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Attachments 2f-2g-2h: First Follow-up Core Survey for SEED 1-3 Caregivers

SEED Follow-Up Health and Development Core Survey

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A. General Health

1. In general, how would you describe this child's health?
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

Height and Weight

2. How tall is this child now (without shoes)?

   Please use a tape measure to measure the height. Have this child back up to a wall with the back of the head, shoulder blades, buttocks, and heels touching the wall. Lay a hard-backed book or other flat item from this child's head to the wall and level with the floor. Mark the wall under the book and then measure from the floor to the mark. Please tell us the height to the nearest quarter inch.

   If your child does not agree to be measured, please record the most recent height measure you recall, such as from a past doctor visit.

   _____inches (measured with tape measure for this study)

   OR
   _____inches (recalled height from past measurement, such as doctor visit)

   OR
   _____I don't know

3. How much does this child weigh now (without shoes)? Please weigh this child on a scale if possible. If your child does not agree to be weighed; please record the most recent weight you recall.

   _____ pounds (weighed on scale at home)

   OR
   _____ pounds (recalled weight from past measurement, such as doctor visit)

   OR
   _____ I don't know

Dental Health

4. DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following? *Please provide a response for each item listed below. If your child does not have any of the conditions listed below, please select 'No'.*

	Yes	No	Don't Know
Toothaches	❑	❑	❑
Bleeding gums	❑	❑	❑
Decayed teeth or cavities	❑	❑	❑

Sleep Health

5. The next set of questions will ask you about your child's typical sleep schedule during the week and on weekends.

SLEEP SCHEDULE ON WEEKDAYS	
What is their typical bedtime on WEEKDAYS? *(Sunday night – Thursday night)*	Bedtime: _____:_____ ☐AM/☐PM
When do they usually wake up on WEEKDAYS? *(Monday morning – Friday morning)*	Wake-up time: _____:_____ ☐AM/☐PM
SLEEP SCHEDULE ON WEEKENDS	
What is their typical bedtime on WEEKENDS? *(Friday night and Saturday night)*	Bedtime: _____:_____ ☐AM/☐PM
When do they usually wake up on WEEKENDS? *(Saturday morning and Sunday mornings)*	Wake-up time: _____:_____ ☐AM/☐PM

6. DURING A TYPICAL WEEK, does this child have FREQUENT or CHRONIC difficulty with any of the following?

	Yes	No	Don't Know
Falling asleep at night	❑	❑	❑
Staying asleep at night	❑	❑	❑
Sleeping too much (day or night)	❑	❑	❑
Waking up feeling well rested	❑	❑	❑
Unintentionally falling asleep during the day	❑	❑	❑
Snoring loudly during sleep	❑	❑	❑
Stop breathing during sleep	❑	❑	❑
Is restless and moves a lot during sleep	❑	❑	❑
Wets the bed at night	❑	❑	❑

7. How confident do you feel in your ability to assess your child's sleep habits and/or sleep problems?
   - ☐ Not confident at all
   - ☐ Slightly confident
   - ☐ Fairly confident
   - ☐ Completely confident

Gastrointestinal Health

8. DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following? *Please provide a response for each item listed below. If your child does not have any of the conditions listed below, please select 'No'.*

	Yes	No	Don't Know
Abdominal pain	❑	❑	❑
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Gaseousness or bloating	❑	❑	❑
Incontinence (loss of bladder control)	❑	❑	❑
Soilage (accidental bowel movements)	❑	❑	❑
Nausea or vomiting	❑	❑	❑
Reflux	❑	❑	❑
Swallowing	❑	❑	❑

9. How confident do you feel in your ability to assess your child's gastrointestinal symptoms?
   - ☐ Not confident at all
   - ☐ Slightly confident
   - ☐ Fairly confident
   - ☐ Completely confident

Diagnosed Conditions

10. Next please tell us whether this child has any of the health conditions listed below.

*Please answer question **A** for all conditions in the table below even if this child does not have any of the conditions. Please answer questions **B and C** for only the conditions this child ever had.*

Medical Conditions

Question A: Has a doctor or other health care provider *ever* told you that this child has **any of the following medical or genetic conditions?** *Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.*		**Question B:** How old was this child when you were first told he or she had the condition? *(Write in 0 if less than 1 year)*	**Question C:** Does this child currently have the condition?
Allergy	❑ **Yes** ❑ **No** ❑ **Don't Know** (***If yes, check all that apply***) ❑ **Food allergy** ❑ **Skin allergy or eczema** ❑ **Seasonal allergy or hay fever** ❑ **Drug allergy, specify: _____** ❑ **Other, specify: _____**	**____ Years** **____ Years** **____ Years** **____ Years**	❑ **Yes** ❑ **No** ❑ **Don't Know** ❑ **Yes** ❑ **No** ❑ **Don't Know** ❑ **Yes** ❑ **No** ❑ **Don't Know** ❑ **Yes** ❑ **No** ❑ **Don't Know**
Arthritis	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Asthma	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Brain injury, concussion, or head injury	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Cancer	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Celiac disease	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Crohn's disease	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Cystic fibrosis	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Diabetes (uses insulin)	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Diabetes (does not use insulin)	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Epilepsy or seizure disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Fragile X Syndrome	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Frequent or severe headaches, including migraine	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know

Heart condition	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
High cholesterol	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Hypertension or high blood pressure	**❑Yes ❑No ❑Don't Know**	**____ Years**	**❑Yes ❑No ❑ Don't Know**
Irritable bowel syndrome	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Sickle cell anemia/thalassemia/other hereditary anemias	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Sleep-Wake disorder	**❑Yes ❑No ❑Don't Know** **(*If yes, check all that apply*)**	**____ Years**	**❑Yes ❑No ❑ Don't Know**
	❑ Sleep Apnea **❑ Insomnia** **❑ Restless Leg Syndrome** **❑ Narcolepsy** **❑ Other, specify: _____**	**____ Years** **____ Years** **____ Years** **____ Years**	**❑Yes ❑No ❑ Don't Know** **❑Yes ❑No ❑ Don't Know** **❑Yes ❑No ❑ Don't Know** **❑Yes ❑No ❑ Don't Know**
Ulcerative colitis	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Other genetic or inherited condition Specify:_____	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know

