B3a. Breathing or other respiratory problems (such as wheezing or shortness of breath)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3b. Eating or swallowing because of a health condition	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3d. Repeated or chronic physical pain, including headaches or other back or body pain	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3e. Using his or her hands	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3f. Coordination or moving around	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3g. Toothaches	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3h. Bleeding gums	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3i. Decayed teeth or cavities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B3j. Ear infections	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

A.69. *[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]*

Does this child have any of the following?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B4a. Deafness or problems with hearing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B4b. Blindness or problems with seeing, even when wearing glasses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>



A.70. Has a doctor or other health care provider ever told you that this child has any of the following? If yes, does this child currently have the condition?

	Ever?	Currently?	DON'T KNOW	PREFER NOT TO ANSWER
B5a. Asthma	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5b. Diabetes	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5c. Down Syndrome	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5d. Frequent or Severe Headaches, including Migraine	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5e. Brain Injury, Concussion or Head Injury	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5f. Anxiety	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5g. Depression	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5h. Autism, ASD, Autism Spectrum Disorder (ASD), Asperger's Disorder, or Pervasive Developmental Disorder (PDD)	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5i. Attention Deficit Disorder (ADD ) or Attention Deficit/Hyperactivity Disorder(ADHD)	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5j. Developmental Delay	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5k. Behavior or Conduct Problems	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5l. Intellectual Disability (also known as mental retardation)	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5m. Speech or Other Language Disorder	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5n. Learning Disability	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B5o. Another Mental Health Condition	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.71. During the past 12 months, how often has this child's health conditions or problems affected his or her ability to do things other children his or her age do?**

- 1  THIS CHILD DOES NOT HAVE ANY HEALTH CONDITIONS [GO TO B8]
- 2  Never [GO TO B8]
- 3  Sometimes
- 4  Usually
- 5  Always
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.72. To what extent do this child's health conditions or problems affect his or her ability to do things?**

- 1  Very little
- 2  Somewhat
- 3  A great deal
- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.73. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**Has a doctor or other health care provider ever told you that this child has Substance Abuse Disorder? Substance Abuse Disorder occurs when the frequent or continued use of alcohol and/or drugs have caused health problems, disability, and failure to meet major responsibilities at work, school, or home.**

- 1  YES
- 2  NO [GO TO B9]
- 79  DON'T KNOW [GO TO B9]
- 101  PREFER NOT TO ANSWER [GO TO B9]

**[IF YES] does this child currently have the condition?**

- 3  YES
- 4  NO [GO TO B9]
- 77  DON'T KNOW [GO TO B9]
- 102  PREFER NOT TO ANSWER [GO TO B9]

**[IF YES] is it:**

- 5  Mild
- 6  Moderate
- 7  Severe
- 78  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**A.74. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

Does this child have any of the following?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B9a. Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B9b. Serious difficulty walking or climbing stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B9c. Difficulty dressing or bathing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B9d. Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B9e. Deafness or problems with hearing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B9f. Blindness or problems with seeing, even when wearing glasses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.75. Has a doctor or other health care provider ever told you that this child had...**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B10a. Rheumatic heart disease	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B10b. Rheumatic fever	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
B10c. Impetigo (or other skin infections)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**[IF YES TO RHEUMATIC HEART DISEASE OR FEVER] Do they take any medication for this condition?**

- 1  YES
- 2  NO
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**[IF YES] Do they take Oral medication (pills) or get a shot?**

- 3  ORAL MEDICATION (PILLS) [GO TO B11]
- 4  SHOT [GO TO B11]

**[IF NO] Why not? CHECK ALL THAT APPLY.**

- 5  Cannot afford the cost.
- 6  No transportation.
- 7  No-one to take my child to hospital.
- 8  Not important
- 9  OTHER REASON, PLEASE SPECIFY
- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.76. Has a doctor or other health care provider ever told you that this child had blood problems such as leukemia, anemia or sickle cell disease? Please do not include Sickle Cell Trait.**

**[READ IF NECESSARY]: Children with anemia have problems with their blood that can cause them to be very tired.**

- 1  YES
- 2  NO
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

Now I'm going to ask you a few questions about injury prevention for your child.

**A.77. Have you or any other adult in your child's life discussed avoidance of violence or prevention of injury with your child? For example, the dangers of playing on the road, climbing trees, and swimming in the ocean.**

- 1  Yes, avoidance of violence
- 2  Yes, prevention of injury
- 3  Both
- 4  Neither
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.78. Do you accompany your child during outdoor activities like swimming or playing?**

- 1  YES
- 2  NO
- 78  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.79. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**When your child rides a bicycle, how often does he or she wear a helmet?**

- 1  My child does not ride a bicycle
- 2  Never wears a helmet
- 3  Rarely wears a helmet
- 4  Sometimes wears a helmet
- 5  Most of the time wears a helmet
- 6  Always wears a helmet
- 79  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.80. [ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]**

**How often does your child ride in a child safety seat or booster seat?**

- 1  Always
- 2  Nearly always
- 3  Sometimes
- 4  Seldom
- 5  Never [IF CHILD 0-5 YEARS OLD, GO TO B17; IF CHILD 6-11 YEARS OLD, GO TO C1]
- 6  MY CHILD DOES NOT RIDE IN CARS [IF CHILD 0-5 YEARS OLD, GO TO B17; IF CHILD 6-11 YEARS OLD, GO TO C1]
- 80  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.81. [ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]**

**Where is your child's safety seat located in your car?**

- 1  Front passenger
- 2  Behind passenger
- 3  Behind driver
- 4  Middle of the back seat
- 81  DON'T KNOW
- 102  PREFER NOT TO ANSWER

**A.82. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

Are your child's immunizations up to date?

