

# CHSTRONG KIDS

[C Returning?](#)

AAA

[English](#) [+](#) [-](#)

Please complete the survey below.

Thank you!

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Select your preferred language:  
Seleccione su idioma preferido:

- English  
 Spanish (Español)

[reset](#)

As explained in the letter you received with this survey, we are contacting you about this survey because our records show that your child was born with a heart condition. We would like to ask you some questions about your child, their health, and your family.

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

Please answer questions with information about your child with a heart condition only. *You may choose to skip any question you do not wish to answer.*

0% complete



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Your child's information

What is this child's age in years?

**ALERT:** Some questions on this survey are specific to the age of your child. If you choose not to provide your child's age, the survey may take longer because it will include questions on the survey that do not apply for your child's age.

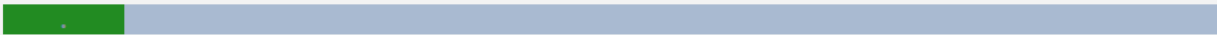
Rectangular Snip

Is this child Hispanic or Latino?  Hispanic or Latino  Not Hispanic or Latino [reset](#)

What is this child's race? (Select all that apply)

- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or other Pacific Islander
- White

10% complete



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Alert ✕

The value you provided is outside the suggested range. (2 - 17). This value is admissible, but you may wish to double check it.

Close

Your child's heart condition

What is the name of the heart condition that this child was born with? (Select all that apply)

- Aortic valve stenosis
- Atrial septal defect (ASD)
- Atrioventricular septal defect (AVSD) or Atrioventricular canal (AV canal)
- Bicuspid aortic valve
- Coarctation of aorta
- Ebstein anomaly
- Hypoplastic left heart syndrome (HLHS)
- Patent ductus arteriosus (PDA)
- Pulmonary atresia
- Pulmonary valve stenosis
- Single ventricle (double inlet left ventricle)
- Tetralogy of Fallot (TOF)
- Transposition of the great arteries (TGA)
- Tricuspid atresia
- Truncus arteriosus
- Ventricular septal defect (VSD)
- Other
- Don't know/not sure
- No heart condition that I know of (*please answer remaining questions to the best of your ability*)

**ALERT: "Don't know/not sure" was selected along with other answers. Please review.**

**ALERT: "No heart condition that I know of" was selected along with other answers. Please review.**

If other, please specify:

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

Has this child ever had surgery for the heart condition they were born with? Heart surgery will result in scars on the middle of the chest, side, or back.

- Yes  
 No  
 Don't know/not sure

[reset](#)

What type of information or help should be available to caregivers of children born with a heart condition?

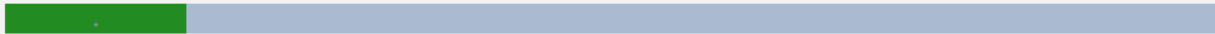
[Expand](#)

When this child was first diagnosed with a heart condition, were you provided enough information on what this meant for their emotional, social and physical health?

- Yes  
 No  
 Don't know/not sure

[reset](#)

15% complete



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Your child's heart doctors

**When is the last time this child saw a heart doctor?**

- Less than 1 year
- 1-2 years
- 3-5 years
- More than 5 years
- Never seen one

[reset](#)

**How many health care provider visits were with a heart doctor or at a cardiology clinic (clinic that only sees patients with heart conditions) in the past 12 months?**

**Who are the majority of patients that this child's primary heart doctor usually sees?**

- Children and adolescents (pediatric cardiologist)
- Adults (adult congenital heart cardiologist or adult cardiologist)
- Don't know/not sure

[reset](#)

**Has a doctor or other health care provider talked with you about when this child will need to see heart doctors who treat adults (adult congenital heart cardiologist or adult cardiologist)?**

- Yes
- No

[reset](#)

**In the past 2 years, how often has this child's heart doctor:**

**Spent enough time with this child?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

**Listened carefully to you?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

**Shown sensitivity to your family's values and customs?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

**Provided the specific information you needed concerning this child?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

**Helped you feel like a partner in this child's care?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

**Discussed with you the range of options to consider for this child's health care or treatment?**

- Always
- Usually
- Sometimes
- Never

[reset](#)

Made it easy for you to raise concerns or disagree with recommendations for this child's health care?

- Always
- Usually
- Sometimes
- Never

reset

Worked with you to decide together which health care and treatment choices would be best for this child?