Behavioral, Developmental, or Mental Health Conditions

Question A: Has a doctor or other health care provider *ever* told you that this child has **any of the following behavioral, developmental, or mental health conditions?** *Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.*		**Question B:** How old was this child when you were first told he or she had the condition? *(Write in 0 if less than 1 year)*	**Question C:** Does this child currently have the condition?
Attention-Deficit/Hyperactivity disorder, combined or hyperactive or inattentive type (ADD or ADHD)	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Anxiety disorder (***This includes generalized anxiety disorder, panic disorder, specific phobia, agoraphobia, selective mutism, or social anxiety disorder***)	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Autism, Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Bipolar disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Cerebral palsy	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Depressive disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Developmental coordination disorder, or motor delay	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Feeding or eating disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Global developmental delay	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Intellectual disability	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Learning disability Specify: _____	❑Yes ❑No ❑ Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Obsessive-compulsive disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Oppositional defiant or conduct disorder	**❑Yes ❑No ❑Don't Know**	**____ Years**	**❑Yes ❑No ❑ Don't Know**
Schizophrenia or other psychotic disorder	**❑Yes ❑No ❑Don't Know**	**____ Years**	**❑Yes ❑No ❑ Don't Know**
Self-injurious behavior (***This includes things like self-hitting, scratching, skin picking, or head banging***)	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Sensory integration disorder	❑Yes ❑No ❑Don't Know	____ Years	❑Yes ❑No ❑ Don't Know

Question A: Has a doctor or other health care provider *ever* told you that this child has **any of the following behavioral, developmental, or mental health conditions?** *Please provide a response for each condition listed below. If your child does not have any of the conditions listed below, please select 'No'.*		**Question B:** How old was this child when you were first told he or she had the condition? *(Write in 0 if less than 1 year)*	**Question C:** Does this child currently have the condition?
Speech or other language disorder	❑Yes ❑No ❑ Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Substance-related & addictive disorders	❑Yes ❑No ❑ Don't Know (*If yes, check all that apply*)		
	❑ Tobacco	____ Years	❑Yes ❑No ❑ Don't Know
	❑ Alcohol	____ Years	❑Yes ❑No ❑ Don't Know
	❑ Opioids (e.g., OxyContin, Vicodin, Morphine, Fentanyl)	____ Years	❑Yes ❑No ❑ Don't Know
	❑ Other, specify: _____	____ Years	❑Yes ❑No ❑ Don't Know
Tourette syndrome	❑Yes ❑No ❑ Don't Know	____ Years	❑Yes ❑No ❑ Don't Know
Any other behavioral, developmental, or mental health disorder Specify: _____	❑Yes ❑No ❑ Don't Know	____ Years	❑Yes ❑No ❑ Don't Know

Food Allergies and Dietary Restrictions

11. Do you currently avoid any foods or food ingredients for this child because of a known or suspected food allergy or intolerance?

- ☐ Yes, diagnosed food allergy
- ☐ Yes, suspected food allergy
- ☐ Yes, confirmed or suspected food intolerance
- ☐ No **(Skip to question 13)**

12. Which foods or food ingredients do you currently avoid for this child? *(Check all that apply)*

Cow's milk or other dairy products	☐	Wheat, gluten, or wheat starch	☐
Soy milk or other soy food	☐	Other grain or cereal (like oats, barley)	☐
Eggs or egg products	☐	Fruit or fruit juice	☐
Peanuts, peanut butter, or peanut oil	☐	Vegetables	☐
Other nuts (like almonds, pecans, walnuts)	☐	Artificial colors or flavors	☐
Sesame seeds or sesame seed oil	☐	Sulfites	☐
Fish (like salmon, codfish, tuna)	☐	Other, specify_____	☐
Crustacean shellfish (like shrimp, crab, lobster)	☐	None of these	☐
Beef, pork, chicken, turkey, or another animal meat	☐		

Communication Abilities

13. Does this child use verbal communication, such as words or noises, to communicate with people?
    - ☐ Verbally communicates using words easily
    - ☐ Verbally communicates using words with a little trouble
    - ☐ Verbally communicates using words with a lot of trouble
    - ☐ Verbally communicates with noises
    - ☐ Does not verbally communicate

14. Does this child communicate with people using any of the following non-verbal methods of communication?

	Yes	No
Sign language	❑	❑
Lip reading	❑	❑
Simple hand movements	❑	❑
Facial gestures	❑	❑
Eye contact	❑	❑
Communication board	❑	❑
Other electronic device (*e.g., uses a tablet, laptop, or smartphone to communicate without talking)*	❑	❑

Level of Support Needed

15. Children and adolescents have different levels of support needs. Overall, how much support does your child need to manage these aspects of life?

	No support	A little support	A lot of support
Understanding and communicating	❑	❑	❑
Moving and getting around	❑	❑	❑
Attending to hygiene, dressing, eating, and staying alone	❑	❑	❑
Interacting with other people	❑	❑	❑
Domestic responsibilities, leisure, work, and school	❑	❑	❑
Joining in community activities, participating in society	❑	❑	❑

B. Service Needs and Utilization

Health Services

1. Is there a place that this child usually goes when he or she is sick, or you need advice about his or her health?

   ☐ Yes
   ☐ No **(Skip to question 3)**

2. If yes, where does this child USUALLY go first? (*Check one box only*)
   ☐ Doctor's Office
   ☐ Hospital Emergency Department
   ☐ Hospital Outpatient Department
   ☐ Clinic or Health Center
   ☐ Retail Store or "minute clinic"
   ☐ School (Nurse's Office, Athletic Trainer's Office, etc.)
   ☐ Some other place, specify: _____

3. DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for routine preventative care (such as well-child visits or check-ups) or sick-child care?