- 1  YES
- 2  NO
- 82  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**Section C. This Child as an Infant**

**A.83. Was this child born more than 3 weeks before his or her due date?**

- 1  YES
- 2  NO
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.84. How much did he or she weigh when born? Answer in pounds and ounces or kilograms and grams. Provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

POUNDS AND OUNCES

<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
----------------------	----------------------	--	----------------------	----------------------

KILOGRAMS AND GRAMS

<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
----------------------	----------------------	--	----------------------	----------------------

- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.85. How old were you when this child was born?**

YEARS

<input type="text"/>	<input type="text"/>
----------------------	----------------------

**A.86. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD]**

In which position do you most often lay this baby down to sleep now?

- 1  On his or her side
- 2  On his or her back
- 3  On his or her stomach
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.87. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD. ELSE GO TO SECTION D]**

Was this child EVER breastfed or fed breast milk?

- 4  YES
- 2  NO [GO TO C6]
- 80  DON'T KNOW [GO TO C6]
- 102  PREFER NOT TO ANSWER [GO TO C6]

**[IF YES] how old was this child when he or she completely stopped breastfeeding or being fed breast milk?**

DAYS (OR)

<input type="text"/>	<input type="text"/>
----------------------	----------------------

WEEKS (OR)  
  MONTHS (OR)  
  YEARS  
 CHILD IS STILL BREASTFEEDING  
<sup>81</sup>  DON'T KNOW  
<sup>103</sup>  PREFER NOT TO ANSWER

**A.88. 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 cereal, or anything else that your child might have been given, even water.**

DAYS (OR)   WEEKS (OR)   MONTHS  
 AT BIRTH  
 CHECK THIS BOX IF CHILD HAS NEVER BEEN FED ANYTHING OTHER THAN  
 BREAST MILK OR FORMULA  
<sup>82</sup>  DON'T KNOW  
<sup>104</sup>  PREFER NOT TO ANSWER

**Section D. Health Care Services**

**A.89. 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?**

- <sup>1</sup>  YES
- <sup>2</sup>  NO [GO TO D2]
- <sup>77</sup>  DON'T KNOW [GO TO D2]
- <sup>99</sup>  PREFER NOT TO ANSWER [GO TO D2]

**[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.**

- <sup>3</sup>  0 VISITS
- <sup>4</sup>  1 VISIT
- <sup>5</sup>  2 OR MORE VISITS
- <sup>78</sup>  DON'T KNOW
- <sup>100</sup>  PREFER NOT TO ANSWER

**A.90. Are you concerned about this child's weight?**

- 1  Yes, it's too high
- 2  Yes, it's too low
- 3  No, I am not concerned
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.91. What is this child's current height (or length)? Please provide your best estimate. [IF NEEDED, READ]: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

    FEET AND           INCHES  
□ □                   □ □

    METERS AND       CENTIMETERS  
□ □                   □ □

- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.92. How much does this child currently weigh? Please provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

    POUNDS AND       OUNCES  
□ □                   □ □

    KILOGRAMS AND   GRAMS  
□ □                   □ □

- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.93. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**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?**

- 1  YES
- 2  NO
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.94. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**[IF THIS CHILD IS YOUNGER THAN 9 MONTHS, GO TO D7]**

**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.**

- 1  YES
- 2  NO [GO TO D7]
- 77  DON'T KNOW [GO TO D7]
- 102  PREFER NOT TO ANSWER [GO TO D7]

**[IF THIS CHILD IS 9-23 MONTHS]**

**Did the questionnaire ask about your concerns or observations about: CHECK ALL THAT APPLY**

- 3  How this child talks or makes speech sounds?
- 4  How this child interacts with you and others?
- 78  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**[IF THIS CHILD IS 2-5 YEARS]**

**Did the questionnaire ask about your concerns or observations about: CHECK ALL THAT APPLY.**

- 5  Words and phrases this child uses and understands?
- 6  How this child behaves and gets along with you and others?
- 79  DON'T KNOW
- 104  PREFER NOT TO ANSWER

**A.95. 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?**

- 1  YES
- 2  NO [GO TO D8]
- 77  DON'T KNOW
- 105  PREFER NOT TO ANSWER

**[IF YES] where does this child usually go?**

- 3  Private doctor's office
- 4  Hospital Emergency Room
- 5  Hospital Outpatient Department
- 6  Community health clinic, community clinic, or public health clinic
- 7  School (Nurse's Office, Athletic Trainer's Office)
- 8  Village Dispensary
- 9  Some other place, PLEASE SPECIFY
- 78  DON'T KNOW
- 106  PREFER NOT TO ANSWER