- Always
- Usually
- Sometimes
- Never

reset

If this child has not seen a heart doctor in the last 2 years or ever, why? (Select all that apply)

- This child felt well
- Did not think this child needed to see a heart doctor
- Doctor told me this child no longer needed to see a heart doctor
- Changed or lost insurance
- Moved to a different city or town
- Did not like this child's heart doctor
- Couldn't find a heart doctor
- I had too many other things going on
- There were issues related to cost
- I chose to postpone or cancel appointments due to COVID-19
- This child's heart doctor postponed or cancelled appointments due to COVID-19
- Other

If other, please specify:

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

20% complete



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## Your child's general health

What is this child's CURRENT height? *(Answer in either feet and inches or meters and centimeters)*

Feet

AND inches

Meters

AND centimeters

How much does this child CURRENTLY weigh? *(Answer in either pounds or kilograms)*

Pounds

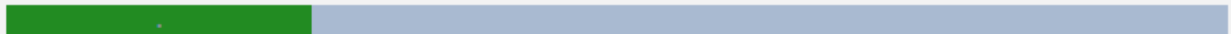
Kilograms

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

- Excellent
- Very Good
- Good
- Fair
- Poor

reset

25% complete



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## Your child's medical conditions

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

Anxiety problems

Yes

No

[reset](#)

Depression

Yes

No

[reset](#)

Developmental delay

Yes

No

[reset](#)

Behavioral or conduct problems

Yes

No

[reset](#)

Intellectual disability

Yes

No

[reset](#)

Speech or language disorder

Yes

No

[reset](#)

Learning disability

Yes

No

[reset](#)

Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD

Yes

No

[reset](#)

|  |  |                       |
|--|--|-----------------------|
| <b>Autism, Autism Spectrum Disorder, Asperger's Disorder, or Pervasive Developmental Disorder (PDD)</b>  | <input type="radio"/> Yes<br><input type="radio"/> No            | <a href="#">reset</a> |
| <b>Diabetes</b>  | <input type="radio"/> Yes<br><input type="radio"/> No            | <a href="#">reset</a> |
| <b>Down syndrome</b>   | <input type="radio"/> Yes<br><input type="radio"/> No            | <a href="#">reset</a> |
| <b>Other genetic or inherited condition</b>  | <input type="radio"/> Yes<br><input type="radio"/> No            | <a href="#">reset</a> |
| <b>Heart failure</b>   | <input type="radio"/> Yes<br><input type="radio"/> No            | <a href="#">reset</a> |
| <b>Other</b>   | <input checked="" type="radio"/> Yes<br><input type="radio"/> No | <a href="#">reset</a> |
| <b>If other, please specify:</b>   | <input type="text"/>   |                       |
| <b>ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.</b> |  |                       |

Does this child have any of the following?

Deafness or problems with hearing

Yes

No

[reset](#)

Blindness or problems with seeing, even when wearing eyeglasses

Yes

No

[reset](#)

Serious difficulty walking or climbing stairs

Yes

No

[reset](#)

*30% complete*



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Your child's healthcare needs

Does this child CURRENTLY need or use medicine prescribed by a doctor, other than vitamins?  Yes  No reset

Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?  Yes  No reset

Is this child limited or prevented in any way in their ability to do the things most children of the same age can do?  Yes  No reset

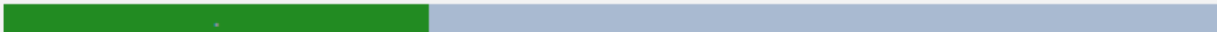
To what extent do this child's health conditions or problems affect their ability to do things?  Very little  Somewhat  A great deal reset

Does this child need or get special therapy, such as physical, occupational, or speech therapy?  Yes  No reset

Does this child have any kind of emotional, developmental, or behavioral problem for which they need treatment or counseling?  Yes  No reset

If YES to any of questions above in this section (questions 19-24), is it because of ANY medical, behavioral, or other health condition that is expected to last 12 months or longer?  Yes  No reset

35% complete



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Your child's school/learning history

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

- Kindergarten
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade

reset

Since starting kindergarten, has this child repeated any grades?

- Yes
- No

reset

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

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

reset

Has this child EVER had any of the following special education or early intervention plans? (Select all that apply)

- Individualized Family Service Plan or IFSP (used for early intervention services in children younger than 3)
- Individualized Education Program or IEP (used for special education services in children 3 or older)
- 504 Plan (sometimes used for special education services instead of or in addition to an IEP)
- Other
- No, this child has never had a plan for special education

If other, please specify:

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

How likely do you think it is that this child will...

