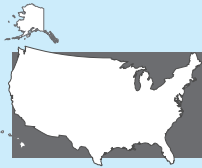


**Appendix D**

**2020 National Survey of Children's Health  
 Screener and Topical Questionnaires**



# National Survey of Children's Health

*A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.*



The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Access to records maintained in the system is restricted to Census Bureau employees and certain individuals authorized by Title 13, U.S. Code (designated as Special Sworn Status individuals). These individuals are subject to the same confidentiality requirements as regular Census Bureau employees identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-S1**  
(03/02/2020)



## Start Here

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

**OR** complete this form and mail it back as soon as possible.

Thank you for helping us learn about the health and well-being of America's children.

If your household has children 0 - 17 years old, the questions on this form should be answered by an adult who is familiar with their health and health care. If your household does not have any children, please answer question **1** below AND return the questionnaire.

For help or questions about completing this form, please call 1-800-845-8241. The telephone call is free.

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

Si necesita ayuda o tiene preguntas sobre cómo completar este formulario, llame al 1-800-845-8241. La llamada es gratuita. Para recibir ayuda relacionada con el Dispositivo Telefónico para Personas Sordas (TDD), llame al 1-800-582-8330. La llamada es gratuita.

## In Your Home

**1** Are there any children 0-17 years old who usually live or stay at this address?

Yes

No – *STOP HERE* after marking “No” and return this survey to us in the enclosed envelope. It is important that we receive a response from every household selected for this study.

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

Number of children living or staying at this address

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

English

Spanish

Other Language, specify:

**4** Is this house, apartment, or mobile home –  
Mark (X) ONE box.

Owned by you or someone in this household with a mortgage or loan? *Include home equity loans.*

Owned by you or someone in this household free and clear (without a mortgage or loan)?

Rented?

Occupied without payment of rent?

**→** 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.



# CHILD 1

(Youngest)

**1** First name, initials, or nickname of the youngest child

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

<input type="text"/>	Years	OR	<input type="text"/>	Months
----------------------	-------	----	----------------------	--------

**3** What is this child's sex?

Male  Female

→ **NOTE:** Answer **BOTH** question **4** about Hispanic origin and question **5** about race. For this survey, Hispanic origins are not races.

**4** Is this child of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin

**5** What is this child's race? *Mark (X) one or more boxes.*

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander |

**6** Answer the following question only if this child is at least 4 years old. Otherwise, SKIP to question **7**.

How well does this child speak English?

- Very well
- Well
- Not well
- Not at all

**7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

Yes  No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

**9** 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?

Yes  No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

Yes  No



## CHILD 2

(Next youngest)

**1** First name, initials, or nickname of the next youngest child

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

<input type="text"/>	Years	OR	<input type="text"/>	Months
----------------------	-------	----	----------------------	--------

**3** What is this child's sex?

Male  Female

➔ **NOTE:** Answer **BOTH** question **4** about Hispanic origin and question **5** about race. For this survey, Hispanic origins are not races.

**4** Is this child of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin

**5** What is this child's race? *Mark (X) one or more boxes.*

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander |

**6** Answer the following question only if this child is at least 4 years old. Otherwise, SKIP to question **7**.

How well does this child speak English?

- Very well
- Well
- Not well
- Not at all

**7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

Yes  No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

**9** 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?

Yes  No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

Yes  No



## CHILD 3

(Next youngest)

**1** First name, initials, or nickname of the next youngest child

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

		Years	OR			Months
--	--	-------	----	--	--	--------

**3** What is this child's sex?

Male  Female

➔ **NOTE:** Answer **BOTH** question **4** about Hispanic origin and question **5** about race. For this survey, Hispanic origins are not races.

**4** Is this child of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin

**5** What is this child's race? Mark (X) one or more boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander |

**6** Answer the following question only if this child is at least 4 years old. Otherwise, SKIP to question **7**.

How well does this child speak English?

- Very well
- Well
- Not well
- Not at all

**7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

Yes  No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

**9** 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?

Yes  No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

Yes  No



## CHILD 4

(Next youngest)

**1** First name, initials, or nickname of the next youngest child

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

		Years	OR			Months
--	--	-------	----	--	--	--------

**3** What is this child's sex?

Male  Female

➔ **NOTE:** Answer BOTH question **4** about Hispanic origin and question **5** about race. For this survey, Hispanic origins are not races.

**4** Is this child of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin

**5** What is this child's race? *Mark (X) one or more boxes.*

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander |

**6** Answer the following question only if this child is at least 4 years old. Otherwise, SKIP to question **7**.

How well does this child speak English?

- Very well
- Well
- Not well
- Not at all

**7** Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?

Yes  No

↳ If yes, is this child's need for prescription medicine because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this child's need for medical care, mental health, or educational services because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

**9** 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?

Yes  No

↳ If yes, is this child's limitation in abilities because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, is this because of ANY medical, behavioral, or other health condition?

Yes  No

↳ If yes, is this a condition that has lasted or is expected to last 12 months or longer?

Yes  No

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

Yes  No

↳ If yes, has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?

Yes  No





If there are more than four children 0-17 years old who usually live or stay at this address, list the first name, initials, or nickname for each child as well as their age and sex.

Do not repeat information for children already included for Child 1 through Child 4.

**CHILD 5***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female

**CHILD 6***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female

**CHILD 7***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female

**CHILD 8***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female

**CHILD 9***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female

**CHILD 10***(Next youngest)* ▶

First name, initials, or nickname

Age

Years

OR

Months

Sex

Male

Female





# Mailing Instructions

## Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about your household and the children of this household.

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.

### → Make sure you have:

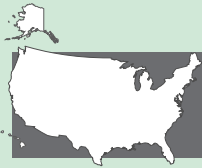
- Listed all first names, initials, or nicknames of children 0-17 years old in the household
- Answered all questions for each child reported

### → Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, please mail the questionnaire to:

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

We estimate that completing the National Survey of Children's Health will take 5 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to [DEMO.Paperwork@census.gov](mailto:DEMO.Paperwork@census.gov); use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.





# National Survey of Children's Health

*A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.*



The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Access to records maintained in the system is restricted to Census Bureau employees and certain individuals authorized by Title 13, U.S. Code (designated as Special Sworn Status individuals). These individuals are subject to the same confidentiality requirements as regular Census Bureau employees identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-T1**  
(03/18/2020)



## Start Here

Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

We have selected only one child per household in an effort to minimize the amount of time you will need to complete the follow-up questions.

The survey should be completed by a parent or adult caregiver who lives in this household and who is familiar with this child's health and health care.

Your participation is important. Thank you.

## A. This Child's Health

**A1** In general, how would you describe this child's health (the one named above)?

- Excellent
- Very good
- Good
- Fair
- Poor

**A2** How would you describe the condition of this child's teeth?

- This child does not have any teeth
- Excellent
- Very good
- Good
- Fair
- Poor

**A3** DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Breathing or other respiratory problems (such as wheezing or shortness of breath) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Eating or swallowing because of a health condition                                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Repeated or chronic physical pain, including headaches or other back or body pain | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Using their hands   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Coordination or moving around   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Toothaches  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Bleeding gums   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Decayed teeth or cavities   | <input type="checkbox"/> | <input type="checkbox"/> |

**A4** Does this child have any of the following?

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Deafness or problems with hearing                            | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Blindness or problems with seeing, even when wearing glasses | <input type="checkbox"/> | <input type="checkbox"/> |

Has a doctor or other health care provider EVER told you that this child has...

**A5** Allergies (including food, drug, insect, or other)?

- Yes  No

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

- Yes  No

↳ If yes, is it:

- Mild  Moderate  Severe

**A6** Arthritis?

- Yes  No

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

- Yes  No

↳ If yes, is it:

- Mild  Moderate  Severe



Has a doctor or other health care provider EVER told you that this child has...

**A7 Asthma?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A8 Cerebral Palsy?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A9 Diabetes?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A10 Epilepsy or Seizure Disorder?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A11 Heart Condition?**

Yes  No

↳ If yes, was this child born with the condition?

Yes  No

Does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

Has a doctor or other health care provider EVER told you that this child has...

**A12 Frequent or severe headaches, including migraine?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A13 Tourette Syndrome?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A14 Anxiety Problems?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A15 Depression?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A16 Down Syndrome?**

Yes  No



Has a doctor or other health care provider EVER told you that this child has...

**A17 Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**Was this child diagnosed with:**

Sickle Cell Disease?  Yes  No

Thalassemia?  Yes  No

Hemophilia?  Yes  No

Other Blood Disorders?  Yes  No

**Were any of these blood disorders identified through a blood test done shortly after birth?**

*These tests are sometimes called newborn screening.*

Yes  No

**A18 Cystic Fibrosis?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**Was this condition identified through a blood test done shortly after birth?** *These tests are sometimes called newborn screening.*

Yes  No

**A19 Other genetic or inherited condition?**

Yes  No

↳ If yes, specify: ↴

**Is it:**

Mild  Moderate  Severe

**Was this condition identified through a blood test done shortly after birth?** *These tests are sometimes called newborn screening.*

Yes  No

Has a doctor, other health care provider, or educator EVER told you that this child has...

*Examples of educators are teachers and school nurses.*

**A20 Behavioral or Conduct Problems?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A21 Developmental Delay?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A22 Intellectual Disability (formerly known as Mental Retardation)?**

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A23 Speech or other language disorder?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A24 Learning Disability?**

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



**A25** Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? *Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).*

Yes  No → **SKIP to question A30**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A26** How old was this child when a doctor or other health care provider FIRST told you that they had Autism, ASD, Asperger's Disorder or PDD?

Age in years  Don't know

**A27** What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD?

Mark (X) ONE box.

- Primary Care Provider
- Specialist
- School Psychologist/Counselor
- Other Psychologist (Non-School)
- Psychiatrist
- Other, specify:

Don't know

**A28** Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes  No

**A29** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A30** Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes  No → **SKIP to question A33**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A31** Is this child CURRENTLY taking medication for ADD or ADHD?