**A.96. 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?**

- 1  YES
- 2  NO [IF CHILD IS 0-5 YEARS OLD, GO TO D9; ELSE IF CHILD 6-17 YEARS OLD, GO TO D10]
- 77  DON'T KNOW
- 107  PREFER NOT TO ANSWER

**[IF YES] is this the same place this child goes when he or she is sick?**

- 3  YES
- 4  NO

**A.97. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**During the past 12 months, did this child use any of the following types of health care or services? Check all that apply.** *Alternative health care can include acupuncture, chiropractic care, relaxation therapies, traditional herbal medicine, and others. Some therapies involve seeing a health care provider, while others can be done on your own.*

- 1  Medical Care
- 2  Vision Care
- 3  Hearing Care
- 4  Dental or Oral Care
- 5  Mental Health Services
- 6  Alternative Health Care or Treatment
- 7  None of these [GO TO D10]
- 77  DON'T KNOW [GO TO D10]
- 108  PREFER NOT TO ANSWER [GO TO D10]

**[IF YES] what kind of place or places did this child have his or her vision tested? Check all that apply.**

- 1  Eye doctor or eye specialist (ophthalmologist, optometrist) office
- 5  Pediatrician or other private doctor's office
- 8  Community health clinic, community clinic, or public health clinic
- 9  School
- 2  Another place, PLEASE SPECIFY

**A.98. During the past 12 months, was there any time when this child needed health care but it was not received or not available? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.**

- 1  YES
- 2  NO [GO TO D15]
- 77  DON'T KNOW [GO TO D15]
- 109  PREFER NOT TO ANSWER [GO TO D15]

**[IF YES] which types of care were not received or not available? Check all that apply.**

- 3  Medical Care
- 6  Dental or Oral Care
- 10  Vision Care
- 11  Hearing Care
- 12  Mental Health Services
- 4  Another type, PLEASE SPECIFY

**A.99. Which of the following contributed to this child not receiving needed health services:**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>D11a. This child was not eligible for the services?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>D11b. The services this child needed were not available in your area?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>D11c. There were problems getting an appointment when this child needed one?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>D11d. There were problems with getting transportation or child care?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>D11e. The (clinic/doctor's) office wasn't open when this child needed care?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>D11f. There were issues related to cost?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.100. During the past 12 months, how many times did this child visit a hospital emergency room?**

- 1  NO VISITS
- 2  1 VISIT
- 3  2 OR MORE VISITS
- 77  DON'T KNOW
- 110  PREFER NOT TO ANSWER

**Section E. Experience with This Child's Health Care Providers**

**A.101. 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.**

- 1  YES, ONE PERSON
- 2  YES, MORE THAN ONE PERSON
- 3  NO

**A.102. During the past 12 months, did this child need a referral to see any doctors or receive any services?**

- 1  YES
- 2  NO [GO TO E3]
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**[IF YES] how much of a problem was it to get referrals?**

- 3  Not a problem
- 4  Small problem
- 5  Big problem

**A.103. [ANSWER THE FOLLOWING QUESTIONS ONLY IF THIS CHILD HAD A HEALTH CARE VISIT IN THE PAST 12 MONTHS. OTHERWISE, GO TO E4.]**

**During the past 12 months, how often did this child's doctors or other health care providers:**

	Always	Usually	Sometimes	Never	DON'T KNOW	PREFER NOT TO ANSWER
<b>E3a. Spend enough time with this child?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E3b. Listen carefully to you?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E3c. Show sensitivity to your family's values and customs?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E3d. Provide the specific information you needed concerning this child?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E3e. Help you feel like a partner in this child's care?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.104. Does anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?**

- 1  YES
- 2  NO
- 3  DID NOT SEE MORE THAN ONE HEALTH CARE PROVIDER IN PAST 12 MONTHS [GO TO E7]

**A.105. 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?**

- 1  YES
- 2  NO [GO TO E6]

**[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?**

- 3  Usually
- 4  Sometimes
- 5  Never

**A.106. Overall, how satisfied are you with the communication among this child's doctors and other health care providers?**

- 1  Very satisfied
- 2  Somewhat satisfied
- 3  Somewhat dissatisfied
- 4  Very dissatisfied
- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.107. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

- 1  YES
- 2  NO [GO TO E8]
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**[If YES] have they talked with you about having this child eventually see doctors or other health care providers who treat adults?**

- 3  YES
- 4  NO
- 80  DON'T KNOW
- 102  PREFER NOT TO ANSWER

**A.108. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>E8a. Think about and plan for his or her future. For example, by taking time to discuss future plans about education, work, relationships, and development of independent living skills?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E8b. Make positive choices about his or her health. For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E8c. Gain skills to manage his or her health and health care. For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications he or she may need?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>E8d. Understand the changes in health care that happen at age 18. For example, by understanding changes in privacy, consent, access to information, or decision-making?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.109. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

**Have this child's doctors or other health care providers worked with you and this child to create a written plan to meet his or her health goals and needs?**

- 1  YES
- 2  NO [GO TO E10]
- 81  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**[IF YES] does this plan identify specific health goals for this child and any health needs or problems this child may have and how to get these needs met?**