Get a regular high school diploma? A regular high school diploma includes a "GED" but does not include a certificate of completion or a special diploma for students in special education

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

Attend school after high school? Including technical or trade school

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Attend a special training program after high school for persons with intellectual disabilities?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Complete a technical or trade school program?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Graduate from a 2-year or community college?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Graduate from a 4-year college?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Get a driver's license?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Eventually live away from home on his or her own without supervision?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Eventually live away on his or her own with supervision?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

**Eventually get a paid job? This includes any paid job -- child does not need to make enough to support self. This can include sheltered or supported employment.**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

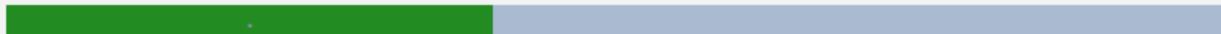
[reset](#)

**Earn enough to support himself or herself without financial help from his or her family or government benefit programs?**

- Definitely Will
- Probably will
- Probably won't
- Definitely won't
- Don't know
- Already has

[reset](#)

*40% complete*



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## Your child's activities and social environment

**DURING THE PAST WEEK, on how many days did this child exercise, play a sport, or participate in physical activity for at least 60 minutes?**

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

[reset](#)

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

**A sports team or did he or she take sports lessons after school or on weekends?**

- Yes
- No

[reset](#)

**Any clubs or organizations after school or on weekends?**

- Yes
- No

[reset](#)

**Any other organized activities or lessons, such as music, dance, language, or other arts?**

- Yes
- No

[reset](#)

**Any type of community service or volunteer work at school, church, or in the community?**

- Yes
- No

[reset](#)

**Any work, including regular jobs as well as babysitting, cutting grass, or other occasional work?**

- Yes
- No

[reset](#)

**DURING THE PAST 12 MONTHS, how often was this child bullied, picked on, or excluded by other children?**

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

reset

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

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

reset

*45% complete*



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## Your child's readiness to learn

How often does this child share toys or games with other children?

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

reset

How often does this child show concern when they see others who are hurt or unhappy?

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

reset

How often does this child play well with other children?

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

reset

How often can this child recognize and name their own emotions?

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

reset

**How often does this child have difficulty when asked to end one activity and start a new activity?**

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

[reset](#)

**How often does this child lose their temper?**

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

[reset](#)

**How often does this child have trouble calming down?**

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

[reset](#)

**How often does this child have difficulty waiting for their turn?**

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

[reset](#)

**How often does this child get easily distracted?**

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

[reset](#)

**How often can this child focus on a task you have given them for at least a few minutes? For example, simple chores?**

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

[reset](#)

**How often does this child keep working at a task even when it is hard for them?**

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

[reset](#)

**50% complete**



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Your child's health care

Where does this child usually go when they are sick or you need advice about their health?

- This child does not have a usual place for health care or advice when sick
- Doctor's Office
- Hospital Emergency Room
- Hospital Outpatient Department
- Urgent Care Center
- Clinic or Health Center
- Retail Store Clinic or "Minute Clinic"
- School (Nurse's Office, Athletic Trainer's Office)
- Some other place

[reset](#)

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

- 0 visits
- 1 visit
- 2 or more visits

[reset](#)

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

- None
- 1 time
- 2 or more times

[reset](#)

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

- Yes
- No

[reset](#)

55% complete



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Your child's unmet needs

DURING THE PAST 12 MONTHS, did this child need any of the following health care but it was not received? (Select all that apply)

- Heart care
- Other medical care
- Dental care
- Vision care
- Hearing care
- Mental health services
- Other
- This child has received all the healthcare they needed in the past 12 months ---> *Go to next page*

**Alert:** "Received all healthcare" is checked with other choices.

If other, please specify:

**ALERT:** "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.

**Did any of the following reasons contribute to this child not receiving needed health services?**

**This child did not have health insurance that covered the services needed**

- Yes  
 No

[reset](#)

**This child was not eligible for the services**

- Yes  
 No

[reset](#)

**The services this child needed were not available in your area**

- Yes  
 No

[reset](#)

**There were problems getting an appointment when this child needed one**

- Yes  
 No

[reset](#)

**There were problems with getting transportation or child care**

- Yes  
 No

[reset](#)