☐ Yes
☐ No **(Skip to question 4)**

	Question A	**Question B**	**Question C**
Type of provider	**Number of visits in <u>past 12 months</u>** ***Complete each blank. (Write in 0 if no visits)***	**If your child received <u>routine preventative care</u>, how much of a problem was it to get service from this type of provider?**	**If your child received <u>sick-child care</u>, how much of a problem was it to get service from this type of provider?**
Dentist or oral health provider	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months
Hearing care provider	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months
Vision care provider	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months
General Physician or Medical care provider	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months
Medical specialist care provider, specify: _____	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months
Psychologist, psychiatrist, counselor, therapist, or mental health care provider (circle type)	# of visits for **routine preventative care**: _____ # of visits for **sick-child care**: _____	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months	❑Not a problem ❑Small problem ❑Big problem ❑Did not receive this type of care in the last 12 months

4. DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency department?

☐ No visits

- ☐ 1 visit
- ☐ 2 or more visits

5. DURING THE PAST 12 MONTHS, how many times was this child hospitalized for any reason?
   - ☐ No hospitalizations
   - ☐ 1 visit
   - ☐ 2 or more hospitalizations

6. DURING THE PAST 12 MONTHS, was there any time when this child needed healthcare, 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 9)**

   7. If yes, which types of care were NOT received? (*Check all that apply*)

   ☐ Dental Care
   ☐ Hearing Care
   ☐ Medical care, routine preventative
   ☐ Medical care, sick or urgent care
   ☐ Medical care, hospital emergency
   ☐ Medical care, specialist
   ☐ Mental Health Services
   ☐ Vision Care
   ☐ Other, Specify _____

8. Which of the following contributed to this child not receiving needed healthcare services? "Yes" means it was a factor in not receiving services and "no" means it was not a factor. *(Check one in each row)*

	Yes	No
This child did not have health insurance that covered the services needed	❑	❑
This child was not eligible for the services	❑	❑
The services this child needed were not available in this child's area	❑	❑
There were problems getting an appointment when this child needed one	❑	❑
There were problems with getting transportation or child care	❑	❑
The (clinic/doctor's) office wasn't open when this child needed care	❑	❑
There were issues related to cost	❑	❑
There were issues related to COVID-19 (e.g., concerned about being around others at doctor's office who may have been exposed to COVID-19)	❑	❑
The child's behaviors limited ability to attend or complete a visit		
Other (Specify:_____)	❑	❑

Experience with Child's Health Care Providers

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

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

10. Answer the following questions only if this child had a health care visit IN THE PAST 12 MONTHS. Otherwise, **Skip to question 17 in this section**.

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

	Never	Sometimes	Usually	Always
Spend enough time with this child?	❑	❑	❑	❑
Listen carefully to you?	❑	❑	❑	❑
Show sensitivity to your family's values and customs?	❑	❑	❑	❑
Provide the specific information you needed concerning this child?	❑	❑	❑	❑
Help you feel like a partner in this child's care?	❑	❑	❑	❑

11. DURING THE PAST 12 MONTHS, were any decisions needed about this child's health care services or treatment, such as whether to start or stop a prescription or therapy services, get a referral to a specialist, or have a medical procedure?

    - ☐ Yes
    - ☐ No **(Skip to question 13)**

12. DURING THE PAST 12 MONTHS, how often did this child's doctors or other healthcare providers: *(Check one in each row)*

	Never	Sometimes	Usually	Always
Discuss with you the range of options to consider for his or her health care or treatment?	❑	❑	❑	❑
Make it easy for you to raise concerns or disagree with recommendations for this child's health care?	❑	❑	❑	❑
Work with you to decide together which health care and treatment choices would be best for this child?	❑	❑	❑	❑

13. Does 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 past 12 months (**Skip to question 15**)

14. 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

15. DURING THE PAST 12 MONTHS, did this child's health care provider communicate with this child's school, childcare provider, or special education program?

- ☐ Yes
- ☐ No **(Skip to question 17)**
- ☐ Did not need health care provider to communicate with these providers **(Skip to question 17)**

16. If yes, overall, how satisfied are you with the health care provider's communication with the school, childcare provider, or special education program?
- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

Health Insurance

17. Is your child currently covered by ANY kind of health insurance or health coverage plan?
- ☐ Yes
- ☐ No (**Skip to question 20**)

18. If yes, please tell us which types of health insurance plans CURRENTLY include coverage for your child.

	Yes	No
a. Insurance through a current or former employer or union	☐	☐
b. Insurance purchased directly from an insurance company	☐	☐
c. Medicaid, Medical Assistance, or any kind of government-assistance plan	☐	☐
d. TRICARE or other military health care	☐	☐
e. Indian Health Service	☐	☐
f. Any other type of health insurance or health coverage plan, specify: _____	☐	☐

19. Thinking specifically about your 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

Education Services

20. DURING THE PAST 12 MONTHS, has this child attended school?

- ☐ Yes (Skip to question 22)
- ☐ No

21. If no, is your child not in school now because they… (***Check one then skip to question 28***)

- ☐ Graduated with regular high school diploma (e.g., the standard high school diploma awarded to students after completing standard high school curriculum & exit exams*)*
- ☐ Graduate with certificate of completion (e.g., certificate or alternative diploma awarded to high school students in special education)
- ☐ Took a test for a diploma without taking all of their high school classes (e.g., GED)
- ☐ Dropped out or stopped going
- ☐ Was suspended
- ☐ Was expelled
- ☐ Is older than the school age limit
- ☐ Some other reason, specify: _____

