

CASE ID:

**Section A. Screener (PROGRAMMER: Add Timestamp)**

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

1  NO [IF NO, STOP HERE. THIS IS THE END OF THE SURVEY]

2  YES

**A2. How many children 0-17 years old usually live or stay at this household?**

NUMBER OF CHILDREN LIVING OR STAYING AT THIS ADDRESS

**A3. What is the primary language spoken in the household?**

1  ENGLISH

2  SPANISH

3  ANOTHER LANGUAGE, PLEASE SPECIFY:

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.

**A4. CHILD 1**

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

**A5. Is this child of Hispanic, Latino, or Spanish origin?**

1  No, not of Hispanic, Latino, or Spanish origin

2  Yes, Mexican, Mexican American, Chicano

3  Yes, Puerto Rican

4  Yes, Cuban

5  Yes, another Hispanic, Latino, or Spanish origin, please specify:

**A6. What is this child's race or ethnicity? SELECT ONE OR MORE.**

- |                                                                                                         |                                                                                                |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1 <input type="checkbox"/> WHITE                                                                        | 11 <input type="checkbox"/> NATIVE HAWAIIAN                                                    |
| 2 <input type="checkbox"/> BLACK OR AFRICAN AMERICAN                                                    | 12 <input type="checkbox"/> GUAMANIAN OR CHAMORRO                                              |
| 3 <input type="checkbox"/> AMERICAN INDIAN OR ALASKA<br>NATIVE, PLEASE SPECIFY:<br><input type="text"/> | 13 <input type="checkbox"/> SAMOAN                                                             |
| 4 <input type="checkbox"/> ASIAN INDIAN                                                                 | 14 <input type="checkbox"/> TONGAN                                                             |
| 5 <input type="checkbox"/> CHINESE                                                                      | 15 <input type="checkbox"/> SAIPANESE                                                          |
| 6 <input type="checkbox"/> FILIPINO                                                                     | 16 <input type="checkbox"/> MORTLOCKESE                                                        |
| 7 <input type="checkbox"/> JAPANESE                                                                     | 17 <input type="checkbox"/> KOSRAEN                                                            |
| 8 <input type="checkbox"/> KOREAN                                                                       | 18 <input type="checkbox"/> CAROLINIAN                                                         |
| 9 <input type="checkbox"/> VIETNAMESE                                                                   | 19 <input type="checkbox"/> PALAUAN                                                            |
| 10 <input type="checkbox"/> OTHER ASIAN, PLEASE SPECIFY:<br><input type="text"/>                        | 20 <input type="checkbox"/> POHNPEIAN                                                          |
|                                                                                                         | 21 <input type="checkbox"/> YAPESE                                                             |
|                                                                                                         | 22 <input type="checkbox"/> CHUUKESE                                                           |
|                                                                                                         | 23 <input type="checkbox"/> MARSHALLESE                                                        |
|                                                                                                         | 24 <input type="checkbox"/> OTHER PACIFIC ISLANDER,<br>PLEASE SPECIFY:<br><input type="text"/> |

**A7. What is this child's sex?**

- 1  MALE  
2  FEMALE

**A8. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)   MONTHS

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

**A9. PUERTO RICO: How well does this child speak Spanish?**

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

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

**A10. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES  
2  NO [GO TO A11]

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

- 1  YES  
1  NO [GO TO A11]

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

- 1  YES  
1  NO

**A11. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A12]

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

- 1  YES
- 1  NO [GO TO A12]

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

- 1  YES
- 1  NO

**A12. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES
- 2  NO [GO TO A13]

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

- 1  YES
- 1  NO [GO TO A13]

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

- 1  YES
- 1  NO

**A13. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES
- 2  NO [GO TO A14]

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

- 1  YES
- 1  NO [GO TO A14]

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

- 1  YES
- 1  NO

**A14. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES
- 2  NO [GO TO A15]

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

- 1  YES
- 1  NO

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

**A15. CHILD 2**

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

**A16. Is this child of Hispanic, Latino, or Spanish origin?**

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

**A17. What is this child's race or ethnicity? SELECT ONE OR MORE.**

- |                                                                                        |                                                                               |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1 <input type="checkbox"/> WHITE                                                       | 11 <input type="checkbox"/> NATIVE HAWAIIAN                                   |
| 2 <input type="checkbox"/> BLACK OR AFRICAN AMERICAN                                   | 12 <input type="checkbox"/> GUAMANIAN OR CHAMORRO                             |
| 3 <input type="checkbox"/> AMERICAN INDIAN OR ALASKA<br>NATIVE, <i>PLEASE SPECIFY:</i> | 13 <input type="checkbox"/> SAMOAN                                            |
| <input type="text"/>                                                                   | 14 <input type="checkbox"/> TONGAN                                            |
| 4 <input type="checkbox"/> ASIAN INDIAN                                                | 15 <input type="checkbox"/> SAIPANESE                                         |
| 5 <input type="checkbox"/> CHINESE                                                     | 16 <input type="checkbox"/> MORTLOCKESE                                       |
| 6 <input type="checkbox"/> FILIPINO                                                    | 17 <input type="checkbox"/> KOSRAEN                                           |
| 7 <input type="checkbox"/> JAPANESE                                                    | 18 <input type="checkbox"/> CAROLINIAN                                        |
| 8 <input type="checkbox"/> KOREAN                                                      | 19 <input type="checkbox"/> PALAUAN                                           |
| 9 <input type="checkbox"/> VIETNAMESE                                                  | 20 <input type="checkbox"/> POHNPEIAN                                         |
| 10 <input type="checkbox"/> OTHER ASIAN, <i>PLEASE SPECIFY:</i>                        | 21 <input type="checkbox"/> YAPESE                                            |
| <input type="text"/>                                                                   | 22 <input type="checkbox"/> CHUUKESE                                          |
|                                                                                        | 23 <input type="checkbox"/> MARSHALLESE                                       |
|                                                                                        | 24 <input type="checkbox"/> OTHER PACIFIC ISLANDER,<br><i>PLEASE SPECIFY:</i> |
|                                                                                        | <input type="text"/>                                                          |