**I had too many other things going on**

- Yes  
 No

[reset](#)



The clinic or doctor's office wasn't open when this child needed care

- Yes  
 No

[reset](#)

There were issues related to cost

- Yes  
 No

[reset](#)

I chose to postpone or cancel appointments due to COVID-19

- Yes  
 No

[reset](#)

The clinic or doctor's office postponed or cancelled appointments due to COVID-19

- Yes  
 No

[reset](#)

Other

- Yes  
 No

[reset](#)

If other, please specify:

[Expand](#)

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

60% complete



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| Your child's insurance   |   |       |
|--|---|-------|
| Is this child CURRENTLY covered by ANY kind of health insurance or health coverage plan?   | <input type="radio"/> Yes<br><input type="radio"/> No ---> <i>Go to next page</i> | reset |
| Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans?  |   |       |
| Insurance through a current or former employer or union  | <input type="radio"/> Yes<br><input type="radio"/> No                             | reset |
| Insurance purchased directly from an insurance company, including the Health Insurance Marketplace from the Affordable Care Act (ACA)  | <input type="radio"/> Yes<br><input type="radio"/> No                             | reset |
| Medicaid (including MassHealth, MinnesotaCare, PeachCare, or Georgia Families), Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability | <input type="radio"/> Yes<br><input type="radio"/> No                             | reset |
| TRICARE or other military health care  | <input type="radio"/> Yes<br><input type="radio"/> No                             | reset |

Indian Health Service

Yes

No

reset

Other

Yes

No

reset

If other, please specify:

**ALERT:** "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.

65% complete



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## Transition to adult healthcare

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

- Yes  
 No

[reset](#)

If no, has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?

- Yes  
 No

[reset](#)

Has a doctor or other health care provider ever discussed with you this child's need to see a heart doctor throughout their life?

- Yes  
 No

[reset](#)

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

Make positive choices about his/her health? For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity

- Yes  
 No  
 Don't Know

[reset](#)

Gain skills to manage his/her health and health care? For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications he/she may need

- Yes  
 No  
 Don't Know

[reset](#)

**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**

- Yes
- No
- Don't Know

[reset](#)

**How prepared do you feel this child is to make positive choices about his/her health, manage his/her own health and health care, and handle changes in health care that happen at age 18?**

- Very prepared
- Somewhat prepared
- Not very prepared
- Not at all prepared

[reset](#)

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

- Yes
- No

[reset](#)

**Please rate how concerned you are about this child's future health**

- Very concerned
- Somewhat concerned
- Not very concerned
- Not at all concerned

[reset](#)

*70% complete*



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Immunizations

DURING THE PAST 12 MONTHS, has this child had a flu vaccination? A flu vaccination is usually given in the fall and protects against influenza for the flu season.

- Yes
- No

reset

75% complete



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COVID-19

Has this child ever had coronavirus or COVID-19 (based on a positive test for COVID-19 or a health professional telling you the child had COVID-19)?

- Yes
- No
- Did not receive results

reset

Please select the statement that best describes this child regarding the COVID-19 vaccine:

- This child has received all recommended doses of vaccine for COVID-19 ---> Go to next page
- This child has received some but not all recommended doses of vaccine, and I intend for them to receive all recommended doses ---> Go to next page
- This child has received some but not all recommended doses of vaccine, and I do not intend for them to receive all recommended doses
- This child has not received any vaccine for COVID-19
- Other

reset

What are your reasons for choosing not to get this child fully vaccinated? (Select all that apply)

- I'm concerned about the potential side effects of the vaccine
- I feel the vaccines were created too quickly
- I don't believe the vaccines are effective at preventing the spread of COVID-19
- I'm not concerned about this child contracting COVID-19
- I'm generally opposed to vaccinations
- A friend or family member had a bad reaction to the vaccine
- I don't think that a vaccine is necessary because COVID-19 is not a serious threat
- This child's doctor advised me not to get this child vaccinated
- Other
- I prefer not to say

If other, please specify:

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

80% complete



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## About you

How are you related to this child?

- Biological, adoptive, or step parent
- Foster parent
- Other: Relative
- Other: Non-relative

[reset](#)

What is your age in years?

- 19 or younger
- 20-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70 or older

[reset](#)

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

- 12th grade or less; No diploma
- High School Graduate or GED Completed
- College Graduate or higher

[reset](#)

Which of the following best describes your current employment status?