- 3  YES
- 4  NO
- 82  DON'T KNOW
- 104  PREFER NOT TO ANSWER

**Did you and this child receive a written copy of this plan of care?**

- 5  YES
- 6  NO
- 83  DON'T KNOW
- 105  PREFER NOT TO ANSWER

**Is this plan currently up-to-date for this child?**

- 7  YES
- 8  NO
- 84  DON'T KNOW
- 106  PREFER NOT TO ANSWER

**A.110. Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as he or she becomes an adult?**

- 1  YES [GO TO F]
- 2  NO

**[IF NO] has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?**

- 3  YES
- 4  NO

**Section F. This Child's Health Insurance Coverage**

**A.111. During the past 12 months, was this child ever covered by any kind of health insurance or health coverage plan? This includes medical savings accounts, supplemental health, and government funded or subsidized insurance programs.**

- 1  Yes, this child was covered all 12 months or, if under 1 year old, since birth [GO TO F4]
- 2  Yes, but this child had a gap in coverage
- 3  No

**A.112. Please indicate whether each of the following is a reason this child was not covered by health insurance during the past 12 months:**

	YES	NO
F2a. Change in employer or employment status	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2b. Cancellation from inability to pay insurance fee	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2c. Dropped coverage because it was unaffordable	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2d. Dropped coverage because benefits were inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2e. Dropped coverage because choice of health care providers was inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2f. Problems with application or renewal process	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F2g. Another reason, <i>please specify</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<input style="width: 50%; height: 20px;" type="text"/>		

**A.113. Is this child currently covered by any kind of health insurance or health coverage plan?**

- <sup>1</sup>  YES
- <sup>2</sup>  NO [GO TO SECTION G]
- <sup>77</sup>  DON'T KNOW [GO TO SECTION G]
- <sup>99</sup>  PREFER NOT TO ANSWER [GO TO SECTION G]

**A.114. Is this child covered by any of the following types of health insurance or health coverage plans? [Interviewer Note: Only read jurisdiction-specific insurance types for your jurisdiction].**

	YES	NO
F4a. Private health insurance	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4b. Insurance through your (or your spouse's) current or former employer or union	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4c. Medicaid, Medical Assistance, or any kind of government assistance plan <i>(includes Guam Medical Indigent Program, Palau National Health Insurance Program, and Puerto Rico Government Health Plan)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4d. Other government funded or subsidized insurance <i>(includes Micronesia MiCare or Chuuk State, Marshall Islands Public Insurance, and Marshall Islands Supplemental Health Fund)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4e. Medical savings account	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4f. CHIP (Children's Health Insurance Program)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4g. TRICARE or other military health care	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4h. Indian Health Service	1 <input type="checkbox"/>	2 <input type="checkbox"/>
F4i. Another type, please specify	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<input style="width: 50%; height: 20px;" type="text"/>		

**A.115. How often does this child's health insurance offer benefits or cover services that meet this child's needs? *Examples include dental or vision services, prescription medications, emergency room visits, maternity services, mental health services, and yearly check-ups or screenings?***

- 1  Always
- 2  Usually
- 3  Sometimes
- 4  Never
- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.116. How often does this child's health insurance allow him or her to see the health care providers he or she needs?**

- 1  Always
- 2  Usually
- 3  Sometimes
- 4  Never
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

#### Section G. Providing for This Child's Health

**A.117. Including co-pays and amounts from medical savings accounts, 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.**

- 1  \$0 (NO MEDICAL OR HEALTH-RELATED EXPENSES) [GO TO G4]
- 2  \$1-\$249
- 3  \$250-\$499
- 4  \$500-\$999
- 5  \$1,000-\$5,000
- 6  MORE THAN \$5,000
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.118. How often are these costs reasonable?**

- 1  Always
- 2  Usually
- 3  Sometimes
- 4  Never
- 78  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.119. During the past 12 months, did your family have problems paying for any of this child's medical or health care bills?**

- 1  YES
- 2  NO
- 79  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.120. During the past 12 months, have you or other family members:**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>G4a. Stopped working because of this child's health or health conditions?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>G4b. Cut down on the hours you work because of this child's health or health conditions?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>G4c. Avoided changing jobs because of concerns about maintaining health insurance for this child?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>G4d. Received help from extended family members?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.121. 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.**

- 1  THIS CHILD DOES NOT NEED HEALTH CARE PROVIDED ON A WEEKLY BASIS
- 2  NO AT HOME CARE WAS PROVIDED BY ME OR OTHER FAMILY MEMBERS
- 3  LESS THAN 1 HOUR PER WEEK
- 4  1-4 HOURS PER WEEK
- 5  5-10 HOURS PER WEEK
- 6  11 OR MORE HOURS PER WEEK
- 80  DON'T KNOW
- 102  PREFER NOT TO ANSWER

**A.122. 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?**

- 1  THIS CHILD DOES NOT NEED HEALTH CARE PROVIDED ON A WEEKLY BASIS
- 2  NO AT HOME CARE WAS PROVIDED BY ME OR OTHER FAMILY MEMBERS
- 3  LESS THAN 1 HOUR PER WEEK
- 4  1-4 HOURS PER WEEK
- 5  5-10 HOURS PER WEEK
- 6  11 OR MORE HOURS PER WEEK
- 81  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**Section H. This Child's Learning**