**A18. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A19. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)   MONTHS

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

**A20. PUERTO RICO: How well does this child speak Spanish?**

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

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

**A21. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES
- 2  NO [GO TO A22]

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

- 1  YES
- 1  NO [GO TO A22]

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

- 1  YES
- 1  NO

**A22. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A23]

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

- 1  YES
- 1  NO [GO TO A23]

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

- 1  YES
- 1  NO

**A23. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES
- 2  NO [GO TO A24]

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

- 1  YES
- 1  NO [GO TO A24]

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

- 1  YES
- 1  NO

**A24. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES
- 2  NO [GO TO A25]

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

- 1  YES
- 1  NO [GO TO A25]

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

- 1  YES
- 1  NO

**A25. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES
- 2  NO [GO TO A26]

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

- 1  YES
- 1  NO

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

**A26. CHILD 3**

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

**A27. Is this child of Hispanic, Latino, or Spanish origin?**

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

**A28. What is this child's race or ethnicity? SELECT ONE OR MORE.**

- 1  WHITE
- 2  BLACK OR AFRICAN AMERICAN
- 3  AMERICAN INDIAN OR ALASKA NATIVE, PLEASE SPECIFY:

- 4  ASIAN INDIAN
- 5  CHINESE
- 6  FILIPINO
- 7  JAPANESE
- 8  KOREAN
- 9  VIETNAMESE
- 10  OTHER ASIAN, PLEASE SPECIFY:

- 11  NATIVE HAWAIIAN
- 12  GUAMANIAN OR CHAMORRO
- 13  SAMOAN
- 14  TONGAN
- 15  SAIPANESE
- 16  MORTLOCKESE
- 17  KOSRAEN
- 18  CAROLINIAN
- 19  PALAUAN
- 20  POHNPEIAN
- 21  YAPESE
- 22  CHUUKESE
- 23  MARSHALLESE
- 24  OTHER PACIFIC ISLANDER, PLEASE SPECIFY:

**A29. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A30. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)   MONTHS

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

**A31. PUERTO RICO: How well does this child speak Spanish?**

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

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

**A32. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES
- 2  NO [GO TO A33]

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

- 1  YES
- 1  NO [GO TO A33]

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

- 1  YES
- 1  NO

**A33. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A34]

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

- 1  YES
- 1  NO [GO TO A34]

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

- 1  YES
- 1  NO

**A34. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES
- 2  NO [GO TO A35]

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

- 1  YES
- 1  NO [GO TO A35]

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

- 1  YES
- 1  NO

**A35. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES
- 2  NO [GO TO A36]

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

- 1  YES
- 1  NO [GO TO A36]

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

- 1  YES
- 1  NO

**A36. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES
- 2  NO [GO TO A37]

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

- 1  YES
- 1  NO



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

**A37. CHILD 4**

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

**A38. Is this child of Hispanic, Latino, or Spanish origin?**

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

**A39. What is this child's race or ethnicity? SELECT ONE OR MORE.**

- 1  WHITE
- 2  BLACK OR AFRICAN AMERICAN
- 3  AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*

- 4  ASIAN INDIAN
- 5  CHINESE
- 6  FILIPINO
- 7  JAPANESE
- 8  KOREAN
- 9  VIETNAMESE
- 10  OTHER ASIAN, *PLEASE SPECIFY:*

- 11  NATIVE HAWAIIAN
- 12  GUAMANIAN OR CHAMORRO
- 13  SAMOAN
- 14  TONGAN
- 15  SAIPANESE
- 16  MORTLOCKESE
- 17  KOSRAEN
- 18  CAROLINIAN
- 19  PALAUAN
- 20  POHNPEIAN
- 21  YAPESE
- 22  CHUUKESE
- 23  MARSHALLESE
- 24  OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

**A40. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A41. How old is this child? If the child is less than one month old, round age in months to 1.**

YEARS (OR)   MONTHS

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

**A42. PUERTO RICO: How well does this child speak Spanish?**

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

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

**A43. Does this child currently need or use medicine prescribed by a doctor, other than vitamins?**

- 1  YES
- 2  NO [GO TO A44]

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

- 1  YES
- 1  NO [GO TO A44]