Please skip to question 28

22. If yes, which of the following best describes the school this child currently attends (or most recently attended)? *If this child currently attends 2 schools, describe the school where he or she spends the most time. If this child only attends a school that offers instruction on a specific topic rather than general education check "other (specify)."*

- ☐ A regular public school that serves a wide variety of students
- ☐ A regular private school that serves a wide variety of students
- ☐ A school that serves only children with disabilities
- ☐ A charter school or alternative school
- ☐ An "online" school
- ☐ Home instruction by a professional
- ☐ Home schooling by a parent

- ☐ A vocational/technical school (voc-tech)
- ☐ 2-year community college
- ☐ 4-year college or university
- ☐ Medical or mental health facility, convalescent hospital, institution for people with disabilities, correctional or juvenile justice facility
- ☐ Other (Specify) _____

23. Which of the following best describes this child's classroom setting:

- ☐ Regular classroom with a wide variety of students
  - ○ Typical classroom with classroom support (for example, pull out or in class; one-to-one (1-to-1) aide; Collaborative Team Teaching (CTT) or Integrated Co-teaching (ICT) classroom)
  - ○ Typical classroom without support
- ☐ Special education classroom for students with disabilities or special needs
- ☐ Mix of regular and special education classrooms
- ☐ Does not apply because this child is home-schooled or not attending school

24. What grade is this child currently in? (If summer, what is the highest grade level this child has already completed)?

☐ Pre-school	☐ 9th grade
☐ Kindergarten	☐ 10th grade
☐ 1st grade	☐ 11th grade
☐ 2nd grade	☐ 12th grade
☐ 3rd grade	☐ Some college, but less than 1 year
☐ 4th grade	☐ 1 or more years of college, *please indicate most recent year completed below*
☐ 5th grade	☐Freshman ☐ Sophomore ☐Junior ☐Senior
☐ 6th grade	☐ Does not apply, my child did not attend a typical public or private school
☐ 7th grade	☐ Don't know
☐ 8th grade	☐ Other, specify: _____

25. DURING THE PAST 12 MONTHS, about how many days did this child miss school because of illness or injury?

- ☐ No missed school days
- ☐ 1-3 days
- ☐ 4-6 days
- ☐ 7-10 days
- ☐ 11 or more days

26. DURING THE PAST 12 MONTHS, how many times has this child's school contacted you or another adult in your household about any problems he or she is having with school?

- ☐ No calls
- ☐ 1 time

- 2 or more times

27. DURING THE PAST 12 MONTHS, how many times has this child been suspended or expelled from school?

- None
- 1 time
- 2 or more times

28. Since starting kindergarten, has this child repeated any grades?

- Yes
- No

29. Has this child ever changed schools or educational setting because his or her education needs were not being met?

- Yes
- No

30. Have you ever been involved in mediation, a due process hearing, or litigation concerning the child's education services?

- Yes
- No

31. Has this child EVER received special education or early intervention services such as an Individualized Education Plan (IEP), 504 plan, tutoring, classroom aide, reader/interpreter, communication device, enrichment program, pull-out program, or accelerated curriculum?

- Yes
- No, my child has never had a plan or services for special education (**Skip to question 34**)

32. If yes, please indicate below which of the following plans or services your child has received

Question A: Has your child ever received one of these plans or services? *Please provide a response for each plan or service listed below. If your child did not receive a plan or service listed below, please select 'No'*		Question B: If yes, at what age in years did your child first receive the plan or service?	Question C: Does the child currently have this plan or received this service IN THE PAST 12 MONTHS?
Individualized Education Plan or IEP (*used for special education services in children 3 or older)*	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
504 Plan (sometimes *used for special education services instead of or in addition to an IEP)*	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Gifted and talented services, such as enrichment, pull-out program, or accelerated curriculum	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Tutoring	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Classroom aide	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Reader/interpreter	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Communication device or other electronic device (e.g., tablet, laptop, smartphone) to assist with classwork or to communicate without talking	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No
Other plan or service, specify _____	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No

33. Overall, how satisfied are you with the educational plans or services your child has received?

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

Developmental Services

34. Please tell us whether this child has ever used any of the developmental services or supports listed below. These types of services might be received through the school, a healthcare provider, or some other person or place such as an independent therapist.

*Please answer question **A** for all services and supports in the table below, even if the child does not use the service or support. Please answer questions **B, C, and D** for only services and supports the child ever received.*

		*If **Question A** is YES, please answer **Questions B to D**.*		
			If yes, has this child received the service or support DURING THE PAST 12 MONTHS?	
Question A: Has this child EVER received …		**Question B:** If yes, at what age in years did your child first receive this service?	**Question C:** Received THROUGH SCHOOL DURING PAST 12 MONTHS?	**Question D:** Received OUTSIDE OF SCHOOL DURING PAST 12 MONTHS?
Audiology or hearing services?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Behavioral therapy, such as applied behavior analysis?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Occupational therapy or sensory therapy?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Physical therapy?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Psychological or mental health services or counseling?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Social skills therapy or training?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Speech or language therapy?	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Other services? Specify:_____	❑Yes ❑No ❑Don't Know	____Years	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know

35. Overall, how satisfied are you with the developmental services or supports your child has received?

- ❑ Very satisfied
- ❑ Somewhat satisfied
- ❑ Somewhat dissatisfied
- ❑ Very dissatisfied
- ❑ My child did not receive any developmental services or supports

Medications

36. Please tell us whether this child has taken medication because of the difficulties noted below. The medication can be prescription or over the counter.