**A.123. 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?**

- 1  NONE
- 2  LESS THAN 1 HOUR
- 3  1 HOUR
- 4  2 HOURS
- 5  3 HOURS
- 6  4 OR MORE HOURS
- 77  DON'T KNOW
- 104  PREFER NOT TO ANSWER



**A.124. 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?**

- 1  NONE
- 2  LESS THAN 1 HOUR
- 3  1 HOUR
- 4  2 HOURS
- 5  3 HOURS
- 6  4 OR MORE HOURS
- 78  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**A.125. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

- 1  Very well
- 2  Somewhat
- 3  Poorly
- 4  Not at all
- 79  DON'T KNOW
- 100  PREFER NOT TO ANSWER

**A.126. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

- 1  Very confident
- 2  Mostly confident
- 3  Somewhat confident
- 4  Not confident at all
- 80  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.127. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**During the past 12 months, about how many days did this child miss school because of illness or injury?**

- 1  NO MISSED SCHOOL DAYS
- 2  1-3 DAYS
- 3  4-6 DAYS
- 4  7-10 DAYS
- 5  11 OR MORE DAYS
- 81  DON'T KNOW
- 102  PREFER NOT TO ANSWER

**A.128. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**During the past 12 months, how many times has this child's school contacted you or another adult in your household about any problems he or she is having with school?**

- 1  NO TIMES
- 2  1 TIME
- 3  2 OR MORE TIMES
- 82  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**A.129. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**Since starting kindergarten, has this child repeated any grades?**

- 1  YES  
2  NO  
83  DON'T KNOW  
104  PREFER NOT TO ANSWER

**A.130. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

**During the past week, on how many days did this child exercise, play a sport, or participate in physical activity for at least 60 minutes?**

- 1  0 DAYS  
2  1-3 DAYS  
3  4-6 DAYS  
4  EVERY DAY  
84  DON'T KNOW  
105  PREFER NOT TO ANSWER

**Section I. About You and This Child**

**A.131. How many times has this child moved to a new address or location since he or she was born?**

NUMBER OF TIMES

- 77  DON'T KNOW  
99  PREFER NOT TO ANSWER

**A.132. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**During the past week, how many days did you or other family members read to this child?**

- 1  0 DAYS  
2  1-3 DAYS  
3  4-6 DAYS  
4  EVERY DAY  
78  DON'T KNOW  
100  PREFER NOT TO ANSWER

**A.133. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**During the past week, how many days did you or other family members tell stories or sing songs to this child?**

- 1  0 DAYS  
2  1-3 DAYS  
3  4-6 DAYS  
4  EVERY DAY  
79  DON'T KNOW  
101  PREFER NOT TO ANSWER

**A.134. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**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.**

- <sup>1</sup>  YES  
<sup>2</sup>  NO  
<sup>80</sup>  DON'T KNOW  
<sup>102</sup>  PREFER NOT TO ANSWER

**Section J. About Your Family and Household**

**A.135. Does anyone living in your household use cigarettes, e-cigarettes or vapors, cigars, pipe tobacco, chewing tobacco, or chew betel nut?** [READ IF NECESSARY:] Please answer to the best of your ability. Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid).

- <sup>1</sup>  YES  
<sup>2</sup>  NO [GO TO J3]  
<sup>77</sup>  DON'T KNOW [GO TO J3]  
<sup>99</sup>  PREFER NOT TO ANSWER [GO TO J3]

**A.136. Does anyone smoke inside your home?**

- <sup>1</sup>  YES  
<sup>2</sup>  NO  
<sup>78</sup>  DON'T KNOW  
<sup>100</sup>  PREFER NOT TO ANSWER

**A.137. Has your child ever chewed betel nut?** [READ IF NECESSARY: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid)].

- <sup>1</sup>  YES  
<sup>2</sup>  NO  
<sup>79</sup>  DON'T KNOW  
<sup>101</sup>  PREFER NOT TO ANSWER

**A.138. Are you aware of the effects of chewing betel nut?**

- <sup>1</sup>  YES  
<sup>2</sup>  NO  
<sup>80</sup>  DON'T KNOW  
<sup>102</sup>  PREFER NOT TO ANSWER

*The next three questions are about money.*

**A.139. 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?**

- <sup>1</sup>  Never  
<sup>2</sup>  Rarely  
<sup>3</sup>  Somewhat often  
<sup>4</sup>  Very often  
<sup>81</sup>  DON'T KNOW  
<sup>103</sup>  PREFER NOT TO ANSWER

**A.140. 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?**

- 1  We could always afford to eat good nutritious meals.
- 2  We could always afford enough to eat but not always the kinds of food we should eat.
- 3  Sometimes we could not afford enough to eat.
- 4  Often we could not afford enough to eat.
- 82  DON'T KNOW
- 104  PREFER NOT TO ANSWER

**A.141. At any time during the past 12 months, even for one month, did anyone in your family receive:**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>J7a. Cash assistance from a government welfare program?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>J7b. [Programming note: For Puerto Rico show "Nutrition Assistance Program (NAP) (known as PAN)"] Food Stamps or Supplemental Nutrition Assistance Program benefits (SNAP)?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>J7c. Free or reduced-cost breakfasts or lunches at school?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>J7d. [Programming note: Do not show for RMI, Palau, FSM, Puerto Rico] Benefits from the Woman, Infants, and Children (WIC) Program?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**Section K. 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.*