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

- 1  YES
- 1  NO

**A44. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?**

- 1  YES
- 2  NO [GO TO A45]

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

- 1  YES
- 1  NO [GO TO A45]

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

- 1  YES
- 1  NO

**A45. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

- 1  YES
- 2  NO [GO TO A46]

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

- 1  YES
- 1  NO [GO TO A46]

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

- 1  YES
- 1  NO

**A46. Does this child need or get special therapy, such as physical, occupational, or speech therapy?**

- 1  YES
- 2  NO [GO TO A47]

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

- 1  YES
- 1  NO [GO TO A47]

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

- 1  YES
- 1  NO

**A47. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?**

- 1  YES
- 2  NO [GO TO A48]

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

- 1  YES
- 1  NO

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

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

**A48. CHILD 5**

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

**A49. How old is this child?**

YEARS (OR)   MONTHS

**A50. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A51. CHILD 6**

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

**A52. How old is this child?**

YEARS (OR)   MONTHS

**A53. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A54. CHILD 7**

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

**A55. How old is this child?**

YEARS (OR)   MONTHS

**A56. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A57. CHILD 8**

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

**A58. How old is this child?**

YEARS (OR)   MONTHS

**A59. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A60. CHILD 9**

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

**A61. How old is this child?**

YEARS (OR)   MONTHS

**A62. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**A63. CHILD 10**

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

**A64. How old is this child?**

YEARS (OR)   MONTHS

**A65. What is this child's sex?**

- 1  MALE
- 2  FEMALE

**Section B. This Child's Health (PROGRAMMER: Add Timestamp)**

*We now have some follow up questions to ask about [SPECIFY CHILD]. These questions will collect more detailed information on various aspects of this child's health including his or her health status, visits to health care providers, health care costs, and health insurance coverage. We have selected only one child per household in an effort to minimize the amount of time necessary to complete the follow-up questions.*

**B1. In general, how would you describe this child's health?**

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

**B2. How would you describe the condition of this child's teeth?**

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

**B3. During the past 12 months, has this child had frequent or chronic difficulty with any of the following?**

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

**B4. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

Does this child have any of the following?

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

**B5. Has a doctor or other health care provider ever told you that this child has any of the following? If yes, does this child currently have the condition?**

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

	Ever?	Currently?	DON'T KNOW	PREFER NOT TO ANSWER
<b>B5m. Speech or Other Language Disorder</b>	1 <input type="checkbox"/> YES	1 <input type="checkbox"/> YES	77 <input type="checkbox"/>	99 <input type="checkbox"/>
	2 <input type="checkbox"/> NO	2 <input type="checkbox"/> NO		
<b>B5n. Learning Disability</b>	1 <input type="checkbox"/> YES	1 <input type="checkbox"/> YES	77 <input type="checkbox"/>	99 <input type="checkbox"/>
	2 <input type="checkbox"/> NO	2 <input type="checkbox"/> NO		
<b>B5o. Another Mental Health Condition</b>	1 <input type="checkbox"/> YES	1 <input type="checkbox"/> YES	77 <input type="checkbox"/>	99 <input type="checkbox"/>
	2 <input type="checkbox"/> NO	2 <input type="checkbox"/> NO		

**B6. During the past 12 months, how often has this child's health conditions or problems affected his or her ability to do things other children his or her age do?**

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

**B7. To what extent do this child's health conditions or problems affect his or her ability to do things?**

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



**B8. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

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

1  YES  
 1  NO [GO TO B9]  
 1  DON'T KNOW [GO TO B9]  
 1  PREFER NOT TO ANSWER [GO TO B9]

→ **[IF YES] is it:**

1  Mild  
 1  Moderate  
 2  Severe  
 1  DON'T KNOW  
 1  PREFER NOT TO ANSWER

**B9. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

Does this child have any of the following?

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

**B10. Has a doctor or other health care provider ever told you that this child had...**

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

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

- YES
  - 2  NO
  - 1  DON'T KNOW
  - 1  PREFER NOT TO ANSWER
- **[IF YES] Do they take Oral medication (pills) or get a shot?**
- 1  ORAL MEDICATION (PILLS) [GO TO B11]
  - 1  SHOT [GO TO B11]
- **[IF NO] Why not? CHECK ALL THAT APPLY.**
- 1  Cannot afford the cost.
  - 1  No transportation.
  - 3  No-one to take my child to hospital.
  - 4  Not important
  - 5  OTHER REASON, PLEASE SPECIFY
  - 1  DON'T KNOW
  - 1  PREFER NOT TO ANSWER

**B11. Has a doctor or other health care provider ever told you that this child had blood problems such as leukemia, anemia or sickle cell disease? Please do not include Sickle Cell Trait.**

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

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

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

**B12. Have you or any other adult in your child's life discussed avoidance of violence or prevention of injury with your child? For example, the dangers of playing on the road, climbing trees, and swimming in the ocean.**

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

**B13. Do you accompany your child during outdoor activities like swimming or playing?**

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

**B14. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

**B15. [ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]**

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

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

**B16. [ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]**

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

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

**B17. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**Are your child's immunizations up to date?**

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

**Section C. This Child as an Infant (PROGRAMMER: Add Timestamp)**

**C1. Was this child born more than 3 weeks before his or her due date?**

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

**C2. How much did he or she weigh when born? Answer in pounds and ounces or kilograms and grams. Provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