*Please answer question **A** for all conditions that may be treated with medication, even if the child does not take medication. Please answer questions **B** and **C** for only those conditions that are treated with medication.*

Question A: DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties noted below at least once per month for at least 3 months?		**Question B:** If yes to Question A, did the child take a medication prescribed by a doctor or other healthcare provider?	**Question C:** If yes to Question A, did the child take an over-the-counter medication?
Aggression	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Anxiety	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Asthma	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Attention, concentration, or hyperactivity	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Autism	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Depression	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Gastrointestinal problems	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Repetitive behaviors	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Restricted interests	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Obsessive Compulsive Disorder	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Seizures	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Self-injurious behaviors (*This includes things like self-hitting, scratching, skin picking, or head banging*)	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know
Sleep problems	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know	❑Yes ❑No ❑Don't Know

Complementary and Alternative Treatments

37. DURING THE PAST 12 MONTHS, did your child use any type of complementary or alternative health care or treatment to help improve or manage their behavior or development? This could be acupuncture, animal

therapy, art or music therapy, relaxation or mindfulness therapy, special diets or supplements, or other alternative treatments.

- ☐ Yes
- ☐ No (**Skip to Section C**)

38. If yes, please select all below that apply. Where relevant, please include these regardless of how it was given (e.g., pill, spray, cream, injection, etc.)

- ❑ Acupuncture
- ❑ Animal therapy
- ❑ Arts therapy (includes music, art, dance, or drama/acting therapy)
- ❑ Auditory integration
- ❑ Chiropractic care
- ❑ Wellness or Mindfulness (includes massage therapy, relaxation therapy, meditation, and yoga)
- ❑ Vitamin or mineral supplements (includes supplements of any vitamin, folic acid, omega-3 FA and fish oils, and multi-vitamin and/or multi-mineral)
- ❑ CBD/cannabis (e.g., CBD oil, marijuana, hash, weed, THC edibles)
- ❑ Melatonin
- ❑ Oxytocin
- ❑ Special diet such as gluten-free casein-free (GFCF), gluten-free only, casein-free only, Feingold diet, ketogenic diet)
- ❑ Other (specify): _____

C. Community and Social Participation

1. DURING THE PAST 12 MONTHS, did this child participate in:
   (Check one in each row)

	Yes	No
Any sports team or sports lessons after school or on weekends?	❑	❑
Any clubs or organizations after school or on weekends?	❑	❑
Any other organized activities or lessons, such as music, dance, language, or other arts after school or on weekends?	❑	❑
Any type of community service or volunteer work at school, church, or in the community?	❑	❑
Any work, including regular jobs as well as babysitting, cutting grass, or other occasional work?	❑	❑

2. DURING THE PAST 2 WEEKS, did this child:

	Yes	No
Get together socially with friends or neighbors?	❑	❑
Talk with friends or neighbors on the telephone, video conferencing system, or social media APP (e.g., SnapChat, Facebook, etc.)?	❑	❑
Get together with ANY relatives not including those who live with you?	❑	❑
Go to church, temple, or another place of worship for services or other activities?	❑	❑
Go to a show or movie, sports events, club meeting, after school class or other group event?	❑	❑
Go out to eat at a restaurant?	❑	❑

3. DURING THE PAST WEEK, on how many days was this child physically active for at least 60 minutes per day? *Add all the time that he or she spent in any kind of physical activity that increased his or her heart rate and made him or her breathe hard some of the time.*

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ Every day
- ☐ I don't know

4. ON AN AVERAGE WEEKDAY, about how much time does this child usually spend watching TV programs or movies, including streaming services such as Netflix, Hulu, Apple+?
   - ☐ None
   - ☐ Less than 1 hour
   - ☐ 1 hour
   - ☐ 2 hours
   - ☐ 3 hours
   - ☐ 4 or more hours
   - ☐ I don't know

5. ON AN AVERAGE WEEKDAY, about how much time does your child usually spend playing on an electronic device? *This does NOT include doing schoolwork or watching TV shows, movies, or videos on YouTube/TikTok*.

   - ☐ None
   - ☐ Less than 1 hour
   - ☐ 1 hour
   - ☐ 2 hours
   - ☐ 3 hours
   - ☐ 4 or more hours
   - ☐ I don't know

D. Bullying and Discrimination

1. DURING THE PAST 12 MONTHS, has this child faced a barrier to community or social participation because of:

	Yes	No
A physical environment that is not accessible?	❑	❑
Lack of assistive or adaptive technology?	❑	❑
Negative attitudes towards people with disability?	❑	❑
A service, system, or policy that prevents equal participation for everyone?	❑	❑

2. Discrimination occurs when people are unfairly treated because they are perceived as different from others. Disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.

   Has this child been discriminated against because of a disability?

   - ☐ Yes
   - ☐ No, my child has not been discriminated against because a disability **(Skip to question 4)**
   - ☐ Not applicable, my child does not have a disability (**Skip to question 4**)
   - ☐ I don't know **(Skip to question 4)**

3. If so, who discriminated against this child (check all that apply)?

   - ☐ Employer
   - ☐ Educator
   - ☐ Healthcare provider
   - ☐ Community worker (e.g., staff in shops)
   - ☐ Other; Specify:_____

4. DURING THE PAST MONTH (30 days), how often has this child <u>been bullied by someone else</u>?

   - ☐ Never (**Skip to question 6**)
   - ☐ 1 time
   - ☐ 2-3 times
   - ☐ 4 or more times
   - ☐ Don't know (**Skip to question 6**)

5. Please check all the ways this child has been bullied.

	Yes	If yes, check if the behavior occurred in the last 30 days	No	Don't Know
Called bad names	☐	☐	☐	☐
Threatened that they would be hurt or hit	☐	☐	☐	☐
Teased, picked on, or made fun of	☐	☐	☐	☐
Pushed or shoved	☐	☐	☐	☐