Yes  No

**A32** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A33** Do you think this child has EVER had a concussion or brain injury? *A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.*

Yes  No

↳ If yes, did you seek medical care from a doctor or other health care provider?

Yes  No

↳ If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?

Yes  No

**A34** DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected their ability to do things other children their age do?

This child does not have any health conditions → **SKIP to question B1 on page 6**

- Never
- Sometimes
- Usually
- Always

**A35** To what extent do this child's health conditions or problems affect their ability to do things?

- Very little
- Somewhat
- A great deal



## B. This Child as an Infant

**B1** Was this child born more than 3 weeks before their due date?

Yes

No

**B2** What month and year was this child born?

Birth Month / 4-Digit Birth Year

/ 20

**B3** How much did they weigh when born? Answer in pounds and ounces OR kilograms and grams. Your best estimate is fine.

pounds AND   ounces

OR

kilograms AND    grams

**B4** What was the age of the mother when this child was born? Your best estimate is fine.

Age in years

**B5** Was this child EVER breastfed or fed breast milk?

Yes

No → SKIP to question **B7**

**B6** If yes, how old was this child when they COMPLETELY stopped breastfeeding or being fed breast milk? Your best estimate is fine.

This child is still breastfeeding

OR

days

OR

weeks

OR

months

**B7** How old was this child when they were FIRST fed formula? Your best estimate is fine.

This child has never been fed formula

OR

At birth

OR

days

OR

weeks

OR

months

**B8** How old was this child when they were FIRST fed anything other than breast milk or formula? Include water, juice, cow's milk, sugar water, baby food, or anything else that your child might have been given. Your best estimate is fine.

This child has never been fed anything other than breast milk or formula

OR

At birth

OR

days

OR

weeks

OR

months



## C. Health Care Services

**C1** DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

Yes

No → **SKIP to question C4**

**C2** If yes, DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up?

*A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.*

0 visits

1 visit

2 or more visits

**C3** Thinking about the LAST TIME you took this child for a PREVENTIVE check-up, about how long was the doctor or health care provider who examined this child in the room with you? *Your best estimate is fine.*

Less than 10 minutes

10-20 minutes

More than 20 minutes

**C4** Are you concerned about this child's weight?

Yes, it's too high

Yes, it's too low

No, I am not concerned

**C5** Has a doctor or other health care provider ever told you that this child is overweight?

Yes

No

**C6** DURING THE PAST 12 MONTHS, did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?

Yes

No

**C7** Answer the following question only if this child is at least 9 months old. Otherwise skip to question **C8**.

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

Yes  No

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

**Did the questionnaire ask about your concerns or observations about:**

*Mark (X) ALL that apply.*

How this child talks or makes speech sounds?

How this child interacts with you and others?

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

**Did the questionnaire ask about your concerns or observations about:**

*Mark (X) ALL that apply.*

Words and phrases this child uses and understands?

How this child behaves and gets along with you and others?

**C8** Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?

Yes

No → **SKIP to question C10 on page 8**

**C9** If yes, where does this child USUALLY go first? *Mark (X) ONE box.*

Doctor's Office

Hospital Emergency Room

Hospital Outpatient Department

Clinic or Health Center

Retail Store Clinic or "Minute Clinic"

School (Nurse's Office, Athletic Trainer's Office)

Some other place





**C10** Is there a place that this child **USUALLY** goes when they need routine preventive care, such as a physical examination or well-child check-up?

- Yes
- No → **SKIP to question C12**

**C11** If yes, is this the same place this child goes when they are sick?

- Yes
- No

**C12** **DURING THE PAST 12 MONTHS**, has this child had their vision tested, such as with pictures, shapes, or letters?

- Yes
- No → **SKIP to question C14**

**C13** If yes, where was this child's vision tested?  
Mark (X) ALL that apply.

- Eye doctor or eye specialist (ophthalmologist, optometrist) office
- Pediatrician or other general doctor's office
- Clinic or health center
- School
- Other, specify:

**C14** **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for any kind of dental or oral health care?

- Yes, saw a dentist
- Yes, saw other oral health care provider
- No → **SKIP to question C17**

**C15** If yes, **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for **PREVENTIVE** dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?

- No preventive visits in the past 12 months → **SKIP to question C17**
- Yes, 1 visit
- Yes, 2 or more visits

**C16** If yes, **DURING THE PAST 12 MONTHS**, what **PREVENTIVE** dental service(s) did this child receive?  
Mark (X) ALL that apply.

- Check-up
- Cleaning
- Instruction on tooth brushing and oral health care
- X-Rays
- Fluoride treatment
- Sealant (plastic coatings on back teeth)
- Don't know

**C17** **DURING THE PAST 12 MONTHS**, has this child received any treatment or counseling from a mental health professional? *Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.*

- Yes
- No, but this child needed to see a mental health professional
- No, this child did not need to see a mental health professional → **SKIP to question C19**

**C18** How difficult was it to get the mental health treatment or counseling that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C19** **DURING THE PAST 12 MONTHS**, has this child taken any medication because of difficulties with their emotions, concentration, or behavior?

- Yes
- No

**C20** **DURING THE PAST 12 MONTHS**, did this child see a specialist other than a mental health professional? *Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.*

- Yes
- No, but this child needed to see a specialist
- No, this child did not need to see a specialist → **SKIP to question C22 on page 9**



**C21** How difficult was it to get the specialist care that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C22** DURING THE PAST 12 MONTHS, did this child use any type of alternative health care or treatment? *Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.*

- Yes
- No

**C23** DURING THE PAST 12 MONTHS, was there any time when this child needed health care but it was not received? *By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.*

- Yes
- No → **SKIP to question C26**

**C24** If yes, which types of care were not received? Mark (X) ALL that apply.

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

**C25** Did any of the following reasons contribute to this child not receiving needed health services? Mark (X) Yes or No for EACH item.

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

**C26** DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?

- Never
- Sometimes
- Usually
- Always

**C27** DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

**C28** DURING THE PAST 12 MONTHS, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

**C29** Has this child EVER had a special education or early intervention plan? *Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).*

- Yes
- No → **SKIP to question C32**

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

years AND  months

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

- Yes
- No

**C32** Has this child EVER received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes
- No → **SKIP to question D1 on page 10**

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

years AND  months

**C34** Is this child CURRENTLY receiving these special services?

- Yes
- No



## D. Experience with This Child's Health Care Providers

**D1** Do you have one or more persons you think of as this child's personal doctor or nurse? A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.

- Yes, one person
- Yes, more than one person
- No

**D2** DURING THE PAST 12 MONTHS, did this child need a referral to see any doctors or receive any services?

- Yes
- No → **SKIP to question D4**

**D3** How difficult was it to get referrals?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to get a referral

**D4** Answer the following questions only if this child had a health care visit **IN THE PAST 12 MONTHS**. Otherwise skip to question **E1** on page 11.

DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...

- |   | Always                   | Usually                  | Sometimes                | Never                    |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Spend enough time with this child?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Listen carefully to you?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Show sensitivity to your family's values and customs?              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Provide the specific information you needed concerning this child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help you feel like a partner in this child's care?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**D5** DURING THE PAST 12 MONTHS, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?

- Yes
- No → **SKIP to question D7**

**D6** If yes, DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...

- |   | Always                   | Usually                  | Sometimes                | Never                    |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Discuss with you the range of options to consider for their health care or treatment?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Make it easy for you to raise concerns or disagree with recommendations for this child's health care?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Work with you to decide together which health care and treatment choices would be best for this child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**D7** DURING THE PAST 12 MONTHS, did anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?

- Yes
- No
- Did not see more than one health care provider in the PAST 12 MONTHS → **SKIP to question D11 on page 11**

**D8** DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?

- Yes
- No → **SKIP to question D10**

**D9** If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?

- Usually
- Sometimes
- Never

**D10** DURING THE PAST 12 MONTHS, how satisfied were you with the communication between this child's doctors and other health care providers?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied



**D11** DURING THE PAST 12 MONTHS, did this child's health care provider communicate with the child's school, child care provider, or special education program?

- Yes
- No → **SKIP to question E1**
- Did not need health care provider to communicate with these providers → **SKIP to question E1**

**D12** If yes, during this time, how satisfied were you with the health care provider's communication with the school, child care provider, or special education program?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

## E. This Child's Health Insurance Coverage

**E1** DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, this child was covered all 12 months → **SKIP to question E4**
- Yes, but this child had a gap in coverage
- No

**E2** Indicate whether any of the following is a reason this child was not covered by health insurance at any time DURING THE PAST 12 MONTHS:

	Yes	No
a. Change in employer or employment status	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancellation due to overdue premiums	<input type="checkbox"/>	<input type="checkbox"/>
c. Dropped coverage because it was unaffordable	<input type="checkbox"/>	<input type="checkbox"/>
d. Dropped coverage because benefits were inadequate	<input type="checkbox"/>	<input type="checkbox"/>
e. Dropped coverage because choice of health care providers was inadequate	<input type="checkbox"/>	<input type="checkbox"/>
f. Problems with application or renewal process	<input type="checkbox"/>	<input type="checkbox"/>
g. Other, specify: <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E3** Is this child CURRENTLY covered by ANY kind of health insurance or health coverage plan?

- Yes
- No → **SKIP to question F1 on page 12**

**E4** Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark (X) Yes or No for EACH item.

	Yes	No
a. Insurance through a current or former employer or union	<input type="checkbox"/>	<input type="checkbox"/>
b. Insurance purchased directly from an insurance company	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability	<input type="checkbox"/>	<input type="checkbox"/>
d. TRICARE or other military health care	<input type="checkbox"/>	<input type="checkbox"/>
e. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
f. Other, specify: <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E5** How often does this child's health insurance offer benefits or cover services that meet this child's needs?