POUNDS AND   OUNCES

KILOGRAMS AND   GRAMS

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**C3. How old were you when this child was born?**

YEARS

**C4. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD]**

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

1  On his or her side

2  On his or her back

3  On his or her stomach

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**C5. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD. ELSE GO TO SECTION D]**

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

1  YES

2  NO [GO TO C6]

1  DON'T KNOW [GO TO C6]

1  PREFER NOT TO ANSWER [GO TO C6]

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

DAYS (OR)

WEEKS (OR)

MONTHS (OR)

YEARS

CHILD IS STILL BREASTFEEDING

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**C6. How old was this child when he or she was first fed anything other than breast milk or formula? Include juice, cow's milk, sugar water, baby food or cereal, or anything else that your child might have been given, even water.**

DAYS (OR)   WEEKS (OR)   MONTHS

AT BIRTH

CHECK THIS BOX IF CHILD HAS NEVER BEEN FED ANYTHING OTHER THAN BREAST MILK OR FORMULA

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**Section D. Health Care Services (PROGRAMMER: Add Timestamp)**

**D1. 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?**

- 1  YES
- 2  NO [GO TO D2]
- 1  DON'T KNOW [GO TO D2]
- 1  PREFER NOT TO ANSWER [GO TO D2]

→ **[IF YES] During the past 12 months, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up? A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.**

- 1  0 VISITS
- 1  1 VISIT
- 2  2 OR MORE VISITS
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**D2. Are you concerned about this child's weight?**

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

**D3. What is this child's current height (or length)? Please provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

FEET AND   INCHES  
  METERS AND   CENTIMETERS

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**[DO NOT READ TO RESPONDENT] How was the measurement taken?**

- 1  RESPONDENT ESTIMATE
- 2  MEASURED ON SITE

**D4. How much does this child currently weigh? Please provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].**

POUNDS AND   OUNCES

KILOGRAMS AND   GRAMS

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**[DO NOT READ TO RESPONDENT] How was the measurement taken?**

1  RESPONDENT ESTIMATE

2  MEASURED ON SITE

**D5. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**During the past 12 months, did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?**

1  YES

2  NO

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**D6. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

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

1  YES

2  NO [GO TO D7]

1  DON'T KNOW [GO TO D7]

1  PREFER NOT TO ANSWER [GO TO D7]

→ **[IF THIS CHILD IS 9-23 MONTHS]**

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

1  How this child talks or makes speech sounds?

1  How this child interacts with you and others?

1  DON'T KNOW

1  PREFER NOT TO ANSWER

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

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

1  Words and phrases this child uses and understands?

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

1  DON'T KNOW

1  PREFER NOT TO ANSWER

**D7. Is there a place that this child usually goes when he or she is sick or you or another caregiver needs advice about his or her health?**

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

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

- 1  Private doctor's office
- 1  Hospital emergency room
  - 2  Hospital outpatient department
  - 3  Community health clinic, community clinic, or public health clinic
  - 4  School (nurse's office, athletic trainer's office)
  - 5  Village dispensary
  - 6  Some other place, PLEASE SPECIFY
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**D8. Is there a place that this child usually goes when he or she needs routine preventive care, such as a physical examination or well-child check-up?**

- 1  YES
- 2  NO [GO TO D9]
- 1  DON'T KNOW [GO TO D9]
- 1  PREFER NOT TO ANSWER [GO TO D9]

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

- 1  YES
- 1  NO

**D9. During the past 12 months, did this child use any of the following types of health care or services? Check all that apply. Alternative health care can include acupuncture, chiropractic care, relaxation therapies, traditional herbal medicine, and others. Some therapies involve seeing a health care provider, while others can be done on your own.**

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

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

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

**D10. During the past 12 months, was there any time when this child needed health care but it was not received or not available? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.**

- 1  YES
- 2  NO [GO TO D12]
- 1  DON'T KNOW [GO TO D12]
- 1  PREFER NOT TO ANSWER [GO TO D12]

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

- 1  Medical Care
- 1  Dental or Oral Care
- 2  Vision Care
- 3  Hearing Care
- 4  Mental Health Services
- 5

**D11. Which of the following contributed to this child not receiving needed health services:**

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

**D12. In the past 12 months, has this child been admitted to the hospital? Please include emergency room visits and overnight hospital stays.**

- 1  Yes
- 2  No
- 1  DON'T KNOW
- 1  REFUSED

→ **[IF YES] In the past 12 months, how many times has this child been admitted to the hospital for an injury?** By 'injury', we mean physical harm or damage caused by an accident or an attack. Injuries could include, but are not limited to, broken bones, strains, cuts, burns, bites/stings, or harm from being hit by something.