Hit, slapped or kicked	☐	☐	☐	☐
Was electronically bullied or experienced cyber-bulling (this includes being bullied through texting, Instagram, Facebook, or other social media)	☐	☐	☐	☐
Ignored or left out of things on purpose	☐	☐	☐	☐
Someone tried to keep others from liking them by saying something bad or mean about them, or spreading rumors or lies	☐	☐	☐	☐
Others stole their things	☐	☐	☐	☐
Other - please specify _____	☐	☐	☐	☐

6. DURING THE PAST MONTH (30 days), how often has this child bullied another child?

- ☐ Never (**Skip to Section E**)
- ☐ 1 time
- ☐ 2-3 times
- ☐ 4 or more times
- ☐ Don't know (**Skip to Section E**)

7. In what ways has this child bullied others?

Please check all the ways that this **child bullied others.**

	Yes	If yes, check if the behavior occurred in the last 12 months.	No	Don't Know
Called bad names	☐	☐	☐	☐
Threatened to hurt or hit someone	☐	☐	☐	☐
Teased, picked on, or made fun of someone	☐	☐	☐	☐
Pushed or shoved someone	☐	☐	☐	☐
Hit, slapped or kicked someone	☐	☐	☐	☐
Engaged in electronic or cyber-bulling (this includes being bullied through texting, Instagram, Facebook, or other social media)	☐	☐	☐	☐
Ignored someone or left them out of things on purpose	☐	☐	☐	☐
Tried to keep others from liking someone by saying mean things about them, or spread rumors or lies about someone	☐	☐	☐	☐
Stole others' things	☐	☐	☐	☐
Other - please specify _____	☐	☐	☐	☐

E. Child Safety

1. Some children are likely to wander off and become so lost that it is necessary to search for them.

   DURING THE PAST 12 MONTHS, has this child wandered off or became lost from any of these places, even if it occurred just once. (*Check one in each row*)

	Yes	No
Your home?	❑	❑
Someone else's home such as a relative, friend, neighbor, or babysitter?	❑	❑
School, day care, or summer camp?	❑	❑
A store, restaurant, playground, campsite, or any other public place?	❑	❑

2. Do you currently have any of the following to specifically prevent this child from wandering off or to find them if they become lost? (*Check all that apply*)

	Yes	No
Fences or gates to your home or property (e.g., pool gate)	❑	❑
Locks, alarms, or cameras to your home or property (e.g., motion detectors)	❑	❑
Other barriers to your home or property (e.g., window guards)	❑	❑
A tracking device on this child's accessories, body, or clothing	❑	❑
An APP, feature, or tracking device on this child's cell phone	❑	❑

3. DURING THE PAST 12 MONTHS, has this child had contact with a law enforcement officer for any reason?

   ❑ Yes
   ❑ No **(Skip to question 6)**
   ❑ I Don't Know **(Skip to question 6)**

4. Did the officer sufficiently explain his or her actions or procedures?

   ❑ Yes
   ❑ No

5. Are you satisfied with your child's interaction(s) with your law enforcement agency?

   ❑ Yes
   ❑ No

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

6. To the best of your knowledge, has this child ever experienced any of the following?

	Yes	No
Parent/guardian divorced or separated	❑	❑
Parent/guardian died	❑	❑
Parent/guardian served time in jail	❑	❑
Was a victim of violence or witnessed violence in their neighborhood	❑	❑
Lived with anyone who was mentally ill, suicidal, or severely depressed	❑	❑
Lived with anyone who had a problem with alcohol or drugs	❑	❑
Treated or judged unfairly because of their race or ethnic group	❑	❑
Treated or judged unfairly because of their sexual orientation or gender identify	❑	❑

F. You and Your Family

The next questions are about you and your family

1. How are you related to this child?

   - ☐ Biological or adoptive mother
   - ☐ Biological or adoptive father
   - ☐ Stepparent
   - ☐ Grandparent
   - ☐ Aunt or uncle
   - ☐ Other relative
   - ☐ Other non-relative, specify:_____

2. What is your age?

   __ __ (Print numbers)

3. What is the highest grade or year of school you have completed?

   - ☐ 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 (e.g., AA, AS)
   - ☐ Bachelor's Degree (e.g., BA, BS, AB)
   - ☐ Master's Degree (e.g., MA, MS, MSW, MBA)
   - ☐ Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, JD)

4. Are you currently…?
   If more than one, select the one category which best describes you.

   - ☐ Employed for wages
   - ☐ Self-employed
   - ☐ Out of work for less than 1 year
   - ☐ Out of work for 1 year or more
   - ☐ A homemaker
   - ☐ A student
   - ☐ Retired
   - ☐ Unable to work

5. Are you now married, living with a partner together as an unmarried couple, or neither?

   - ☐ Married
   - ☐ Living with a partner together as unmarried couple

- ☐ Neither **(Skip to question 8)**
- ☐ Prefer not to answer **(Skip to question 8)**

6. What is the highest grade or year of school your spouse or partner has completed?

   - ☐ 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 (e.g., AA, AS)
   - ☐ Bachelor's Degree (e.g., BA, BS, AB)
   - ☐ Master's Degree (e.g., MA, MS, MSW, MBA)
   - ☐ Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, JD)

7. Is your spouse or partner currently…?
   If more than one, select the one category which best describes your spouse or partner.

   - ☐ Employed for wages
   - ☐ Self-employed
   - ☐ Out of work for less than 1 year
   - ☐ Out of work for 1 year or more
   - ☐ A homemaker
   - ☐ A student
   - ☐ Retired
   - ☐ Unable to work

Your Health

The following questions are about your health.

8. In general, what is your physical health status?

   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. DURING THE PAST 2 WEEKS, for about how many days have you felt very healthy and full of energy?

