

National Health Interview Survey



Recently, someone at your address answered a brief survey about members of your household. We randomly selected the child below from your household for a health interview as part of the National Health Interview Survey:

This survey should be completed by a parent or guardian who lives in this household and who is knowledgeable about this child's health. Please complete this questionnaire and return it in the postage-paid return envelope provided.

Instructions

Please use a blue or black pen to complete the paper questionnaire.

Place an X to mark your answers as shown below:

- Yes
 No

When entering numbers, please align the numbers to the right, as shown below:

**For help or questions about completing this form, please call 1-800-618-5888.
The telephone call is free.**

Notice – CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and 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, email nhis@census.gov; ATTN: PRA (0607-0725).

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A. This Child's Health

A1 Would you say this child's health in general is...

- Excellent
- Very good
- Good
- Fair
- Poor

A2 Has a doctor or other health professional EVER told you that this child had asthma?

- Yes No → **SKIP** to question **A3**

→ **a.** Does this child still have asthma?

- Yes No

→ **b.** During the past 12 months, has this child had an episode of asthma or an asthma attack?

- Yes No

→ **c.** During the past 12 months, has this child had to visit an emergency room or urgent care center because of their asthma?

- Yes No

A3 Not including prediabetes, has a doctor or other health professional EVER told you that this child had diabetes?

- Yes No

A4 Has a doctor or other health professional EVER told you that this child had any of the following?

Mark (X) yes or no for each item.

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Attention-deficit/hyperactivity disorder (ADHD) or attention-deficit disorder (ADD) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Intellectual disability, previously known as mental retardation | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Autism, Asperger's disorder, pervasive developmental disorder, or autism spectrum disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other developmental delay | <input type="checkbox"/> | <input type="checkbox"/> |

A5 Has a representative from a school or a health professional EVER told you that this child had a learning disability?

- Yes No

B. This Child's Health Care Coverage

The next questions are about health insurance.

Include health insurance obtained through employment or purchased directly, as well as government programs like Medicare, Medicaid, and Children's Health Insurance Program, that provide medical care or help pay medical bills.

B1 Is this child now covered by any kind of health insurance or some other kind of health care plan?

- Yes
- No → **SKIP** to question **B4** on page 3.

B2 What kind of health insurance or health care coverage does this child have?

Mark (X) yes or no for each item.

	Yes	No
a. Private health insurance	<input type="checkbox"/>	<input type="checkbox"/>
b. Medicare (including Medicare Advantage)	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicare supplement (Medigap)	<input type="checkbox"/>	<input type="checkbox"/>
d. Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
e. Children's Health Insurance Program (CHIP)	<input type="checkbox"/>	<input type="checkbox"/>
f. TRICARE or other military health care (CHAMPUS)	<input type="checkbox"/>	<input type="checkbox"/>
g. VA health care or CHAMPVA	<input type="checkbox"/>	<input type="checkbox"/>
h. Indian Health Service	<input type="checkbox"/>	<input type="checkbox"/>
i. State-sponsored health plan	<input type="checkbox"/>	<input type="checkbox"/>
j. Other government program	<input type="checkbox"/>	<input type="checkbox"/>

B3 Was any of this child's health insurance you marked on B2 obtained through Healthcare.gov, the Health Insurance Marketplace, or a state-based health insurance exchange? *Healthcare.gov is a website for the Affordable Care Act, also known as Obamacare.*

- Yes No

↳ What is the name of this plan?



The next few questions are about types of health insurance this child may have had in the past 12 months.

B4 At any time in the past 12 months, did this child have health insurance purchased through a family member's current or former employer or union?

Yes

No

B5 At any time in the past 12 months, did this child have health insurance purchased through Healthcare.gov, the Health Insurance Marketplace, or a state-based health insurance exchange?

Healthcare.gov is a website for the Affordable Care Act, also known as Obamacare.

Yes

No

B6 At any time in the past 12 months, did this child have Medicaid, Medical Assistance, or the Children's Health Insurance Program?

Yes

No

B7 During the past 12 months, was this child covered by health insurance for...

All of the year

Some of the year → **How many months did this child have coverage?**

None of the year

months

C. This Child's Health Care

C1 About how long has it been since this child last saw a doctor or other health professional about their health? Do not include appointments by video or phone. Do not include dental care. Include doctors seen while a patient in a hospital.

Within the past 12 months

At least 1 year ago but less than 2 years ago

2 years ago or more

Never

C2 About how long has it been since this child last saw a doctor or other health professional for a wellness visit, physical, or general-purpose check-up? If a wellness exam was combined with a visit for some other reason, include this visit. An obstetrician/gynecologist (OB/GYN) may perform this visit.