TIMES



1  DON'T KNOW

**Section E. Experience with This Child's Health Care Providers (PROGRAMMER: Add Timestamp)**

**E1. Do you have one or more persons you think of as this child's personal doctor or nurse? A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.**

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

**E2. During the past 12 months, did this child need a referral to see any doctors or receive any services?**

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

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

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

**E3. [ANSWER THE FOLLOWING QUESTIONS ONLY IF THIS CHILD HAD A HEALTH CARE VISIT IN THE PAST 12 MONTHS. OTHERWISE, GO TO E4.]**

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

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

**E4. Does anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?**

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

**E5. During the past 12 months, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?**

- 1  YES
- 2  NO [GO TO E6]

→ **[IF YES] During the past 12 months, how often did you get as much help as you wanted with arranging or coordinating this child's health care?**

- 1  Usually
- 1  Sometimes
- 2  Never

**E6. Overall, how satisfied are you with the communication among this child's doctors and other health care providers?**

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

**E7. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

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

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

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

**E8. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

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

**E9. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

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

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

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

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

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

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

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

**E10. Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as he or she becomes an adult?**

1  YES [GO TO F]

2  NO

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

1  YES

1  NO

**Section F. This Child's Health Insurance Coverage (PROGRAMMER: Add Timestamp)**

**F1. During the past 12 months, was this child ever covered by any kind of health insurance or health coverage plan? *This includes medical savings accounts, supplemental health, and government funded or subsidized insurance programs.***

1  Yes, this child was covered all 12 months or, if under 1 year old, since birth [GO TO F4]

2  Yes, but this child had a gap in coverage

3  No

**F2. Please indicate whether each of the following is a reason this child was not covered by health insurance during the past 12 months:**

	YES	NO
F2a. Change in employer or employment status	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2b. Cancellation from inability to pay insurance fee	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2c. Dropped coverage because it was unaffordable	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2d. Dropped coverage because benefits were inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2e. Dropped coverage because choice of health care providers was inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2f. Problems with application or renewal process	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	<input type="checkbox"/>	
F2g. Another reason, <i>please specify</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<input style="width: 500px; height: 20px;" type="text"/>	<input type="checkbox"/>	

**F3. Is this child currently covered by any kind of health insurance or health coverage plan?**

- 1  YES
- 2  NO [GO TO SECTION G]
- 1  DON'T KNOW [GO TO SECTION G]
- 1  PREFER NOT TO ANSWER [GO TO SECTION G]

**F4. Is this child covered by any of the following types of health insurance or health coverage plans? [Interviewer Note: Only read jurisdiction-specific insurance types for your jurisdiction].**

	YES	NO
<b>F4a. Private health insurance</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4b. Insurance through your (or your spouse's) current or former employer or union</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4c. Medicaid, Medical Assistance, or any kind of government assistance plan</b> <i>(includes Guam Medical Indigent Program, Palau National Health Insurance Program, and Puerto Rico Government Health Plan)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4d. Other government funded or subsidized insurance</b> <i>(includes Micronesia MiCare or Chuuk State, Marshall Islands Public Insurance, and Marshall Islands Supplemental Health Fund)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4e. Medical savings account</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4f. CHIP (Children's Health Insurance Program)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4g. TRICARE or other military health care</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4h. Indian Health Service</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>F4i. Another type, please specify</b> <div style="border: 1px solid black; height: 20px; width: 500px; margin-top: 5px;"></div>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

**F5. How often does this child's health insurance offer benefits or cover services that meet this child's needs? Examples include dental or vision services, prescription medications, emergency room visits, maternity services, mental health services, and yearly check-ups or screenings.**

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

**F6. How often does this child's health insurance allow him or her to see the health care providers he or she needs?**

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

**Section G. Providing for This Child's Health (PROGRAMMER: Add Timestamp)**

**G1. Including co-pays and amounts from medical savings accounts, how much money did you pay for this child's medical, health, dental, and vision care during the past 12 months? Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.**

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

**G2. How often are these costs reasonable?**

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

**G3. During the past 12 months, did your family have problems paying for any of this child's medical or health care bills?**

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

**G4. During the past 12 months, have you or other family members:**

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

**G5. In an average week, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.**

- 1  This child does not need health care provided on a weekly basis
- 2  No at home care was provided by me or other family members
- 3  Less than 1 hour per week
- 4  1-4 hours per week
- 5  5-10 hours per week
- 6  11 or more hours per week
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**G6. In an average week, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?**

- 1  This child does not need health care provided on a weekly basis
- 2  No at home care was provided by me or other family members
- 3  Less than 1 hour per week
- 4  1-4 hours per week
- 5  5-10 hours per week
- 6  11 or more hours per week
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**Section H. This Child's Learning (PROGRAMMER: Add Timestamp)**

**H1. On an average weekday, about how much time does this child usually spend in front of a TV watching TV programs, videos, or playing video games?**

- 1  None
- 2  Less than 1 hour
- 3  1 hour
- 4  2 hours
- 5  3 hours
- 6  4 or more hours
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**H2. On an average weekday, about how much time does this child usually spend with computers, cell phones, handheld video games, and other electronic devices, doing things other than schoolwork?**

- 1  None
- 2  Less than 1 hour
- 3  1 hour
- 4  2 hours
- 5  3 hours
- 6  4 or more hours
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**H3. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