- ☐ Nearly every day
- ☐ More than half the days
- ☐ Few days
- ☐ No days

10. In general, what is your mental or emotional health status?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

11. Has a doctor or other healthcare provider EVER told you that you had any of the following?

	Yes	No
Attention deficit disorder or Attention deficit hyperactivity disorder (ADD or ADHD)?	❑	❑
Anxiety disorder? (*This includes generalized anxiety disorder, panic disorder, specific phobia, agoraphobia, selective mutism, or social anxiety disorder)*	❑	❑
Obsessive compulsive disorder?	❑	❑
Autism, Asperger's, pervasive developmental disorder, or autism spectrum disorder?	❑	❑
Bipolar disorder?	❑	❑
Depression? (*This includes Major Depressive Disorder, Disruptive Mood Regulation Disorder, Dysthymia, and Premenstrual dysphoric disorder)*	❑	❑
Schizophrenia or other psychotic disorder?	❑	❑

12. How well do you feel that you are coping with the day-to-day demands of raising this child?

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

13. DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising this child?

- ☐ Yes
- ☐ No **(Skip to question 15)**

14. If yes, did you receive emotional support from (check all that apply):

	Yes	No

Spouse?	❑	❑
Other family member or close friend?	❑	❑
Health care provider?	❑	❑
Place of worship or religious leader?	❑	❑
Support or advocacy group related to specific health condition?	❑	❑
Peer support group?	❑	❑
Counselor or other mental health professional?	❑	❑
Other person, specify _____	❑	❑

15. DURING THE PAST 12 MONTHS, have you:

	Yes	No
Delayed getting health care or dental care for yourself because of the time needed to care for this child?	❑	❑
Gotten less physical activity than you wanted because of the time needed to care for this child?	❑	❑
Limited your social life because of the time needed to care for this child?	❑	❑

16. DURING THE PAST 12 MONTHS, have you needed help with any of the following as a result of parenting this child?

	Yes	No
Finding more time for yourself?	❑	❑
Helping your spouse accept any condition your child might have?	❑	❑
Helping your family discuss problems and reach solutions?	❑	❑
Deciding on and doing recreational activities?	❑	❑
Paying for household expenses, such as food, housing, medical care, clothing, or transportation?	❑	❑
Getting any special equipment your child needs?	❑	❑
Paying for therapy, day care, or other services your child needs?	❑	❑
Counseling or help in getting a job?	❑	❑

17. Have you or other family members living in your household EVER stopped working or cut down on the hours you work because of this child's health or health conditions?

- ☐ Yes
- ☐ No

18. Have you or other family members living in your household EVER avoided changing jobs because of concerns about maintaining health insurance for this child?

- ☐ Yes
- ☐ No

19. As a result of parenting this child, do you feel:

	Yes	No
That this child is much harder to care for than most children his or her age?	❑	❑
That this child does things that bother you a lot?	❑	❑
Angry with this child?	❑	❑
An increased sense of personal strength and confidence?	❑	❑
That your priorities have changed?	❑	❑
A greater appreciation of life?	❑	❑
Pleasure in the child's accomplishments?	❑	❑
Increased faith/spirituality?	❑	❑
That you have more meaningful relationships?	❑	❑
The child has had a positive effect on the wider community?	❑	❑

G. Household Information

1. Is this child of Hispanic, Latino, or Spanish origin? (*Check one*)
   - ☐ No, not Hispanic, Latino, or Spanish origin
   - ☐ Yes, Mexican, Mexican American, Chicano
   - ☐ Yes, Puerto Rican
   - ☐ Yes, Cuban
   - ☐ Yes, another Hispanic, Latino, or Spanish origin

2. What is this child's race? (*Check all that apply*)

☐ White	☐ Korean
☐ Black or African American	☐ Vietnamese
☐ American Indian or Alaska Native	☐ Other Asian
☐ Asian Indian	☐ Native Hawaiian
☐ Chinese	☐ Guamanian or Chamorro
☐ Filipino	☐ Samoan
☐ Japanese	☐ Other Pacific Islander

3. How many **other** children under the age of 18 years are now living in the household? ***Not including this child.***

   Number of children _____ **(If 0, Skip to question 3)**

4. Do any of these children have any disability, developmental delay, special need, or condition?

   - ☐ YES
   - ☐ NO

5. How many adults 18 years or older are now living in the household? ***Not including this child.***

   Number of adults ____

6. How many of these adults 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 ____

The next questions are about your total income in the last calendar year before taxes.

Income is important in analyzing the health information we collect. For example, with this information, we can learn whether people in one income group use certain types of medical services more or less often than those in another group. Please be assured that, like all other information you have provided, these answers will be kept strictly private.

7. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What was your yearly total household income before taxes? *Include your income, your spouse's or partner's income, and any other income you may have received.*

$ ☐,☐☐☐,☐☐☐

TOTAL AMOUNT
In the last calendar year

If you are unable to provide a specific amount, please indicate an estimated range of total yearly income below.

- ☐ $0 to $16,000
- ☐ $16,001 to $20,000
- ☐ $20,001 to $24,000
- ☐ $24,001 to $28,000
- ☐ $28,001 to $32,000
- ☐ $32,001 to $40,000
- ☐ $40,001 to $48,000
- ☐ $48,001 to $57,000
- ☐ $57,001 to $60,000
- ☐ $60,001 to $73,000
- ☐ $73,001 to $85,000
- ☐ $85,001 or more

8. DURING THE LAST CALENDAR YEAR, how many people, including yourself and this child, depended on this income?

Number of people___ ____

H. Individual Strengths

The following questions ask about characteristics and abilities you view as individual strengths of your child.