- Always
- Usually
- Sometimes
- Never

**E6** How often does this child's health insurance allow them to see the health care providers they need?

- Always
- Usually
- Sometimes
- Never

**E7** Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs?

- Always
- Usually
- Sometimes
- Never
- This child does not use mental or behavioral health services



## F. Providing for This Child's Health

**F1** Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS? Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- \$0 (No medical or health-related expenses) → SKIP to question **F4**
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5,000

**F2** How often are these costs reasonable?

- Always
- Usually
- Sometimes
- Never

**F3** DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child's medical or health care bills?

- Yes
- No

**F4** DURING THE PAST 12 MONTHS, have you or other family members...

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Left a job or taken a leave of absence because of this child's health or health conditions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cut down on the hours you work because of this child's health or health conditions?          | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Avoided changing jobs because of concerns about maintaining health insurance for this child? | <input type="checkbox"/> | <input type="checkbox"/> |

**F5** IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.

- This child does not need health care provided at home on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

**F6** IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?

- This child does not need health care coordinated on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

## G. This Child's Learning

Answer the following question only if this child is at least 1 year old. Otherwise skip to **H1** on page 15.

**G1** Is this child able to do the following...

Mark (X) Yes or No for EACH item.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Say at least one word, such as "hi" or "dog"?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Use 2 words together, such as "car go"?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Use 3 words together in a sentence, such as, "Mommy come now."?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ask questions like "who," "what," "when," "where"?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Ask questions like "why" and "how"?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tell a story with a beginning, middle, and end?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Understand the meaning of the word "no"?  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Follow a verbal direction without hand gestures, such as "Wash your hands."?    | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Point to things in a book when asked?   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Follow 2-step directions, such as "Get your shoes and put them in the basket."? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Understand words such as "in," "on," and "under"?                               | <input type="checkbox"/> | <input type="checkbox"/> |



**G2** Is this child 3 years old or older?

- Yes
- No → **SKIP to question H1 on page 15**

**G3** Has this child started school? *Include any formal home schooling.*

- Yes, preschool
- Yes, kindergarten
- Yes, first grade
- No

**G4** Are you concerned about how this child is learning to do things for themselves?

- No
- Yes, somewhat concerned
- Yes, very concerned

**G5** How confident are you that this child is ready to be in school?

- Completely confident
- Mostly confident
- Somewhat confident
- Not at all confident

**G6** How often can this child recognize the beginning sound of a word? *For example, can this child tell you that the word "ball" starts with the "buh" sound?*

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G7** About how many letters of the alphabet can this child recognize?

- All of them
- Most of them
- About half of them
- Some of them
- None of them

**G8** Can this child rhyme words?

- Yes
- No

**G9** How often can this child explain things they have seen or done so that you get a very good idea what happened?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G10** How often can this child write their first name, even if some of the letters aren't quite right or are backwards?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G11** How high can this child count?

- This child cannot count
- Up to five
- Up to ten
- Up to 20
- Up to 50
- Up to 100 or more

**G12** How often can this child identify basic shapes such as a triangle, circle, or square?

- Always
- Most of the time
- About half the time
- Sometimes
- Never



**G13** Can this child identify the colors red, yellow, blue, and green by name?

- Yes, all of them
- Yes, some of them
- No, none of them

**G14** How often is this child easily distracted?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G15** How often does this child keep working at something until they are finished?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G16** When this child is paying attention, how often can they follow instructions to complete a simple task?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G17** How does this child usually hold a pencil?

- Uses fingers to hold the pencil
- Grips the pencil in their fist
- This child cannot hold a pencil

**G18** How often does this child play well with others?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G19** How often does this child become angry or anxious when going from one activity to another?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G20** How often does this child show concern when others are hurt or unhappy?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G21** When excited or all wound up, how often can this child calm down quickly?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G22** How often does this child lose control of their temper when things do not go their way?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G23** Compared to other children their age, how much difficulty does this child have making or keeping friends?

- No difficulty
- A little difficulty
- A lot of difficulty



**G24** Compared to other children their age, how often is this child able to sit still?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

**G25** How often...

	Always	Usually	Sometimes	Never
a. Is this child affectionate and tender with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does this child bounce back quickly when things do not go their way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does this child show interest and curiosity in learning new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Does this child smile and laugh?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## H. About You and This Child

**H1** Was this child born in the United States?

- Yes → **SKIP to question H3**
- No

**H2** If no, how long has this child been living in the United States?

years **AND**  months

**H3** How many times has this child moved to a new address since they were born?

Number of times

**H4** How often does this child go to bed at about the same time on weeknights?

- Always
- Usually
- Sometimes
- Rarely
- Never

**H5** DURING THE PAST WEEK, how many hours of sleep did this child get during an average day (count both nighttime sleep and naps)?

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

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

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

Mark (X) **ONE** box.

- On their side
- On their back
- On their stomach

**H7** ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media? Do not include time spent doing schoolwork.

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

**H8** DURING THE PAST WEEK, how many days did you or other family members read to this child?

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





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

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

**H10** How well do you think you are handling the day-to-day demands of raising children?

- Very well
- Somewhat well
- Not very well
- Not well at all

**H11** DURING THE PAST MONTH, how often have you felt...

Never Rarely Sometimes Usually Always

- a. That this child is much harder to care for than most children their age?
- b. That this child does things that really bother you a lot?
- c. Angry with this child?

**H12** DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?

- Yes
- No → **SKIP to question H14**

**H13** If yes, did you receive emotional support from...

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Spouse or domestic partner?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Other family member or close friend?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Health care provider?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Place of worship or religious leader?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Support or advocacy group related to specific health condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Peer support group?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Counselor or other mental health professional?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other person, specify: <input type="text"/>                     | <input type="checkbox"/> | <input type="checkbox"/> |

**H14** Does this child receive care for at least 10 hours per week from someone other than their parent or guardian? *This could be a day care center, preschool, Head Start program, family child care home, nanny, au pair, babysitter or relative.*

- Yes
- No

**H15** DURING THE PAST 12 MONTHS, did you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for this child?

- Yes
- No

## I. About Your Family and Household

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

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

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

- Yes
- No → **SKIP to question I4**

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

- Yes
- No

**I4** SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?

- Never
- Rarely
- Somewhat often
- Very often



- 15** Which of these statements best describes your household's ability to afford the food you need DURING THE PAST 12 MONTHS?
- We could always afford to eat good nutritious meals.
  - We could always afford enough to eat but not always the kinds of food we should eat.
  - Sometimes we could not afford enough to eat.
  - Often we could not afford enough to eat.

- 16** At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive...
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Cash assistance from a government welfare program?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Free or reduced-cost breakfasts or lunches at school?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Benefits from the Women, Infants, and Children (WIC) Program?             | <input type="checkbox"/> | <input type="checkbox"/> |

- 17** In your neighborhood, is/are there...
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Sidewalks or walking paths?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A park or playground?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A recreation center, community center, or boys' and girls' club? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A library or bookmobile?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Litter or garbage on the street or sidewalk?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Poorly kept or rundown housing?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Vandalism such as broken windows or graffiti?                    | <input type="checkbox"/> | <input type="checkbox"/> |

- 18** To what extent do you agree with these statements about your neighborhood or community?
- |  | Definitely agree         | Somewhat agree           | Somewhat disagree        | Definitely disagree      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. People in this neighborhood help each other out                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. We watch out for each other's children in this neighborhood                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. This child is safe in our neighborhood  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. When we encounter difficulties, we know where to go for help in our community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 19** The next questions are about events that may have happened during this child's life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.
- To the best of your knowledge, has this child EVER experienced any of the following?
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Parent or guardian divorced or separated                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Parent or guardian died   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Parent or guardian served time in jail  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Saw or heard parents or adults slap, hit, kick, punch one another in the home | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Was a victim of violence or witnessed violence in their neighborhood          | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lived with anyone who was mentally ill, suicidal, or severely depressed       | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lived with anyone who had a problem with alcohol or drugs                     | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Treated or judged unfairly because of their race or ethnic group              | <input type="checkbox"/> | <input type="checkbox"/> |

- 110** When your family faces problems, how often are you likely to do each of the following?
- |   | All of the time          | Most of the time         | Some of the time         | None of the time         |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Talk together about what to do       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Work together to solve our problems  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Know we have strengths to draw on    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Stay hopeful even in difficult times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## J. Child's Caregivers

### About You

- J1** How are you related to this child?
- Biological or Adoptive Parent
  - Step-parent
  - Grandparent
  - Foster Parent
  - Other: Relative
  - Other: Non-Relative



**J2 What is your sex?**

- Male
- Female

**J3 What is your age?**

Age in years

**J4 Where were you born?**

- In the United States → **SKIP to question J6**
- Outside of the United States

**J5 When did you come to live in the United States?**

Indicate the 4-digit year in which you came to live in the United States.

4-Digit Year

**J6 What is the highest grade or level of school you have completed?**

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J7 What is your marital status?**

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J8 In general, how is your physical health?**

- Excellent
- Very good
- Good
- Fair
- Poor

**J9 In general, how is your mental or emotional health?**

- Excellent
- Very good
- Good
- Fair
- Poor

**J10 Which of the following best describes your current employment status?**

Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J11 Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?**

Mark (X) ONE box.

- Never served in the military → **SKIP to question J13**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question J13**
- Now on active duty
- On active duty in the past, but not now

**J12 Were you deployed at any time during this child's life?**

- Yes
- No

**J13 Does this child have another parent or adult caregiver who lives in this household?**

- Yes → **Complete questions J14 - J25 for this other parent or adult caregiver**
- No → **SKIP to question K1 on page 20**



## Other Parent or Caregiver in the Household

**J14** How is this other caregiver related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

**J15** What is this caregiver's sex?

- Male
- Female

**J16** What is this caregiver's age?

Age in years

**J17** Where was this caregiver born?

- In the United States → **SKIP to question J19**
- Outside of the United States

**J18** When did this caregiver come to live in the United States? Indicate the 4-digit year in which this caregiver came to live in the United States.

4-Digit Year

**J19** What is the highest grade or level of school this caregiver has completed?

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J20** What is this caregiver's marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J21** In general, how is this caregiver's physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J22** In general, how is this caregiver's mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J23** Which of the following best describes this caregiver's current employment status?

Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J24** Has this caregiver ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?

Mark (X) ONE box.