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

**H4. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

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

**H5. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

**H6. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

**H7. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

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



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

**H8. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]**

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

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

**H9. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

**H10. [ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]**

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

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

**Section I. About You and This Child (PROGRAMMER: Add Timestamp)**

**I1. How many times has this child moved to a new address or location since he or she was born?**

- NUMBER OF TIMES
- 1  DON'T KNOW
  - 1  PREFER NOT TO ANSWER

**I2. [ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

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

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

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

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

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

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

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

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

**15. DURING THE PAST 12 MONTHS, has this child had any health care visits by video or phone?**

- 1  YES
- 2  NO

**[If yes] Were any of this child's health care visits by video or phone because of the coronavirus pandemic?**

- 1  YES
- 2  NO

**16. DURING THE PAST 12 MONTHS, did this child miss, delay or skip any PREVENTIVE check-ups because of the coronavirus pandemic?**

- 1  YES
- 2  NO

**17. DURING THE PAST 12 MONTHS, has this child's regular daycare or other childcare arrangement been closed or unavailable at any time as a result of the coronavirus pandemic?**

- 1  YES
- 2  NO

**Section J. About Your Family and Household (PROGRAMMER: Add Timestamp)**

**J1. Does anyone living in your household use cigarettes, e-cigarettes or vapors, cigars, pipe tobacco, chewing tobacco, or chew betel nut?** [READ IF NECESSARY: Please answer to the best of your ability. Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid)].

- 1  YES
- 2  NO [GO TO J3]
- 1  DON'T KNOW [GO TO J3]
- 1  PREFER NOT TO ANSWER [GO TO J3]

**J2. Does anyone smoke inside your home?**

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

*IF PUERTO RICO, GO TO J5*

**J3. Has your child ever chewed betel nut?** [READ IF NECESSARY: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid)].

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

**J4. Are you aware of the effects of chewing betel nut?**

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

*The next three questions are about money.*

**J5. Since this child was born, how often has it been very hard to get by on your family's income – hard to cover the basics like food or housing?**

- 1  Never
- 2  Rarely
- 3  Somewhat often
- 4  Very often
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**J6. The next question is about whether you were able to afford the food you need. Which of these statements best describes the food situation in your household IN THE PAST 12 MONTHS?**

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

**J7. At any time during the past 12 months, even for one month, did anyone in your family receive:**

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

**Section K. About You (PROGRAMMER: Add Timestamp)**

*COMPLETE THE QUESTIONS FOR EACH OF THE TWO ADULTS IN THE HOUSEHOLD WHO ARE THIS CHILD'S PRIMARY CAREGIVERS. IF THERE IS JUST ONE ADULT, PROVIDE ANSWERS FOR THAT ADULT.*

**K1. ADULT 1**

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

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

**K2. What is your sex?**

- 1  MALE
- 2  FEMALE

**K3. What is your age?**

AGE IN YEARS

**K4. What is the highest grade or year of school you have completed? MARK ONE ONLY.**

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

**K5. What is your marital status?**

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

**K6. Do you currently live with a romantic partner?**

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

**K7. In general, how is your physical health?**

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

**K8. In general, how is your mental or emotional health?**

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

**K9. Were you employed at least 50 out of the past 52 weeks?**

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

**K10. Is there another adult in this household who is this child's caregiver or guardian?**

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

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

**K11. How is Adult 2 related to this child?**

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

**K12. What is Adult 2's sex?**

- 1  MALE
- 2  FEMALE

**K13. What is Adult 2's age?**

AGE IN YEARS

**K14. What is the highest grade or year of school Adult 2 has completed? MARK ONE ONLY.**

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

**K15. What is Adult 2's marital status?**

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

**K16. Does Adult 2 currently live with a romantic partner?**

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

**K17. In general, how is Adult 2's physical health?**

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

**K18. In general, how is Adult 2's mental or emotional health?**

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

**K19. Was Adult 2 employed at least 50 out of the past 52 weeks?**

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

**Section L. Health of Child's Mother (PROGRAMMER: Add Timestamp)**

**L1. A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?**

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

**L2. During the past 12 months, have you received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.**

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

**L3. How much of a problem was it to get the mental health treatment or counseling that you needed?**

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

**L4. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?**

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

**L5. Who makes the healthcare decisions for your health?**

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

**L6. Who makes the healthcare decisions for your child(ren)?**

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

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

**L7. During the past 30 days, on how many days did you smoke cigarettes?**

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

**L8. Do you drink alcohol, including drinks you brew or make at home?**

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



**L9. During your life, have you ever used any of the following:** [READ IF NECESSARY: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid). Funta, or fronto, is a dark tobacco leaf that can be used for smoking].