**A.142. ADULT 1**

**How are you related to this child?**

- 1  BIOLOGICAL
- 2  ADOPTIVE PARENT
- 3  STEP-PARENT
- 4  GRANDPARENT
- 5  FOSTER PARENT
- 6  AUNT OR UNCLE
- 7  OTHER: RELATIVE
- 8  OTHER: NON-RELATIVE

**A.143. What is your sex?**

- 1  MALE
- 2  FEMALE

**A.144. What is your age?**

AGE IN YEARS

**A.145. What is the highest grade or year of school you have completed? MARK ONE ONLY.**

- 1  8TH GRADE OR LESS
- 2  9TH-12TH GRADE; NO DIPLOMA
- 3  HIGH SCHOOL GRADUATE OR GED COMPLETED
- 4  COMPLETED A VOCATIONAL, TRADE, OR BUSINESS SCHOOL PROGRAM
- 5  SOME COLLEGE CREDIT, BUT NO DEGREE
- 6  ASSOCIATE DEGREE (AA, AS)
- 7  BACHELOR'S DEGREE (BA, BS, AB)
- 8  MASTER'S DEGREE (MA, MS, MSW, MBA)
- 9  DOCTORATE (PHD, EDD) OR PROFESSIONAL DEGREE (MD, DDS, DVM, JD)

**A.146. What is your marital status?**

- 1  MARRIED [GO TO K7]
- 2  NEVER MARRIED
- 3  DIVORCED
- 4  SEPARATED
- 5  WIDOWED
- 99  PREFER NOT TO ANSWER [GO TO K7]

**A.147. Do you currently live with a romantic partner?**

- 1  YES
- 2  NO
- 100  PREFER NOT TO ANSWER

**A.148. In general, how is your physical health?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 77  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**A.149. In general, how is your mental or emotional health?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 78  DON'T KNOW
- 102  PREFER NOT TO ANSWER

**A.150. Were you employed at least 50 out of the past 52 weeks?**

- 1  YES
- 2  NO
- 79  DON'T KNOW
- 103  PREFER NOT TO ANSWER

**A.151. Is there another adult in this household who is this child's caregiver or guardian?**

- 1  YES
- 2  NO [GO TO SECTION L]
- 104  PREFER NOT TO ANSWER [GO TO SECTION L]

*This other caregiver or guardian will now be referred to as Adult 2.*

**A.152. How is Adult 2 related to this child?**

- 1  BIOLOGICAL OR
- 2  ADOPTIVE PARENT
- 3  STEP-PARENT
- 4  GRANDPARENT
- 5  FOSTER PARENT
- 6  AUNT OR UNCLE
- 7  OTHER: RELATIVE
- 8  OTHER: NON-RELATIVE

**A.153. What is Adult 2's sex?**

- 1  MALE
- 2  FEMALE

**A.154. What is Adult 2's age?**

AGE IN YEARS

**A.155. What is the highest grade or year of school Adult 2 has completed? *MARK ONE ONLY.***

- 1  8TH GRADE OR LESS
- 2  9TH-12TH GRADE; NO DIPLOMA
- 3  HIGH SCHOOL GRADUATE OR GED COMPLETED
- 4  COMPLETED A VOCATIONAL, TRADE, OR BUSINESS SCHOOL PROGRAM
- 5  SOME COLLEGE CREDIT, BUT NO DEGREE
- 6  ASSOCIATE DEGREE (AA, AS)
- 7  BACHELOR'S DEGREE (BA, BS, AB)
- 8  MASTER'S DEGREE (MA, MS, MSW, MBA)
- 9  DOCTORATE (PHD, EDD) OR PROFESSIONAL DEGREE (MD, DDS, DVM, JD)

**A.156. What is Adult 2's marital status?**

- 1  MARRIED [*GO TO K17*]
- 2  NEVER MARRIED
- 3  DIVORCED
- 4  SEPARATED
- 5  WIDOWED
- 105  PREFER NOT TO ANSWER

**A.157. Does Adult 2 currently live with a romantic partner?**

- 1  YES
- 2  NO
- 80  DON'T KNOW
- 106  PREFER NOT TO ANSWER

**A.158. In general, how is Adult 2's physical health?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 81  DON'T KNOW
- 107  PREFER NOT TO ANSWER

**A.159. In general, how is Adult 2's mental or emotional health?**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor
- 82  DON'T KNOW
- 108  PREFER NOT TO ANSWER

**A.160. Was Adult 2 employed at least 50 out of the past 52 weeks?**

- 1  YES
- 2  NO
- 83  DON'T KNOW
- 109  PREFER NOT TO ANSWER

**Section L. Your Health**

**A.161. A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?**

- 1  Within the past year (ANYTIME LESS THAN 12 MONTHS AGO)
- 2  Within the past 2 years (1 YEAR BUT LESS THAN 2 YEARS AGO)
- 3  Within the past 5 years (2 YEARS BUT LESS THAN 5 YEARS AGO)
- 4  5 or more years ago
- 5  Never
- 84  DON'T KNOW
- 6  PREFER NOT TO ANSWER