- Never served in the military → **SKIP to question K1 on page 20**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question K1 on page 20**
- Now on active duty
- On active duty in the past, but not now



**J25** Was this caregiver deployed at any time during this child's life?

Yes

No

## K. Household Information

**K1** How many people are living or staying at this address? Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

**K2** How many of these people in your household are family members? Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.

Number of people

**K3** Income in 2019  
Mark (X) the "Yes" box for EACH type of income this child's family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the "No" box to show types of income NOT received.

**a. Wages, salary, commissions, bonuses, or tips for all jobs.**

Yes → \$  .00

No TOTAL AMOUNT in the last calendar year

**b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships.**

Yes → \$  .00  Loss

No TOTAL AMOUNT in the last calendar year

**c. Interest, dividends, net rental income, royalty income, or income from estates and trusts.**

Yes → \$  .00  Loss

No TOTAL AMOUNT in the last calendar year

**d. Social security or railroad retirement; retirement, survivor, or disability pensions.**

Yes → \$  .00

No TOTAL AMOUNT in the last calendar year

**e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office.**

Yes → \$  .00

No TOTAL AMOUNT in the last calendar year

**f. Any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.**

Yes → \$  .00

No TOTAL AMOUNT in the last calendar year

**K4** The following question is about your 2019 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.

\$  .00

TOTAL AMOUNT in the last calendar year



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## Mailing Instructions

### Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

**Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:**

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

We estimate that completing the National Survey of Children's Health will take 33 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to [DEMO.Paperwork@census.gov](mailto:DEMO.Paperwork@census.gov); use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.





# National Survey of Children's Health

*A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.*



The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Access to records maintained in the system is restricted to Census Bureau employees and certain individuals authorized by Title 13, U.S. Code (designated as Special Sworn Status individuals). These individuals are subject to the same confidentiality requirements as regular Census Bureau employees identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-T2**  
(04/06/2020)



## Start Here

Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

We have selected only one child per household in an effort to minimize the amount of time you will need to complete the follow-up questions.

The survey should be completed by a parent or adult caregiver who lives in this household and who is familiar with this child's health and health care.

Your participation is important. Thank you.

## A. This Child's Health

**A1** In general, how would you describe this child's health (the one named above)?

- Excellent
- Very good
- Good
- Fair
- Poor

**A2** How would you describe the condition of this child's teeth?

- Excellent
- Very good
- Good
- Fair
- Poor

**A3** DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Breathing or other respiratory problems (such as wheezing or shortness of breath) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Eating or swallowing because of a health condition                                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Repeated or chronic physical pain, including headaches or other back or body pain | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Toothaches  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Bleeding gums   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Decayed teeth or cavities   | <input type="checkbox"/> | <input type="checkbox"/> |

**A4** Does this child have any of the following?

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Serious difficulty walking or climbing stairs  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty dressing or bathing   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Deafness or problems with hearing  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Blindness or problems with seeing, even when wearing glasses   | <input type="checkbox"/> | <input type="checkbox"/> |

Has a doctor or other health care provider EVER told you that this child has...

**A5** Allergies (including food, drug, insect, or other)?

- Yes  No

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

- Yes  No

↳ If yes, is it:

- Mild  Moderate  Severe

**A6** Arthritis?

- Yes  No

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

- Yes  No

↳ If yes, is it:

- Mild  Moderate  Severe



Has a doctor or other health care provider EVER told you that this child has...

**A7** Asthma?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A8** Cerebral Palsy?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A9** Diabetes?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A10** Epilepsy or Seizure Disorder?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A11** Heart Condition?

Yes  No

↳ If yes, was this child born with the condition?

Yes  No

Does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

Has a doctor or other health care provider EVER told you that this child has...

**A12** Frequent or severe headaches, including migraine?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A13** Tourette Syndrome?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A14** Anxiety Problems?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A15** Depression?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A16** Down Syndrome?

Yes  No



Has a doctor or other health care provider EVER told you that this child has...

**A17** Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

Was this child diagnosed with:

Sickle Cell Disease?  Yes  No

Thalassemia?  Yes  No

Hemophilia?  Yes  No

Other Blood Disorders?  Yes  No

Were any of these blood disorders identified through a blood test done shortly after birth?

*These tests are sometimes called newborn screening.*

Yes  No

**A18** Cystic Fibrosis?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

Yes  No

**A19** Other genetic or inherited condition?

Yes  No

↳ If yes, specify: ↴

Is it:

Mild  Moderate  Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

Yes  No

Has a doctor, other health care provider, or educator EVER told you that this child has...

*Examples of educators are teachers and school nurses.*

**A20** Behavioral or Conduct Problems?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A21** Developmental Delay?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A22** Intellectual Disability (formerly known as Mental Retardation)?

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A23** Speech or other language disorder?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A24** Learning Disability?

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



**A25** Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Yes  No → **SKIP to question A30**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A26** How old was this child when a doctor or other health care provider FIRST told you that they had Autism, ASD, Asperger's Disorder or PDD?

Age in years  Don't know

**A27** What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD? Mark (X) ONE box.

- Primary Care Provider
- Specialist
- School Psychologist/Counselor
- Other Psychologist (Non-School)
- Psychiatrist
- Other, specify:

Don't know

**A28** Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes  No

**A29** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A30** Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes  No → **SKIP to question A33**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A31** Is this child CURRENTLY taking medication for ADD or ADHD?

Yes  No

**A32** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A33** Do you think this child has EVER had a concussion or brain injury? A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

Yes  No

↳ If yes, did you seek medical care from a doctor or other health care provider?

Yes  No

↳ If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?

Yes  No

**A34** DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected their ability to do things other children their age do?

- This child does not have any health conditions → **SKIP to question B1 on page 6**
- Never
- Sometimes
- Usually
- Always

**A35** To what extent do this child's health conditions or problems affect their ability to do things?

- Very little
- Somewhat
- A great deal



## B. This Child as an Infant

**B1** Was this child born more than 3 weeks before their due date?

Yes

No

**B2** What month and year was this child born?

Birth Month / 4-Digit Birth Year

/  20

**B3** How much did they weigh when born? Answer in pounds and ounces OR kilograms and grams. Your best estimate is fine.

pounds AND  ounces

OR

kilograms AND  grams

**B4** What was the age of the mother when this child was born? Your best estimate is fine.

Age in years

## C. Health Care Services

**C1** DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

Yes

No → **SKIP to question C4**

**C2** If yes, DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up? A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.

0 visits

1 visit

2 or more visits

**C3** Thinking about the LAST TIME you took this child for a PREVENTIVE check-up, about how long was the doctor or health care provider who examined this child in the room with you? Your best estimate is fine.

Less than 10 minutes

10-20 minutes

More than 20 minutes

**C4** What is this child's CURRENT height?

Your best estimate is fine.

feet AND  inches

OR

meters AND  centimeters

**C5** How much does this child CURRENTLY weigh?

Your best estimate is fine.

pounds

OR

kilograms

**C6** Are you concerned about this child's weight?

Yes, it's too high

Yes, it's too low

No, I am not concerned

**C7** Has a doctor or other health care provider ever told you that this child is overweight?

Yes

No

**C8** Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?

Yes

No → **SKIP to question C10 on page 7**

**C9** If yes, where does this child USUALLY go first? Mark (X) ONE box.

Doctor's Office

Hospital Emergency Room

Hospital Outpatient Department

Clinic or Health Center

Retail Store Clinic or "Minute Clinic"

School (Nurse's Office, Athletic Trainer's Office)

Some other place



**C10** Is there a place that this child **USUALLY** goes when they need routine preventive care, such as a physical examination or well-child check-up?

- Yes
- No → **SKIP to question C12**

**C11** If yes, is this the same place this child goes when they are sick?

- Yes
- No

**C12** **DURING THE PAST 12 MONTHS**, has this child had their vision tested, such as with pictures, shapes, or letters?

- Yes
- No → **SKIP to question C14**

**C13** If yes, where was this child's vision tested?  
Mark (X) ALL that apply.

- Eye doctor or eye specialist (ophthalmologist, optometrist) office
- Pediatrician or other general doctor's office
- Clinic or health center
- School
- Other, specify:

**C14** **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for any kind of dental or oral health care?

- Yes, saw a dentist
- Yes, saw other oral health care provider
- No → **SKIP to question C17**

**C15** If yes, **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for **PREVENTIVE** dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?

- No preventive visits in the past 12 months → **SKIP to question C17**
- Yes, 1 visit
- Yes, 2 or more visits

**C16** If yes, **DURING THE PAST 12 MONTHS**, what **PREVENTIVE** dental service(s) did this child receive?  
Mark (X) ALL that apply.

- Check-up
- Cleaning
- Instruction on tooth brushing and oral health care
- X-Rays
- Fluoride treatment
- Sealant (plastic coatings on back teeth)
- Don't know

**C17** **DURING THE PAST 12 MONTHS**, has this child received any treatment or counseling from a mental health professional? *Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.*

- Yes
- No, but this child needed to see a mental health professional
- No, this child did not need to see a mental health professional → **SKIP to question C19**

**C18** How difficult was it to get the mental health treatment or counseling that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C19** **DURING THE PAST 12 MONTHS**, has this child taken any medication because of difficulties with their emotions, concentration, or behavior?

- Yes
- No

**C20** **DURING THE PAST 12 MONTHS**, did this child see a specialist other than a mental health professional? *Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.*

- Yes
- No, but this child needed to see a specialist
- No, this child did not need to see a specialist → **SKIP to question C22 on page 8**





**C21** How difficult was it to get the specialist care that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C22** DURING THE PAST 12 MONTHS, did this child use any type of alternative health care or treatment? *Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.*

- Yes
- No

**C23** DURING THE PAST 12 MONTHS, was there any time when this child needed health care but it was not received? *By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.*

- Yes
- No → **SKIP to question C26**

**C24** If yes, which types of care were not received? *Mark (X) ALL that apply.*

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

**C25** Did any of the following reasons contribute to this child not receiving needed health services? *Mark (X) Yes or No for EACH item.*

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

**C26** DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?

- Never
- Sometimes
- Usually
- Always

**C27** DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

**C28** DURING THE PAST 12 MONTHS, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

**C29** Has this child EVER had a special education or early intervention plan? *Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).*

- Yes
- No → **SKIP to question C32 on page 9**

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

years AND   months



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

- Yes  
 No

**C32** Has this child **EVER** received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes  
 No → **SKIP to question D1**

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

years **AND**   months

**C34** Is this child **CURRENTLY** receiving these special services?

- Yes  
 No

## D. Experience with This Child's Health Care Providers

**D1** Do you have one or more persons you think of as this child's personal doctor or nurse? *A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.*

- Yes, one person  
 Yes, more than one person  
 No

**D2** **DURING THE PAST 12 MONTHS**, did this child need a referral to see any doctors or receive any services?

- Yes  
 No → **SKIP to question D4**

**D3** How difficult was it to get referrals?

- Not difficult  
 Somewhat difficult  
 Very difficult  
 It was not possible to get a referral

**D4** Answer the following questions only if this child had a health care visit **IN THE PAST 12 MONTHS**. Otherwise skip to question **E1** on page 10.