1. Would you say the following are individual strengths of this child?

	Yes	No
Courage	❑	❑
Empathy	❑	❑
Forgiveness	❑	❑
Kindness	❑	❑
Gratitude	❑	❑
Humor	❑	❑
Optimism	❑	❑
Resilience	❑	❑
Self-control	❑	❑
Self-efficacy, or belief he or she can be successful	❑	❑

2. Please describe the best things about your child below.

You have reached the end of the survey.

Thank you for participating!

BASC 3

Parent Rating Scales PRS–A

Adolescent Ages 12–21

Cecil R. Reynolds, PhD · Randy W. Kamphaus, PhD

Child's Name _____ (First / Middle / Last)

Date _____ (Month / Day / Year) Birth Date _____ (Month / Day / Year)

School _____ Grade _____

Child's Gender ☐ Male ☐ Female Age _____

Your Name _____ (First / MI / Last)

Your Gender ☐ Male ☐ Female

Your Relationship to Child ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Do you have concerns about this child's:

(a) Vision? Y N _____

(b) Hearing? Y N _____

(c) Eating habits? Y N _____

Instructions

This form contains phrases that describe how children may act. Please read each phrase and select the response that describes how this child has behaved recently (in the last several months).

Select **N** if the behavior **never** occurs.

Select **S** if the behavior **sometimes** occurs.

Select **O** if the behavior **often** occurs.

Select **A** if the behavior **almost always** occurs.

Please mark every item. If you don't know or are unsure of your response to an item, give your best estimate. A "Never" response does not mean that the child "never" engages in a behavior, only that you have no knowledge of it occurring.

How to Mark Your Responses

Be certain to circle completely the letter you choose:

N S (O) A

If you wish to change a response, mark an X through it and circle your new choice, like this:

N (S) (X) A

Before starting, be sure to complete the information above these instructions.

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13 14 15 16 17 18 A B C D E

PsychCorp

Product Number 30813

Vineland-3

Vineland Adaptive Behavior Scales™–Third Edition

Domain-Level Parent/Caregiver Form

Separate the outside pages (pages 1–2 and 15–16 containing the Scoring Criteria) from the rest of the booklet by gently pulling them off at the staples.

PEARSON

For inquiries and reordering:
800.627.7271
www.PearsonClinical.com

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5 6 7 8 9 10 11 12 B C D E

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Product Number 31327

Vineland-3

Domain-Level Parent/Caregiver Form Score Report

Examinee's Name:

Examiner's Name:

Parent/Caregiver's Name:

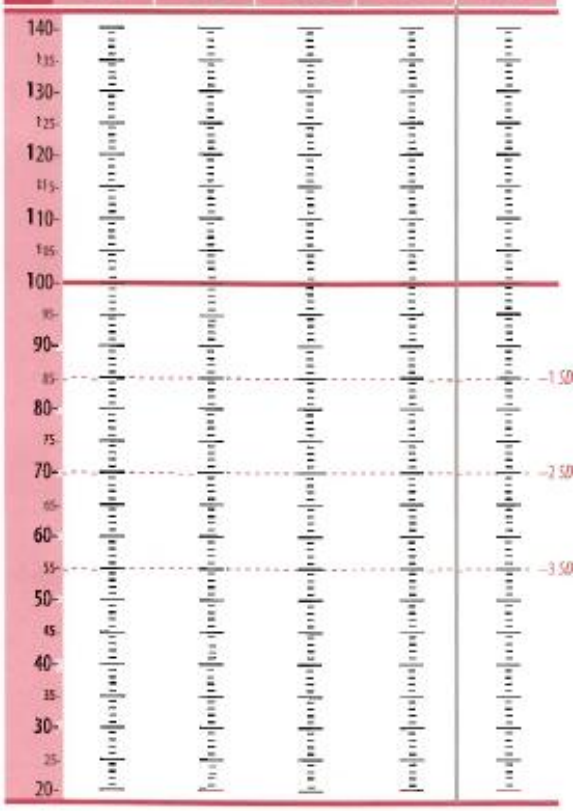
Calculation of Examinee's Age	Year	Month	Day
Test Date			
Birth Date			
Test Age			

Score Summary

Domains and Adaptive Behavior Composite

	Raw Score	Standard Score	85% 90% 95% Confidence Interval	Percentile Rank	% Est
Communication (COM)	1		—		
Daily Living Skills (DLS)	2		—		
Socialization (SOC)	3		—		
Sum of Domain Standard Scores					
See Table C.3 to convert to ABC					
Adaptive Behavior Composite (ABC)			—		
Motor Skills (MOT)	4		—		

Domain and ABC Standard Score Profile



MALADAPTIVE BEHAVIOR

	Raw Score	v-Scale Score	Critical Items (Circle all item scores of 2 or 1)							
Internalizing (Section A)			1. 2 1	4. 2 1	7. 2 1	10. 2 1
			2. 2 1	5. 2 1	8. 2 1	11. 2 1
Externalizing (Section B)			3. 2 1	6. 2 1	9. 2 1	

STRENGTH/WEAKNESS ANALYSIS

		Standard Score (SS)	SS Minus Mean SS	.10 or .05 Critical Value	Strength or Weakness	Base Rate
Domains	COM				S or W	
	+					
	DLS				S or W	
	+					
	SOC				S or W	
	+					
	MOT				S or W	
	=					
		÷	=		Calculation of Mean Domain Standard Score	
		Sum of SS	No. of domains (3 or 4)	Mean SS (one decimal)		

PAIRWISE DIFFERENCE COMPARISONS

		Standard Score	<, >, or =	Standard Score		Standard Score Difference	.10 or .05 Critical Value	Statistically Significant	Base Rate
Domain Comparisons	COM		—		DLS			Y or N	
	COM		—		SOC			Y or N	
	DLS		—		SOC			Y or N	
	COM		—		MOT			Y or N	
	DLS		—		MOT			Y or N	
	SOC		—		MOT			Y or N	

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