**A.162. During the past 12 months, have you received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.**

- 1  Yes
- 2  No, but I needed to see a mental health professional
- 3  No, I did not need to see a mental health professional [GO TO L4]
- 85  DON'T KNOW [GO TO L4]
- 4  PREFER NOT TO ANSWER [GO TO L4]

**A.163. How much of a problem was it to get the mental health treatment or counseling that you needed?**

- 1  Not a problem
- 2  Small problem
- 3  Big problem

**A.164. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?**

- 1  YES
- 2  NO
- 86  DON'T KNOW
- 3  PREFER NOT TO ANSWER

**A.165. Who makes the healthcare decisions for your health?**

- 1  You
- 2  Your spouse
- 3  You and your spouse/partner together
- 4  Your parents
- 5  Someone else, *PLEASE SPECIFY*
- 87  DON'T KNOW
- 6  PREFER NOT TO ANSWER

**A.166. Who makes the healthcare decisions for your child(ren)?**

- 1  You
- 2  Your spouse
- 3  You and your spouse/partner together
- 4  Your parents
- 5  ANOTHER PERSON, *PLEASE SPECIFY*
- 88  DON'T KNOW
- 6  PREFER NOT TO ANSWER

*The next questions ask about smoking, drinking, and drug use. Please remember that all information you share is confidential. Only members of the research team will have access to this information. Please answer to the best of your ability.*

**A.167. During the past 30 days, on how many days did you smoke cigarettes?**

- 1  0 DAYS
- 2  1 OR 2 DAYS
- 3  3 TO 5 DAYS
- 4  6 TO 9 DAYS
- 5  10 TO 19 DAYS
- 6  20 TO 29 DAYS
- 7  ALL 30 DAYS
- 89  DON'T KNOW
- 8  PREFER NOT TO ANSWER

**A.168. Do you drink alcohol, including drinks you brew or make at home?**

- 1  YES
- 2  NO
- 90  DON'T KNOW
- 3  PREFER NOT TO ANSWER



**A.169. During your life, have you ever used any of the following:** [READ IF NECESSARY]: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid). Funta, or fronto, is a dark tobacco leaf that can be used for smoking]

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>L9a. Betel nut</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9b. Vape or e-cigarette</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9c. Funta</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9d. Marijuana (also called grass, pot, weed, or reefer)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9e. Cocaine, including powder, crack, or freebase</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9f. Heroin (also called smack, junk, or China White)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9g. Methamphetamines (also called speed, crystal, crank, or ice)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9h. Ecstasy (also called MDMA)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9i. Synthetic marijuana (also called K2, Spice, fake weed, King Kong, Yucatan Fire, Skunk, or Moon Rocks)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9j. Steroid pills or shots without a doctor's prescription</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L9k. Prescription pain medicine without a doctor's prescription or differently than how a doctor told you to use it? (Count drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

[IF RESPONDENT CHEWED BETEL NUT, CONTINUE TO L10. ELSE IF RESPONDENT USED ANY OTHER SUBSTANCE IN L9 GO TO L11. ELSE IF NO SUBSTANCES USED, GO TO L12.]

**A.170. During the past 30 days, on how many days did you chew betel nut?**

- 1  0 DAYS
- 2  1 OR 2 DAYS
- 3  3 TO 5 DAYS
- 4  6 TO 9 DAYS
- 5  10 TO 19 DAYS
- 6  20 TO 29 DAYS
- 7  ALL 30 DAYS
- 91  DON'T KNOW
- 8  PREFER NOT TO ANSWER

**A.171. Have you been referred to, or did you receive, any form of intervention/counseling/treatment for substance use issues?**

- 1  YES
- 2  NO
- 92  DON'T KNOW
- 3  PREFER NOT TO ANSWER

**A.172. Has your doctor or health care professional told you that you had type 1 or type 2 diabetes?**

- 1  TYPE 1 DIABETES
- 2  TYPE 2 DIABETES
- 3  NEITHER [GO TO L14]
- 93  DON'T KNOW [GO TO L14]
- 4  PREFER NOT TO ANSWER [GO TO L14]

**A.173. Are you taking medication for this?**

- 1  Insulin
- 2  Pills
- 3  Insulin and Pills
- 4  I do not take medication
- 94  DON'T KNOW
- 5  PREFER NOT TO ANSWER

**A.174. Has a doctor or other health care provider EVER told you that you have any of the following conditions...?**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>L14a. Rheumatic heart disease</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L14b. Rheumatic fever</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L14c. Cervical cancer</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>L14d. Anemia</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**A.175. How do you describe your weight?**

- 1  Very underweight
- 2  Slightly underweight
- 3  About the right weight
- 4  Slightly overweight
- 5  Very overweight

**A.176. Which of the following are you trying to do about your weight?**

- 1  Lose weight
- 2  Gain weight
- 3  Stay the same weight
- 4  I AM NOT TRYING TO DO ANYTHING ABOUT MY WEIGHT

**A.177. During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.**

- 1  0 DAYS
- 2  1 DAY
- 3  2 DAYS
- 4  3 DAYS
- 5  4 DAYS
- 6  5 DAYS
- 7  6 DAYS
- 8  7 DAYS
- 95  DON'T KNOW
- 9  PREFER NOT TO ANSWER

**A.178. Are you currently pregnant?**

- 13  Yes
- 14  No [GO TO M1]
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER]

IF RESPONDENT IS NOT PREGNANT AND/OR HAS INFANT 12-MONTHS OR YOUNGER, GO TO M1.