**DURING THE PAST 12 MONTHS**, how often did this child's doctors or other health care providers...

	Always	Usually	Sometimes	Never
a. Spend enough time with this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Listen carefully to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Show sensitivity to your family's values and customs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Provide the specific information you needed concerning this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Help you feel like a partner in this child's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D5** **DURING THE PAST 12 MONTHS**, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?

- Yes  
 No → **SKIP to question D7**

**D6** If yes, **DURING THE PAST 12 MONTHS**, how often did this child's doctors or other health care providers...

	Always	Usually	Sometimes	Never
a. Discuss with you the range of options to consider for their health care or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Make it easy for you to raise concerns or disagree with recommendations for this child's health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Work with you to decide together which health care and treatment choices would be best for this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D7** **DURING THE PAST 12 MONTHS**, did anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?

- Yes  
 No  
 Did not see more than one health care provider in the PAST 12 MONTHS → **SKIP to question D11 on page 10**



**D8** DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?

- Yes
- No → **SKIP to question D10**

**D9** If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?

- Usually
- Sometimes
- Never

**D10** DURING THE PAST 12 MONTHS, how satisfied were you with the communication between this child's doctors and other health care providers?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

**D11** DURING THE PAST 12 MONTHS, did this child's health care provider communicate with the child's school, child care provider, or special education program?

- Yes
- No → **SKIP to question E1**
- Did not need health care provider to communicate with these providers → **SKIP to question E1**

**D12** If yes, during this time, how satisfied were you with the health care provider's communication with the school, child care provider, or special education program?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

## E. This Child's Health Insurance Coverage

**E1** DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, this child was covered all 12 months → **SKIP to question E4**
- Yes, but this child had a gap in coverage
- No

**E2** Indicate whether any of the following is a reason this child was not covered by health insurance at any time DURING THE PAST 12 MONTHS:

	Yes	No
a. Change in employer or employment status	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancellation due to overdue premiums	<input type="checkbox"/>	<input type="checkbox"/>
c. Dropped coverage because it was unaffordable	<input type="checkbox"/>	<input type="checkbox"/>
d. Dropped coverage because benefits were inadequate	<input type="checkbox"/>	<input type="checkbox"/>
e. Dropped coverage because choice of health care providers was inadequate	<input type="checkbox"/>	<input type="checkbox"/>
f. Problems with application or renewal process	<input type="checkbox"/>	<input type="checkbox"/>
g. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>

**E3** Is this child CURRENTLY covered by ANY kind of health insurance or health coverage plan?

- Yes
- No → **SKIP to question F1 on page 11**

**E4** Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark (X) Yes or No for EACH item.

	Yes	No
a. Insurance through a current or former employer or union	<input type="checkbox"/>	<input type="checkbox"/>
b. Insurance purchased directly from an insurance company	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability	<input type="checkbox"/>	<input type="checkbox"/>
d. TRICARE or other military health care	<input type="checkbox"/>	<input type="checkbox"/>
e. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
f. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>



**E5** How often does this child's health insurance offer benefits or cover services that meet this child's needs?

- Always
- Usually
- Sometimes
- Never

**E6** How often does this child's health insurance allow them to see the health care providers they need?

- Always
- Usually
- Sometimes
- Never

**E7** Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs?

- Always
- Usually
- Sometimes
- Never
- This child does not use mental or behavioral health services

## F. Providing for This Child's Health

**F1** Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS? Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- \$0 (No medical or health-related expenses) → **SKIP to question F4**
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5,000

**F2** How often are these costs reasonable?

- Always
- Usually
- Sometimes
- Never

**F3** DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child's medical or health care bills?

- Yes
- No

**F4** DURING THE PAST 12 MONTHS, have you or other family members...

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Left a job or taken a leave of absence because of this child's health or health conditions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cut down on the hours you work because of this child's health or health conditions?          | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Avoided changing jobs because of concerns about maintaining health insurance for this child? | <input type="checkbox"/> | <input type="checkbox"/> |

**F5** IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.

- This child does not need health care provided at home on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

**F6** IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?

- This child does not need health care coordinated on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week



## G. This Child's Schooling and Activities

**G1** DURING THE PAST 12 MONTHS, about how many days did this child miss school because of illness or injury? Include days missed from any formal home schooling.

- No missed school days
- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days
- This child was not enrolled in school

**G2** DURING THE PAST 12 MONTHS, how many times has this child's school contacted you or another adult in your household about any problems they are having with school?

- None
- 1 time
- 2 or more times

**G3** SINCE STARTING KINDERGARTEN, has this child repeated any grades?

- Yes
- No

**G4** DURING THE PAST 12 MONTHS, how often did you attend events or activities that this child participated in?

- Always
- Usually
- Sometimes
- Rarely
- Never

**G5** DURING THE PAST 12 MONTHS, did this child participate in...

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. A sports team or did they take sports lessons after school or on weekends?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Any clubs or organizations after school or on weekends?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other organized activities or lessons, such as music, dance, language, or other arts?              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any type of community service or volunteer work at school, place of worship, or in the community?      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any paid work, including regular jobs as well as babysitting, cutting grass, or other occasional work? | <input type="checkbox"/> | <input type="checkbox"/> |

**G6** 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?

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

**G7** Compared to other children their age, how much difficulty does this child have making or keeping friends?

- No difficulty
- A little difficulty
- A lot of difficulty

**G8** DURING THE PAST 12 MONTHS, how often was this child bullied, picked on, or excluded by other children? If the frequency changed throughout the year, report the highest frequency.

- Never (in the past 12 months)
- 1-2 times (in the past 12 months)
- 1-2 times per month
- 1-2 times per week
- Almost every day



**G9** DURING THE PAST 12 MONTHS, how often did this child bully others, pick on them, or exclude them?  
If the frequency changed throughout the year, report the highest frequency.

- Never (in the past 12 months)
- 1-2 times (in the past 12 months)
- 1-2 times per month
- 1-2 times per week
- Almost every day

**G10** How often does this child...

	Always	Usually	Sometimes	Never
a. Show interest and curiosity in learning new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Work to finish tasks they start?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Stay calm and in control when faced with a challenge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Care about doing well in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do all required homework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Argue too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## H. About You and This Child

**H1** Was this child born in the United States?

- Yes → **SKIP to question H3**
- No

**H2** If no, how long has this child been living in the United States?

years AND  months

**H3** How many times has this child moved to a new address since they were born?

Number of times

**H4** How often does this child go to bed at about the same time on weeknights?

- Always
- Usually
- Sometimes
- Rarely
- Never

**H5** DURING THE PAST WEEK, how many hours of sleep did this child get on most weeknights?

- Less than 6 hours
- 6 hours
- 7 hours
- 8 hours
- 9 hours
- 10 hours
- 11 or more hours

**H6** ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media?  
Do not include time spent doing schoolwork.

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

**H7** How well can you and this child share ideas or talk about things that really matter?

- Very well
- Somewhat well
- Not very well
- Not well at all



**H8** How well do you think you are handling the day-to-day demands of raising children?

- Very well
- Somewhat well
- Not very well
- Not well at all

**H9** DURING THE PAST MONTH, how often have you felt...

	Never	Rarely	Sometimes	Usually	Always
a. That this child is much harder to care for than most children their age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. That this child does things that really bother you a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Angry with this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**H10** DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?

- Yes
- No → **SKIP to question I1**

**H11** If yes, did you receive emotional support from...

	Yes	No
a. Spouse or domestic partner?	<input type="checkbox"/>	<input type="checkbox"/>
b. Other family member or close friend?	<input type="checkbox"/>	<input type="checkbox"/>
c. Health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
d. Place of worship or religious leader?	<input type="checkbox"/>	<input type="checkbox"/>
e. Support or advocacy group related to specific health condition?	<input type="checkbox"/>	<input type="checkbox"/>
f. Peer support group?	<input type="checkbox"/>	<input type="checkbox"/>
g. Counselor or other mental health professional?	<input type="checkbox"/>	<input type="checkbox"/>
h. Other person, specify: ↴	<input type="checkbox"/>	<input type="checkbox"/>

## I. About Your Family and Household

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

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

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

- Yes
- No → **SKIP to question I4**

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

- Yes
- No

**I4** SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?

- Never
- Rarely
- Somewhat often
- Very often

**I5** Which of these statements best describes your household's ability to afford the food you need DURING THE PAST 12 MONTHS?

- We could always afford to eat good nutritious meals.
- We could always afford enough to eat but not always the kinds of food we should eat.
- Sometimes we could not afford enough to eat.
- Often we could not afford enough to eat.



**16** At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive...

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Cash assistance from a government welfare program?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Free or reduced-cost breakfasts or lunches at school?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Benefits from the Women, Infants, and Children (WIC) Program?             | <input type="checkbox"/> | <input type="checkbox"/> |

**17** In your neighborhood, is/are there...

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

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

- |  | Definitely agree         | Somewhat agree           | Somewhat disagree        | Definitely disagree      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. People in this neighborhood help each other out                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. We watch out for each other's children in this neighborhood                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. This child is safe in our neighborhood  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. When we encounter difficulties, we know where to go for help in our community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. This child is safe at school  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**19** Other than you or other adults in your home, is there at least one other adult in this child's school, neighborhood, or community who knows this child well and who they can rely on for advice or guidance?