- Employed full-time
- Employed part-time
- Not employed or working WITHOUT pay

[reset](#)

In general, how is your mental or emotional health?

- Excellent
- Very Good
- Good
- Fair
- Poor

[reset](#)

How well do you feel that you are handling the day-to-day demands of raising a child with a heart condition?

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

[reset](#)



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

- Yes  
 No

[reset](#)

**If yes, did you receive support from:**

**Spouse or domestic partner?**

- Yes  
 No

[reset](#)

**Other family member or close friend?**

- Yes  
 No

[reset](#)

**Health care provider?**

- Yes  
 No

[reset](#)

**Place of worship or religious leader?**

- Yes  
 No

[reset](#)

**Support or advocacy group related to specific health condition?**

- Yes  
 No

[reset](#)

**Peer support group?**

- Yes  
 No

[reset](#)

**Counselor or other mental health professional?**

- Yes  
 No

[reset](#)

**Other person**

- Yes  
 No

[reset](#)

**If other person, please specify:**

[Expand](#)

**ALERT: "Other person" was selected, but "If other person, please specify" was not answered. You may have forgotten to type your response into the text box.**

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

- Yes  
 No

[reset](#)

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

**Left a job or taken a leave of absence because of this child's health or health conditions?**

- Yes  
 No

[reset](#)

**Cut down on the hours you work because of this child's health or health conditions?**

- Yes  
 No

[reset](#)

**Avoided changing jobs because of concerns about maintaining health insurance for this child?**

- Yes  
 No

[reset](#)

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

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

[reset](#)

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

Cash assistance from a government welfare program?  Yes  
 No

[reset](#)

Food stamps or Supplemental Nutrition Assistance Program (SNAP) benefits?  Yes  
 No

[reset](#)

Free or reduced-cost breakfast or lunches at school?  Yes  
 No

[reset](#)

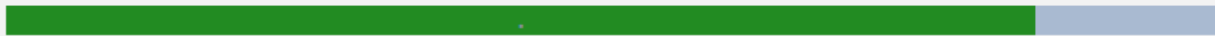
Benefits from the Women, Infants, and Children (WIC) program?  Yes  
 No

[reset](#)

SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?  Never  
 Rarely  
 Somewhat Often  
 Very often

[reset](#)

85% complete



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Household information

Does this child have another parent or adult caregiver who lives in this household?  Yes  No [reset](#)

How is this other caregiver related to this child?  Biological, adoptive, or step parent  Foster parent  Other: Relative  Other: Non-relative [reset](#)

What is the highest grade or level of school this caregiver has completed?  12th grade or less; No diploma  High School Graduate or GED Completed  College Graduate or higher [reset](#)

Which of the following best describes this caregiver's current employment status?  Employed full-time  Employed part-time  Not employed or working WITHOUT pay [reset](#)

How many children under the age of 18 are now living in the household, *not including this child*?

What is the primary language spoken in the household?

- English
- Spanish
- Somali
- Other

[reset](#)

If other, please specify:

[Expand](#)

**ALERT: "Other" was selected, but "If other, please specify" was not answered. You may have forgotten to type your response into the text box.**

90% complete



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## Childhood experiences

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

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

Parent or guardian divorced or separated

Yes

No

[reset](#)

Parent or guardian died

Yes

No

[reset](#)

Parent or guardian served time in jail or prison

Yes

No

[reset](#)

Saw or heard parents or adults slap, hit, kick, or punch one another in the home

Yes

No

[reset](#)

Was a victim of violence or witnessed violence in their neighborhood

Yes

No

[reset](#)

Lived with anyone who was mentally ill, suicidal, or severely depressed

Yes

No

[reset](#)

Lived with anyone who had a problem with alcohol or drugs  Yes  
 No

[reset](#)

Treated or judged unfairly because of his or her race or ethnic group  Yes  
 No

[reset](#)

Treated or judged unfairly because of a health condition or disability  Yes  
 No

[reset](#)

Treated or judged unfairly because of their sexual orientation or gender identity  Yes  
 No

[reset](#)

**95% complete**



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Future needs

What expectations do you have for this child in the future?

Expand

What concerns do you have for this child in the future?

Expand

Thank you for completing our survey!

*Public reporting burden for this collection of information is estimated to average 20 minutes, including completing and reviewing the collection of information. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, GA 30333: ATTN: PRA (0920-22CL).*

100% complete



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