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

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

**L10. During the past 30 days, on how many days did you chew betel nut?**

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

**L11. Have you been referred to, or did you receive, any form of intervention/counseling/treatment for substance use issues?**

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

**L12. Has your doctor or health care professional told you that you had type 1 or type 2 diabetes?**

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

**L13. Are you taking medication for this?**

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

**L14. Has a doctor or other health care provider EVER told you that you have any of the following conditions...?**

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

**L15. How do you describe your weight?**

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

**L16. Which of the following are you trying to do about your weight?**

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

**L17. During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.**

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

**L18. Are you currently pregnant?**

- 1  Yes
- 2  No [GO TO M1]
- 1  DON'T KNOW [GO TO M1]
- 1  PREFER NOT TO ANSWER [GO TO M1]

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

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

**L19. During your most recent pregnancy, how worried were you about getting infected with Zika virus? Check ONE answer.**

- 1  Very worried
- 2  Somewhat worried
- 3  Not at all worried
- 4  I HAD NEVER HEARD OF ZIKA VIRUS DURING MY MOST RECENT PREGNANCY [GO TO M1]
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**L20. At any time during your most recent pregnancy, did you talk with a doctor, nurse, or other healthcare worker about Zika virus?**

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

**L21. During your most recent pregnancy, did you get a blood test for Zika virus?**

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

**L22. Were you diagnosed with Zika during your most recent pregnancy?**

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

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

*IF PUERTO RICO, GO TO SECTION M*

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

**L23. During your most recent pregnancy, did you travel to areas with the Zika virus?**

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

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

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

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

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

**Section M. Household Information (PROGRAMMER: Add Timestamp)**

**M1. 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

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**M2. 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

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**M3. The following** information is for data analysis purposes only so that MCH can better assess services received and potential health care needs among different income groups. Only members of the research team will have access to this information. Your best guess is fine. It does not have to be exact. **Think about your total combined family income for the year for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from business, farm, or rent, and any other money income received.**

,, TOTAL AMOUNT (\$)

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**M4. How about if I give you some categories? Would you say your household's income was...**

- 1  Less than \$10,000
- 2  \$10,000 to less than \$15,000
- 3  \$15,000 to less than \$20,000
- 4  \$20,000 to less than \$25,000
- 5  \$25,000 to less than \$35,000
- 6  \$35,000 to less than \$50,000
- 7  \$50,000 to less than \$75,000
- 8  \$75,000 or more
- 77  DON'T KNOW
- 99  PREFER NOT TO ANSWER

**Section N. Guam Jurisdiction Specific Module (PROGRAMMER: Add Timestamp)**

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

*I will start by asking a few questions about your health.*

**GM1. Since your new baby was born, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
<b>GM1a. Breastfeeding my baby</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1b. How long to wait before getting pregnant again</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1c. Family planning services or using contraception</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1d. Postpartum depression</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1e. Resources in my community to support new parents</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1f. Getting to and staying at a healthy weight after delivery</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1g. How to quit or keep from smoking</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
<b>GM1h. How to get the health care that my baby or I need</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**GM2. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

**Did you have a regular checkup about 4-6 weeks after giving birth?**

- 1  YES
- 2  NO [GO TO GM3]
- 1  DON'T KNOW [GO TO GM3]
- 1  PREFER NOT TO ANSWER [GO TO GM3]

→ **[IF YES] where did you go for your checkup?**

- 1  MY FAMILY DOCTOR'S OFFICE
- 2  MY OB/GYN'S OFFICE
- 3  HOSPITAL CLINIC
- 4  HEALTH DEPARTMENT CLINIC
- 5  OTHER, PLEASE SPECIFY

- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**GM3. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEARS OLD AND IF BIOLOGICAL MOTHER]**

**For the next set of questions, please select the answer that comes closest to how you have felt since your most recent pregnancy?**

**GM3a. I have been able to laugh and see the funny side of things.**

- 1  As much as I always could
- 2  Not quite so much now
- 3  Definitely not so much now
- 4  Not at all

**GM3b. I have looked forward with enjoyment to things.**

- 1  As much as I ever did
- 2  Rather less than I used to
- 3  Definitely less than I used to
- 4  Hardly at all

**GM3c. I have blamed myself unnecessarily when things went wrong.**

- 1  Yes, most of the time
- 2  Yes, some of the time
- 3  Not very often
- 4  No, never

**GM3d. I have been anxious or worried for no good reason.**

- 1  No not at all
- 2  Hardly ever
- 3  Yes, sometimes
- 4  Yes, very often

**GM3e. I have felt scared or panicky for no very good reason.**

- 1  Yes, quite a lot
- 2  Yes, sometimes
- 3  No, not much
- 4  No, not at all

**GM3f. I have been so unhappy that I have had difficulty sleeping.**

- 1  Yes, most of the time
- 2  Yes, sometimes
- 3  Not very often
- 4  No, not at all

**GM3g. I have felt sad or miserable.**

- 1  Yes, most of the time
- 2  Yes, sometimes
- 3  Not very often
- 4  No, not at all

**GM3h. I have been so unhappy that I have been crying.**

- 1  Yes, most of the time
- 2  Yes, quite often
- 3  Only occasionally
- 4  No, never

**GM3i. The thought of harming myself has occurred to me.**

- 1  Yes, quite often
- 2  Sometimes
- 3  Hardly ever

4  Never

**GM4. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

**Did any of these things keep you from having a checkup after your most recent pregnancy?**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM4a. I didn't have health insurance to cover the cost of the visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4b. I felt fine and did not think I needed to have a visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4c. I couldn't get an appointment when I wanted one	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4d. I didn't have any transportation to get to the clinic or doctor's office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4e. I had too many things going on	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4f. I couldn't take time off from work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM4g. Something else, <i>please specify</i> <div style="border: 1px solid black; height: 20px; width: 400px; margin-top: 5px;"></div>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**GM5. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

**How did you feel about the care you got during your postpartum checkup?**

	SATISFIED	NOT SATISFIED	DON'T KNOW	PREFER NOT TO ANSWER
GM5a. The amount of time you had to wait	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM5b. The amount of time the doctor, nurse, or health care worker spent with you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM5c. The advice you got on how to take care of yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM5d. The understanding and respect shown toward you as a person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**GM6. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

The next few questions are about the national health problem of HIV, the virus that causes AIDS. Please remember that your answers are strictly confidential and that you don't have to answer every question if you do not want to. Although we will ask you about testing, we will not ask you about the results of any test you may have had.

Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing saliva or spit from your mouth.

- 1  YES
- 2  NO [GO TO G8]
- 1  DON'T KNOW [GO TO G8]
- 1  PREFER NOT TO ANSWER [GO TO G8]



**GM7. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

**Have you been tested for HIV in the past 12 months?**

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

**GM8. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

**Have you ever been tested for any other sexually transmitted diseases (STD)? Do not count tests you may have had as part of a blood donation. Include testing fluid saliva or spit from your mouth.**

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

**GM9. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

**At any time during the most recent pregnancy, did you talk with a doctor, nurse or healthcare worker about STDs?**

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

**GM10. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

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

- 1  YES
- 2  NO [GO TO GM12]
- 1  DON'T KNOW [GO TO GM12]
- 1  PREFER NOT TO ANSWER [GO TO GM12]

**→ [IF YES] which types of care were not received or not available?**

**CHECK ALL THAT APPLY.**

- 1  Medical Care
- 2  Dental Care
- 3  Vision Care
- 4  Hearing Care
- 5  Mental Health Services
- 6  Other, *please specify*

**GM11. [ONLY ASK THIS QUESTION IF BIOLOGICAL MOTHER]**

**Why were you unable to get health care for yourself?**

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM11a.	I couldn't afford it.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11b.	I did not know where to go.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11c.	It was too far away.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11d.	I could not get there when it was open.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11e.	I could not get an appointment soon enough.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11f.	I did not have transportation.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11g.	I didn't have time to go.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11h.	I was worried that it wasn't covered under my insurance.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM11i.	Some other reason, <i>please specify</i> <div style="border: 1px solid black; height: 20px; width: 400px; margin-top: 5px;"></div>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

**GM12. [ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]**

**During your most recent pregnancy, how many times did you visit a doctor, nurse, or other health care professional to receive a prenatal check-up?**

- 1  0 VISITS
- 2  1 VISIT [GO TO GM13]
- 3  2 VISITS [GO TO GM13]
- 4  3 VISITS [GO TO GM13]
- 5  4 OR MORE VISITS [GO TO GM13]
- 1  DON'T KNOW [GO TO GM13]
- 1  PREFER NOT TO ANSWER [GO TO GM13]

→ [IF 0 VISITS] Did any of these things keep you from having a prenatal checkup?

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM12a.	I couldn't get an appointment when I wanted one	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12b.	I didn't have any transportation to get to the clinic or doctor's office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12c.	The doctor or my health plan would not start as early as I wanted	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12d.	I had too many things going on	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12e.	I couldn't take time off from work or school	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12f.	I didn't have anyone to take care of my children	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM12g. I didn't know that I was pregnant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12h. I didn't have health insurance to cover the cost of the visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12i. I felt fine and did not think I needed to have a visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12j. I didn't want prenatal care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12k. I didn't want anyone else to know I was pregnant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM12l. Some other reason, please specify	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

The next few questions ask about the use of cribs and car seats for your child.

**GM13.[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?**

- 1  Always
- 2  Often
- 3  Sometimes
- 4  Rarely
- 5  Never
- 6  BABY DOES NOT SLEEP IN CRIB OR BED
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**GM14.[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**When your new baby sleeps alone, is his or her crib or bed in the same room where you sleep?**

- 1  Yes
- 2  No
- 3  NOT APPLICABLE, BABY DOES NOT SLEEP IN CRIB OR BED
- 1  DON'T KNOW
- 1  PREFER NOT TO ANSWER

**GM15.[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]**

**How did you learn to install and use your infant car seat(s)?**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM15a. A friend or family member showed me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM15b. A health or safety professional showed me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM15c. I figured it out myself.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>
GM15d. I already knew how to install it because I have other children.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	77 <input type="checkbox"/>	99 <input type="checkbox"/>

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM15e. Some other way, <i>please specify</i>	1	2	77	99
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**[ONLY ASK THIS QUESTION IF CHILD IS 6-11 or 12-17 YEARS OLD]**

*The last set of questions ask about swim safety.*

**GM16. Please tell me whether your child can do each of the following or if you are not sure.**

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
GM16a. Step or jump into water over his or her head and return to the surface	1	2	77	99
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GM16b. Float or tread water for 1 minute without using a flotation device	1	2	77	99
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GM16c. Turn around in a full circle in the water and then find a way out of the water	1	2	77	99
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GM16d. Swim 25 yards (equal to the length of a standard swimming pool) without stopping	1	2	77	99
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GM16e. Exit a pool, not using a ladder	1	2	77	99
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(END TIME: :)

*Thank you for your participation.*

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

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

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