- Yes
- No

**110** The next questions are about events that may have happened during this child's life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

To the best of your knowledge, has this child EVER experienced any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Parent or guardian divorced or separated  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Parent or guardian died   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Parent or guardian served time in jail  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Saw or heard parents or adults slap, hit, kick, punch one another in the home     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Was a victim of violence or witnessed violence in their neighborhood              | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lived with anyone who was mentally ill, suicidal, or severely depressed           | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lived with anyone who had a problem with alcohol or drugs                         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Treated or judged unfairly because of their race or ethnic group                  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Treated or judged unfairly because of their sexual orientation or gender identity | <input type="checkbox"/> | <input type="checkbox"/> |

**111** When your family faces problems, how often are you likely to do each of the following?

- |   | All of the time          | Most of the time         | Some of the time         | None of the time         |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Talk together about what to do       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Work together to solve our problems  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Know we have strengths to draw on    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Stay hopeful even in difficult times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |





# J. Child's Caregivers

## About You

**J1** How are you related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

**J2** What is your sex?

- Male
- Female

**J3** What is your age?

Age in years

**J4** Where were you born?

- In the United States → **SKIP to question J6**
- Outside of the United States

**J5** When did you come to live in the United States?  
Indicate the 4-digit year in which you came to live in the United States.

4-Digit Year

**J6** What is the highest grade or level of school you have completed?

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J7** What is your marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J8** In general, how is your physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J9** In general, how is your mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor



**J10** Which of the following best describes your current employment status?

Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J11** Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?

Mark (X) ONE box.

- Never served in the military → **SKIP to question J13**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question J13**
- Now on active duty
- On active duty in the past, but not now

**J12** Were you deployed at any time during this child's life?

- Yes
- No

**J13** Does this child have another parent or adult caregiver who lives in this household?

- Yes → **Complete questions J14 - J25 for this other parent or adult caregiver**
- No → **SKIP to question K1 on page 19**

## Other Parent or Caregiver in the Household

**J14** How is this other caregiver related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

**J15** What is this caregiver's sex?

- Male
- Female

**J16** What is this caregiver's age?

Age in years

**J17** Where was this caregiver born?

- In the United States → **SKIP to question J19 on page 18**
- Outside of the United States

**J18** When did this caregiver come to live in the United States? Indicate the 4-digit year in which this caregiver came to live in the United States.

4-Digit Year



**J19** What is the highest grade or level of school this caregiver has completed?

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J20** What is this caregiver's marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J21** In general, how is this caregiver's physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J22** In general, how is this caregiver's mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J23** Which of the following best describes this caregiver's current employment status?

Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J24** Has this caregiver ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?

Mark (X) ONE box.

- Never served in the military → **SKIP to question K1 on page 19**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question K1 on page 19**
- Now on active duty
- On active duty in the past, but not now

**J25** Was this caregiver deployed at any time during this child's life?

- Yes
- No



# K. Household Information

**K1** How many people are living or staying at this address? Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

**K2** How many of these people in your household are family members? Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.

Number of people

**K3** Income in 2019  
Mark (X) the "Yes" box for EACH type of income this child's family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the "No" box to show types of income NOT received.

a. Wages, salary, commissions, bonuses, or tips for all jobs.

Yes → \$ .00  
 No TOTAL AMOUNT in the last calendar year

b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships.

Yes → \$ .00  Loss  
 No TOTAL AMOUNT in the last calendar year

c. Interest, dividends, net rental income, royalty income, or income from estates and trusts.

Yes → \$ .00  Loss  
 No TOTAL AMOUNT in the last calendar year

d. Social security or railroad retirement; retirement, survivor, or disability pensions.

Yes → \$ .00  
 No TOTAL AMOUNT in the last calendar year

e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office.

Yes → \$ .00  
 No TOTAL AMOUNT in the last calendar year

f. Any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.

Yes → \$ .00  
 No TOTAL AMOUNT in the last calendar year

**K4** The following question is about your 2019 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.

\$ .00  
 TOTAL AMOUNT in the last calendar year



## Mailing Instructions

### Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

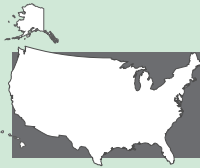
Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

**Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:**

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

We estimate that completing the National Survey of Children's Health will take 33 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to [DEMO.Paperwork@census.gov](mailto:DEMO.Paperwork@census.gov); use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.





# National Survey of Children's Health

*A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.*



The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Access to records maintained in the system is restricted to Census Bureau employees and certain individuals authorized by Title 13, U.S. Code (designated as Special Sworn Status individuals). These individuals are subject to the same confidentiality requirements as regular Census Bureau employees identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

**NSCH-T3**  
(04/06/2020)



## Start Here

Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

We have selected only one child per household in an effort to minimize the amount of time you will need to complete the follow-up questions.

The survey should be completed by a parent or adult caregiver who lives in this household and who is familiar with this child's health and health care.

Your participation is important. Thank you.

## A. This Child's Health

**A1** In general, how would you describe this child's health (the one named above)?

- Excellent
- Very good
- Good
- Fair
- Poor

**A2** How would you describe the condition of this child's teeth?

- Excellent
- Very good
- Good
- Fair
- Poor

**A3** DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Breathing or other respiratory problems (such as wheezing or shortness of breath) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Eating or swallowing because of a health condition                                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Repeated or chronic physical pain, including headaches or other back or body pain | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Toothaches  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Bleeding gums   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Decayed teeth or cavities   | <input type="checkbox"/> | <input type="checkbox"/> |

**A4** Does this child have any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition              | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Serious difficulty walking or climbing stairs   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty dressing or bathing  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Deafness or problems with hearing   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Blindness or problems with seeing, even when wearing glasses  | <input type="checkbox"/> | <input type="checkbox"/> |

Has a doctor or other health care provider EVER told you that this child has...

**A5** Allergies (including food, drug, insect, or other)?

- Yes  No
- ↳ If yes, does this child CURRENTLY have the condition?
- Yes  No
- ↳ If yes, is it:
- Mild  Moderate  Severe

**A6** Arthritis?

- Yes  No
- ↳ If yes, does this child CURRENTLY have the condition?
- Yes  No
- ↳ If yes, is it:
- Mild  Moderate  Severe



Has a doctor or other health care provider EVER told you that this child has...

**A7** Asthma?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A8** Cerebral Palsy?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A9** Diabetes?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A10** Epilepsy or Seizure Disorder?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A11** Heart Condition?

Yes  No

↳ If yes, was this child born with the condition?

Yes  No

Does this child CURRENTLY have the condition?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

Has a doctor or other health care provider EVER told you that this child has...

**A12** Frequent or severe headaches, including migraine?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A13** Tourette Syndrome?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A14** Anxiety Problems?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A15** Depression?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A16** Down Syndrome?

Yes  No





Has a doctor or other health care provider EVER told you that this child has...

**A17 Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**Was this child diagnosed with:**

Sickle Cell Disease?  Yes  No

Thalassemia?  Yes  No

Hemophilia?  Yes  No

Other Blood Disorders?  Yes  No

**Were any of these blood disorders identified through a blood test done shortly after birth?**

*These tests are sometimes called newborn screening.*

Yes  No

**A18 Cystic Fibrosis?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**Was this condition identified through a blood test done shortly after birth?** *These tests are sometimes called newborn screening.*

Yes  No

**A19 Other genetic or inherited condition?**

Yes  No

↳ If yes, specify:

**Is it:**

Mild  Moderate  Severe

**Was this condition identified through a blood test done shortly after birth?** *These tests are sometimes called newborn screening.*

Yes  No

Has a doctor, other health care provider, or educator EVER told you that this child has...

*Examples of educators are teachers and school nurses.*

**A20 Behavioral or Conduct Problems?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A21 Developmental Delay?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A22 Intellectual Disability (formerly known as Mental Retardation)?**

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A23 Speech or other language disorder?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A24 Learning Disability?**

Yes  No

↳ If yes, does this child CURRENTLY have the disability?

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



**A25** Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Yes  No → **SKIP to question A30**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A26** How old was this child when a doctor or other health care provider FIRST told you that they had Autism, ASD, Asperger's Disorder or PDD?

Age in years  Don't know

**A27** What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD? Mark (X) ONE box.

Primary Care Provider

Specialist

School Psychologist/Counselor

Other Psychologist (Non-School)

Psychiatrist

Other, specify:

Don't know

**A28** Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes  No

**A29** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A30** Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes  No → **SKIP to question A33**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A31** Is this child CURRENTLY taking medication for ADD or ADHD?

Yes  No

**A32** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with their behavior?

Yes  No

**A33** Do you think this child has EVER had a concussion or brain injury? A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

Yes  No

↳ If yes, did you seek medical care from a doctor or other health care provider?

Yes  No

↳ If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?

Yes  No

**A34** DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected their ability to do things other children their age do?

This child does not have any health conditions → **SKIP to question B1 on page 6**

Never

Sometimes

Usually

Always

**A35** To what extent do this child's health conditions or problems affect their ability to do things?

Very little

Somewhat

A great deal



## B. This Child as an Infant

**B1** Was this child born more than 3 weeks before their due date?

Yes

No

**B2** What month and year was this child born?

Birth Month / 4-Digit Birth Year

/

**B3** How much did they weigh when born? Answer in pounds and ounces OR kilograms and grams. Your best estimate is fine.

pounds AND  ounces

OR

kilograms AND  grams

**B4** What was the age of the mother when this child was born? Your best estimate is fine.

Age in years

## C. Health Care Services

**C1** DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

Yes

No → SKIP to question **C5**

**C2** If yes, at their LAST medical care visit, did this child have a chance to speak with a doctor or other health care provider privately, without you or another caregiver in the room?

Yes

No

**C3** DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up? A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.

0 visits

1 visit

2 or more visits

**C4** Thinking about the LAST TIME you took this child for a PREVENTIVE check-up, about how long was the doctor or health care provider who examined this child in the room with you? Your best estimate is fine.