These next questions are about Zika virus. Zika virus infection is an illness that is most often spread by the bite of a mosquito but may also be spread by having sex with a man who has the Zika virus.

**A.179. During your most recent pregnancy, how worried were you about getting infected with Zika virus? Check ONE answer.**

- 1  Very worried
- 2  Somewhat worried
- 3  Not at all worried
- 4  I HAD NEVER HEARD OF ZIKA VIRUS DURING MY MOST RECENT PREGNANCY
- 96  DON'T KNOW
- 5  PREFER NOT TO ANSWER

**A.180. At any time during your most recent pregnancy, did you talk with a doctor, nurse, or other healthcare worker about Zika virus?**

- 1  No
- 2  Yes, a healthcare worker talked with me without my asking about it
- 3  Yes, a healthcare worker talked with me, but only after I asked about it
- 97  DON'T KNOW
- 4  PREFER NOT TO ANSWER

**A.181. During your most recent pregnancy, did you get a blood test for Zika virus?**

- 1  YES
- 2  NO [GO TO L23]
- 98  DON'T KNOW
- 3  PREFER NOT TO ANSWER

**A.182. Were you diagnosed with Zika during your most recent pregnancy?**

- 1  YES
- 2  NO [GO TO M1]
- 99  DON'T KNOW [GO TO M1]
- 3  PREFER NOT TO ANSWER [GO TO M1]

**[IF YES] which child were you carrying?**

IF PUERTO RICO, GO TO SECTION M

The next questions are about travel during your most recent pregnancy.

**A.183. During your most recent pregnancy, did you travel to areas with the Zika virus?**

- 1  YES
- 2  NO
- 100  DON'T KNOW
- 3  PREFER NOT TO ANSWER

**[IF YES] During your most recent pregnancy, were you aware of recommendations that pregnant women should avoid travel to areas with Zika virus?**

- 4  YES
- 5  NO
- 101  DON'T KNOW
- 6  PREFER NOT TO ANSWER

**[IF NO] During your most recent pregnancy, did you avoid travel to areas with the Zika virus because of recommendations that pregnant women should avoid travel to those areas?**

- 7  YES
- 8  NO
- 102  DON'T KNOW
- 9  PREFER NOT TO ANSWER

Section M. Household Information

**A.184. 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
- 
- 77  DON'T KNOW
  - 99  PREFER NOT TO ANSWER

**A.185. 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
- 
- 78  DON'T KNOW
  - 100  PREFER NOT TO ANSWER

**A.186. The following** information is for data analysis purposes only so that MCH can better assess services received and potential health care needs among different income groups. Only members of the research team will have access to this information. Your best guess is fine. It does not have to be exact. **Think about your total combined family income for the 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 (\$)

<sup>79</sup>  DON'T KNOW

<sup>80</sup>  PREFER NOT TO ANSWER

**A.187. How about if I give you some categories? Would you say your household's income was...**

<sup>1</sup>  Less than \$10,000

<sup>2</sup>  \$10,000 to less than \$15,000

<sup>3</sup>  \$15,000 to less than \$20,000

<sup>4</sup>  \$20,000 to less than \$25,000

<sup>5</sup>  \$25,000 to less than \$35,000

<sup>6</sup>  \$35,000 to less than \$50,000

<sup>7</sup>  \$50,000 to less than \$75,000

<sup>8</sup>  \$75,000 or more

<sup>77</sup>  DON'T KNOW

<sup>78</sup>  PREFER NOT TO ANSWER

Section N. Palau Jurisdiction Specific Module

**[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**PA1. Has your child ever completed the Ages and Stages Questionnaire (ASQ) from their doctor or another professional?**

<sup>15</sup>  YES

<sup>16</sup>  NO

<sup>77</sup>  DON'T KNOW

<sup>99</sup>  PREFER NOT TO ANSWER

**[ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

*The next 2 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.*

**PA2. Has your child ever been bullied on school property?**

<sup>17</sup>  YES

<sup>18</sup>  NO

<sup>77</sup>  DON'T KNOW

<sup>100</sup>  PREFER NOT TO ANSWER

**PA3. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

**Has your child ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)**

- 19  YES
- 20  NO
- 77  DON'T KNOW
- 101  PREFER NOT TO ANSWER

**PA4. Have you or any other adult in your child's life discussed avoidance of violence or prevention of injury with your child?**

- 21  YES
- 22  NO
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**[ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

*The next few questions are about your health during and post pregnancy.*

**PA5. During your most recent pregnancy, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each one, check No if no one talked with you about it or Yes if someone did.**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>PA5a. Foods that are good to eat during pregnancy</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>PA5b. Exercise during pregnancy</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>PA5c. Programs or resources to help me gain the right amount of weight during pregnancy</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>PA5d. Programs or resources to help me lose weight after pregnancy</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**PA6. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

**How much weight did you gain during your most recent pregnancy?**

LBS OR   KILOS

- 23  I DIDN'T GAIN ANY WEIGHT DURING MY PREGNANCY
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

*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, you, 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*