Less than 10 minutes

10-20 minutes

More than 20 minutes

**C5** What is this child's CURRENT height? Your best estimate is fine.

feet AND  inches

OR

meters AND  centimeters

**C6** How much does this child CURRENTLY weigh? Your best estimate is fine.

pounds

OR

kilograms

**C7** Are you concerned about this child's weight?

Yes, it's too high

Yes, it's too low

No, I am not concerned

**C8** Has a doctor or other health care provider ever told you that this child is overweight?

Yes

No

**C9** Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?

Yes

No → SKIP to question **C11** on page 7



**C10** If yes, where does this child **USUALLY** go first?

Mark (X) *ONE* box.

- Doctor's Office
- Hospital Emergency Room
- Hospital Outpatient Department
- Clinic or Health Center
- Retail Store Clinic or "Minute Clinic"
- School (Nurse's Office, Athletic Trainer's Office)
- Some other place

**C11** Is there a place that this child **USUALLY** goes when they need routine preventive care, such as a physical examination or well-child check-up?

- Yes
- No → **SKIP to question C13**

**C12** If yes, is this the same place this child goes when they are sick?

- Yes
- No

**C13** **DURING THE PAST 12 MONTHS**, has this child had their vision tested, such as with pictures, shapes, or letters?

- Yes
- No → **SKIP to question C15**

**C14** If yes, where was this child's vision tested?

Mark (X) *ALL* that apply.

- Eye doctor or eye specialist (ophthalmologist, optometrist) office
- Pediatrician or other general doctor's office
- Clinic or health center
- School
- Other, specify:

**C15** **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for any kind of dental or oral health care?

- Yes, saw a dentist
- Yes, saw other oral health care provider
- No → **SKIP to question C18**

**C16** If yes, **DURING THE PAST 12 MONTHS**, did this child see a dentist or other oral health care provider for **PREVENTIVE** dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?

- No preventive visits in the past 12 months → **SKIP to question C18**
- Yes, 1 visit
- Yes, 2 or more visits

**C17** If yes, **DURING THE PAST 12 MONTHS**, what **PREVENTIVE** dental service(s) did this child receive? Mark (X) *ALL* that apply.

- Check-up
- Cleaning
- Instruction on tooth brushing and oral health care
- X-Rays
- Fluoride treatment
- Sealant (plastic coatings on back teeth)
- Don't know

**C18** **DURING THE PAST 12 MONTHS**, has this child received any treatment or counseling from a mental health professional? *Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.*

- Yes
- No, but this child needed to see a mental health professional
- No, this child did not need to see a mental health professional → **SKIP to question C20**

**C19** How difficult was it to get the mental health treatment or counseling that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C20** **DURING THE PAST 12 MONTHS**, has this child taken any medication because of difficulties with their emotions, concentration, or behavior?

- Yes
- No



**C21** DURING THE PAST 12 MONTHS, did this child see a specialist other than a mental health professional? Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.

- Yes
- No, but this child needed to see a specialist
- No, this child did not need to see a specialist → **SKIP to question C23**

**C22** How difficult was it to get the specialist care that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

**C23** DURING THE PAST 12 MONTHS, did this child use any type of alternative health care or treatment? Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.

- Yes
- No

**C24** DURING THE PAST 12 MONTHS, was there any time when this child needed health care but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.

- Yes
- No → **SKIP to question C27**

**C25** If yes, which types of care were not received? Mark (X) ALL that apply.

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

**C26** Did any of the following reasons contribute to this child not receiving needed health services? Mark (X) Yes or No for EACH item.

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

**C27** DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?

- Never
- Sometimes
- Usually
- Always

**C28** DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

**C29** DURING THE PAST 12 MONTHS, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

**C30** Has this child EVER had a special education or early intervention plan? Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).

- Yes
- No → **SKIP to question C33 on page 9**

**C31** If yes, how old was this child at the time of the FIRST plan?

00	years	AND	00	months
----	-------	-----	----	--------



**C32** Is this child **CURRENTLY** receiving services under one of these plans?

- Yes  
 No

**C33** Has this child **EVER** received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes  
 No → **SKIP to question D1**

**C34** If yes, how old was this child when they began receiving these special services?

years AND  months

**C35** Is this child **CURRENTLY** receiving these special services?

- Yes  
 No

## D. Experience with This Child's Health Care Providers

**D1** Do you have one or more persons you think of as this child's personal doctor or nurse? *A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.*

- Yes, one person  
 Yes, more than one person  
 No

**D2** **DURING THE PAST 12 MONTHS**, did this child need a referral to see any doctors or receive any services?

- Yes  
 No → **SKIP to question D4**

**D3** How difficult was it to get referrals?

- Not difficult  
 Somewhat difficult  
 Very difficult  
 It was not possible to get a referral

**D4** Answer the following questions only if this child had a health care visit **IN THE PAST 12 MONTHS**. Otherwise skip to question **D13** on page 10.

**DURING THE PAST 12 MONTHS**, how often did this child's doctors or other health care providers...

	Always	Usually	Sometimes	Never
a. Spend enough time with this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Listen carefully to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Show sensitivity to your family's values and customs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Provide the specific information you needed concerning this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Help you feel like a partner in this child's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D5** **DURING THE PAST 12 MONTHS**, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?

- Yes  
 No → **SKIP to question D7**

**D6** If yes, **DURING THE PAST 12 MONTHS**, how often did this child's doctors or other health care providers...

	Always	Usually	Sometimes	Never
a. Discuss with you the range of options to consider for their health care or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Make it easy for you to raise concerns or disagree with recommendations for this child's health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Work with you to decide together which health care and treatment choices would be best for this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D7** **DURING THE PAST 12 MONTHS**, did anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?

- Yes  
 No  
 Did not see more than one health care provider in the PAST 12 MONTHS → **SKIP to question D11 on page 10**



**D8** DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?

Yes

No → *SKIP to question D10*

**D9** If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?

Usually

Sometimes

Never

**D10** DURING THE PAST 12 MONTHS, how satisfied were you with the communication between this child's doctors and other health care providers?

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied

**D11** DURING THE PAST 12 MONTHS, did this child's health care provider communicate with the child's school, child care provider, or special education program?

Yes

No → *SKIP to question D13*

Did not need health care provider to communicate with these providers → *SKIP to question D13*

**D12** If yes, during this time, how satisfied were you with the health care provider's communication with the school, child care provider, or special education program?

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied

**D13** Do any of this child's doctors or other health care providers treat only children?

Yes

No → *SKIP to question D15*

**D14** If yes, have they talked with you about when this child will need to see doctors or other health care providers who treat adults?

Yes

No

**D15** Has this child's doctor or other health care provider actively worked with this child to:

- |   | Yes                      | No                       | Don't know               |
|---|--------------------------|--------------------------|--------------------------|
| a. <b>Make positive choices about their health.</b> For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <b>Gain skills to manage their health and health care.</b> For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications they may need? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <b>Understand the changes in health care that happen at age 18.</b> For example, by understanding changes in privacy, consent, access to information, or decision-making?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**D16** Did you and this child receive a summary of your child's medical history (for example, medical conditions, allergies, medications, immunizations)?

Yes

No

**D17** Have this child's doctors or other health care providers worked with you and this child to create a plan of care to meet their health goals and needs?

Yes

No → *SKIP to question D20 on page 11*

**D18** If yes, do you and this child have access to this plan of care?

Yes

No

**D19** Does this plan of care address transition to doctors and other health care providers who treat adults?

Yes

No

No, child already sees providers who treat adults



**D20** Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as they become an adult?

- Yes → **SKIP to question E1**
- No

**D21** If no, has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?

- Yes
- No

## E. This Child's Health Insurance Coverage

**E1** DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

- Yes, this child was covered all 12 months → **SKIP to question E4**
- Yes, but this child had a gap in coverage
- No

**E2** Indicate whether any of the following is a reason this child was not covered by health insurance at any time DURING THE PAST 12 MONTHS:

	Yes	No
a. Change in employer or employment status	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancellation due to overdue premiums	<input type="checkbox"/>	<input type="checkbox"/>
c. Dropped coverage because it was unaffordable	<input type="checkbox"/>	<input type="checkbox"/>
d. Dropped coverage because benefits were inadequate	<input type="checkbox"/>	<input type="checkbox"/>
e. Dropped coverage because choice of health care providers was inadequate	<input type="checkbox"/>	<input type="checkbox"/>
f. Problems with application or renewal process	<input type="checkbox"/>	<input type="checkbox"/>
g. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>

**E3** Is this child CURRENTLY covered by ANY kind of health insurance or health coverage plan?

- Yes
- No → **SKIP to question F1 on page 12**

**E4** Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark (X) Yes or No for EACH item.

	Yes	No
a. Insurance through a current or former employer or union	<input type="checkbox"/>	<input type="checkbox"/>
b. Insurance purchased directly from an insurance company	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability	<input type="checkbox"/>	<input type="checkbox"/>
d. TRICARE or other military health care	<input type="checkbox"/>	<input type="checkbox"/>
e. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
f. Other, specify: ↘	<input type="checkbox"/>	<input type="checkbox"/>

**E5** How often does this child's health insurance offer benefits or cover services that meet this child's needs?

- Always
- Usually
- Sometimes
- Never

**E6** How often does this child's health insurance allow them to see the health care providers they need?

- Always
- Usually
- Sometimes
- Never

**E7** Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs?

- Always
- Usually
- Sometimes
- Never
- This child does not use mental or behavioral health services





## F. Providing for This Child's Health

**F1** Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS? Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- \$0 (No medical or health-related expenses) → **SKIP to question F4**
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5,000

**F2** How often are these costs reasonable?

- Always
- Usually
- Sometimes
- Never

**F3** DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child's medical or health care bills?

- Yes
- No

**F4** DURING THE PAST 12 MONTHS, have you or other family members...

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Left a job or taken a leave of absence because of this child's health or health conditions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cut down on the hours you work because of this child's health or health conditions?          | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Avoided changing jobs because of concerns about maintaining health insurance for this child? | <input type="checkbox"/> | <input type="checkbox"/> |

**F5** IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.

- This child does not need health care provided at home on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

**F6** IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?

- This child does not need health care coordinated on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

## G. This Child's Schooling and Activities

**G1** DURING THE PAST 12 MONTHS, about how many days did this child miss school because of illness or injury? Include days missed from any formal home schooling.

- No missed school days
- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days
- This child was not enrolled in school

**G2** DURING THE PAST 12 MONTHS, how many times has this child's school contacted you or another adult in your household about any problems they are having with school?

- None
- 1 time
- 2 or more times



**G3** SINCE STARTING KINDERGARTEN, has this child repeated any grades?

- Yes
- No

**G4** DURING THE PAST 12 MONTHS, how often did you attend events or activities that this child participated in?

- Always
- Usually
- Sometimes
- Rarely
- Never

**G5** DURING THE PAST 12 MONTHS, did this child participate in...

	Yes	No
a. A sports team or did they take sports lessons after school or on weekends?	<input type="checkbox"/>	<input type="checkbox"/>
b. Any clubs or organizations after school or on weekends?	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other organized activities or lessons, such as music, dance, language, or other arts?	<input type="checkbox"/>	<input type="checkbox"/>
d. Any type of community service or volunteer work at school, place of worship, or in the community?	<input type="checkbox"/>	<input type="checkbox"/>
e. Any paid work, including regular jobs as well as babysitting, cutting grass, or other occasional work?	<input type="checkbox"/>	<input type="checkbox"/>

**G6** 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?

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

**G7** Compared to other children their age, how much difficulty does this child have making or keeping friends?

- No difficulty
- A little difficulty
- A lot of difficulty

**G8** DURING THE PAST 12 MONTHS, how often was this child bullied, picked on, or excluded by other children? *If the frequency changed throughout the year, report the highest frequency.*

- Never (in the past 12 months)
- 1-2 times (in the past 12 months)
- 1-2 times per month
- 1-2 times per week
- Almost every day

**G9** DURING THE PAST 12 MONTHS, how often did this child bully others, pick on them, or exclude them? *If the frequency changed throughout the year, report the highest frequency.*

- Never (in the past 12 months)
- 1-2 times (in the past 12 months)
- 1-2 times per month
- 1-2 times per week
- Almost every day

**G10** How often does this child...

	Always	Usually	Sometimes	Never
a. Show interest and curiosity in learning new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Work to finish tasks they start?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Stay calm and in control when faced with a challenge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Care about doing well in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do all required homework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Argue too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## H. About You and This Child

**H1** Was this child born in the United States?

- Yes → *SKIP to question **H3** on page 14*
- No

**H2** If no, how long has this child been living in the United States?

years **AND**  months



**H3** How many times has this child moved to a new address since they were born?

Number of times

**H4** How often does this child go to bed at about the same time on weeknights?

- Always
- Usually
- Sometimes
- Rarely
- Never

**H5** DURING THE PAST WEEK, how many hours of sleep did this child get on most weeknights?

- Less than 6 hours
- 6 hours
- 7 hours
- 8 hours
- 9 hours
- 10 hours
- 11 or more hours

**H6** ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media?  
*Do not include time spent doing schoolwork.*

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

**H7** How well can you and this child share ideas or talk about things that really matter?

- Very well
- Somewhat well
- Not very well
- Not well at all

**H8** How well do you think you are handling the day-to-day demands of raising children?

- Very well
- Somewhat well
- Not very well
- Not well at all

**H9** DURING THE PAST MONTH, how often have you felt...

	Never	Rarely	Sometimes	Usually	Always
a. That this child is much harder to care for than most children their age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. That this child does things that really bother you a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Angry with this child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**H10** DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?

- Yes
- No → **SKIP to question I1 on page 15**

**H11** If yes, did you receive emotional support from...

	Yes	No
a. Spouse or domestic partner?	<input type="checkbox"/>	<input type="checkbox"/>
b. Other family member or close friend?	<input type="checkbox"/>	<input type="checkbox"/>
c. Health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
d. Place of worship or religious leader?	<input type="checkbox"/>	<input type="checkbox"/>
e. Support or advocacy group related to specific health condition?	<input type="checkbox"/>	<input type="checkbox"/>
f. Peer support group?	<input type="checkbox"/>	<input type="checkbox"/>
g. Counselor or other mental health professional?	<input type="checkbox"/>	<input type="checkbox"/>
h. Other person, specify: ➤	<input type="checkbox"/>	<input type="checkbox"/>



## I. About Your Family and Household

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

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

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

- Yes
- No → **SKIP to question 14**

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

- Yes
- No

**14** SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?

- Never
- Rarely
- Somewhat often
- Very often

**15** Which of these statements best describes your household's ability to afford the food you need DURING THE PAST 12 MONTHS?

- We could always afford to eat good nutritious meals.
- We could always afford enough to eat but not always the kinds of food we should eat.
- Sometimes we could not afford enough to eat.
- Often we could not afford enough to eat.

**16** At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive...

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Cash assistance from a government welfare program?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Free or reduced-cost breakfasts or lunches at school?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Benefits from the Women, Infants, and Children (WIC) Program?             | <input type="checkbox"/> | <input type="checkbox"/> |

**17** In your neighborhood, is/are there...

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

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

- |  | Definitely agree         | Somewhat agree           | Somewhat disagree        | Definitely disagree      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. People in this neighborhood help each other out                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. We watch out for each other's children in this neighborhood                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. This child is safe in our neighborhood  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. When we encounter difficulties, we know where to go for help in our community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. This child is safe at school  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



**19** Other than you or other adults in your home, is there at least one other adult in this child’s school, neighborhood, or community who knows this child well and who they can rely on for advice or guidance?

- Yes
- No

**110** The next questions are about events that may have happened during this child’s life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

To the best of your knowledge, has this child EVER experienced any of the following?

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Parent or guardian divorced or separated  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Parent or guardian died   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Parent or guardian served time in jail  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Saw or heard parents or adults slap, hit, kick, punch one another in the home     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Was a victim of violence or witnessed violence in their neighborhood              | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lived with anyone who was mentally ill, suicidal, or severely depressed           | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lived with anyone who had a problem with alcohol or drugs                         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Treated or judged unfairly because of their race or ethnic group                  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Treated or judged unfairly because of their sexual orientation or gender identity | <input type="checkbox"/> | <input type="checkbox"/> |

**111** When your family faces problems, how often are you likely to do each of the following?

- |   | All of the time          | Most of the time         | Some of the time         | None of the time         |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Talk together about what to do       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Work together to solve our problems  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Know we have strengths to draw on    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Stay hopeful even in difficult times | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## J. Child’s Caregivers

### About You

**J1** How are you related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

**J2** What is your sex?

- Male
- Female

**J3** What is your age?

Age in years

**J4** Where were you born?

- In the United States → **SKIP to question J6 on page 17**
- Outside of the United States

**J5** When did you come to live in the United States? Indicate the 4-digit year in which you came to live in the United States.

4-Digit Year



**J6** What is the highest grade or level of school you have completed?

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J7** What is your marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J8** In general, how is your physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J9** In general, how is your mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J10** Which of the following best describes your current employment status?

Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J11** Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?

Mark (X) ONE box.

- Never served in the military → **SKIP to question J13**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question J13**
- Now on active duty
- On active duty in the past, but not now

**J12** Were you deployed at any time during this child's life?

- Yes
- No

**J13** Does this child have another parent or adult caregiver who lives in this household?

- Yes → **Complete questions J14 - J25 for this other parent or adult caregiver**
- No → **SKIP to question K1 on page 19**



## Other Parent or Caregiver in the Household

**J14** How is this other caregiver related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

**J15** What is this caregiver's sex?

- Male
- Female

**J16** What is this caregiver's age?

Age in years

**J17** Where was this caregiver born?

- In the United States → **SKIP to question J19**
- Outside of the United States

**J18** When did this caregiver come to live in the United States? Indicate the 4-digit year in which this caregiver came to live in the United States.

4-Digit Year

**J19** What is the highest grade or level of school this caregiver has completed?

Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J20** What is this caregiver's marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

**J21** In general, how is this caregiver's physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

**J22** In general, how is this caregiver's mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor



**J23** Which of the following best describes this caregiver's current employment status?  
Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

**J24** Has this caregiver ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?  
Mark (X) ONE box.

- Never served in the military → **SKIP to question K1**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question K1**
- Now on active duty
- On active duty in the past, but not now

**J25** Was this caregiver deployed at any time during this child's life?

- Yes
- No

## K. Household Information

**K1** How many people are living or staying at this address?  
Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

**K2** How many of these people in your household are family members? Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.

Number of people

**K3** Income in 2019  
Mark (X) the "Yes" box for EACH type of income this child's family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the "No" box to show types of income NOT received.

**a. Wages, salary, commissions, bonuses, or tips for all jobs.**

Yes → \$  ,  ,  .00

No TOTAL AMOUNT in the last calendar year

**b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships.**

Yes → \$  ,  ,  .00  Loss

No TOTAL AMOUNT in the last calendar year

**c. Interest, dividends, net rental income, royalty income, or income from estates and trusts.**

Yes → \$  ,  ,  .00  Loss

No TOTAL AMOUNT in the last calendar year

**d. Social security or railroad retirement; retirement, survivor, or disability pensions.**

Yes → \$  ,  ,  .00

No TOTAL AMOUNT in the last calendar year

**e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office.**

Yes → \$  ,  ,  .00

No TOTAL AMOUNT in the last calendar year

**f. Any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.**

Yes → \$  ,  ,  .00

No TOTAL AMOUNT in the last calendar year

**K4** The following question is about your 2019 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.

\$  ,  ,  .00

TOTAL AMOUNT in the last calendar year





## Mailing Instructions

### Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

**Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:**

U.S. Census Bureau  
ATTN: DCB 60-A  
1201 E. 10th Street  
Jeffersonville, IN 47132-0001

We estimate that completing the National Survey of Children's Health will take 33 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to [DEMO.Paperwork@census.gov](mailto:DEMO.Paperwork@census.gov); use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.