Within the past 12 months

At least 1 year ago but less than 2 years ago

2 years ago or more

Never

C3 During the past 12 months, how many times has this child gone to a retail health clinic about their health? Retail health clinics are located in a pharmacy, grocery store, or supercenter. These clinics can provide common services, such as certain vaccinations, as well as testing for or treatment of minor uncomplicated illnesses.

None

1 time

2 or 3 times

4 or more times

C4 During the past 12 months, how many times has this child gone to an urgent care center about their health? An urgent care center is located in its own building or space. These centers can provide services such as x-rays and stitches.

None

1 time

2 or 3 times

4 or more times



C5 During the past 12 months, how many times has this child gone to a hospital emergency room about their health? *This includes emergency room visits that resulted in a hospital admission.*

- None
- 1 time
- 2 or 3 times
- 4 or more times

C6 During the past 12 months, how many nights has this child been hospitalized? *Do not include an overnight stay in the emergency room.*

- None
- 1 night
- 2 or 3 nights
- 4 or more nights

C7 During the past 12 months, has this child had an appointment with a doctor, nurse, or other health professional by video or by phone?

- Yes
- No

C8 During the past 12 months, has this child had a dental examination or cleaning? *Include examinations or cleanings from all types of dental care providers, such as dentists, orthodontists, oral surgeons, dental hygienists, and all other dental specialists.*

- Yes
- No

C9 During the past 12 months, has this child had an eye exam from an eye specialist, such as an optometrist, ophthalmologist, or eye doctor?

- Yes
- No

C10 During the past 12 months, did this child receive counseling or therapy from a mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker?

- Yes
- No

C11 Is there a place that this child **USUALLY** goes if they are sick and need health care?

- Yes, there is ONE or MORE THAN ONE place
- No, there is NO place

C12 During the past 12 months, has this child had a flu vaccination? *There are 2 types of flu vaccinations. One is a shot and the other is a spray, mist, or drop in the nose.*

- Yes
- No

C13 At any time in the past 12 months, did this child take prescription medication?

- Yes No

↳ Was this medication to help with this child's emotions, concentration, behavior, or mental health?

- Yes No

D. This Child's Health Care Costs

D1 During the past 12 months, has dental care been **DELAYED** for this child because of cost?

- Yes
- No

D2 During the past 12 months, was there any time when this child needed dental care, but did **NOT** get it because of the cost?

- Yes
- No

D3 During the past 12 months, has medical care been **DELAYED** for this child because of cost? *Do not include dental care.*

- Yes
- No

D4 During the past 12 months, was there any time when this child needed medical care, but did **NOT** get it because of the cost? *Do not include dental care.*

- Yes
- No

D5 During the past 12 months, was there any time when this child needed prescription medication, but did **NOT** get it because of the cost?

- Yes
- No



D6 During the past 12 months, was there any time when this child needed counseling or therapy from a mental health professional, but did NOT get it because of the cost?

- Yes
 No

D7 If this child gets sick or has an accident, how worried are you that your family will be able to pay this child's medical bills?

- Very worried
 Somewhat worried
 Not at all worried

E. This Child's Day-to-Day Experiences

E1 What is this child's age today?

Enter '0' if this child is less than a year old.

Age in years ↕

If under 5 years, SKIP to **G. About You and This Child** on page 7.

E2 Does this child have difficulty seeing, even if wearing glasses or contact lenses?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E3 Does this child have difficulty hearing, even if using a hearing aid(s)?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E4 Does this child have difficulty walking, even if using equipment or assistance?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E5 Does this child have difficulty with self-care, such as eating or dressing?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E6 When this child speaks, do they have difficulty being understood by people inside or outside of their household?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E7 Compared with other children their age, does this child have difficulty learning things?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E8 Compared with other children their age, does this child have difficulty remembering things?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E9 Compared with other children their age, does this child have difficulty controlling their behavior?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all

E10 Does this child have difficulty concentrating on an activity they enjoy doing?

- No difficulty
 Some difficulty
 A lot of difficulty
 Cannot do at all



E11 Does this child have difficulty accepting changes in their routine?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

E12 Does this child have difficulty making friends?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

E13 How often does this child seem anxious, nervous, or worried?

- Daily
- Weekly
- Monthly
- A few times a year
- Never

E14 How often does this child seem very sad or depressed?

- Daily
- Weekly
- Monthly
- A few times a year
- Never

E15 During the past 12 months, about how many days of school did this child miss because of an illness, injury, or disability?

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

F. This Child's Health Behaviors

F1 In a typical week during the school year, how often does this child exercise, play a sport, or participate in physical activity for at least 60 minutes a day?

- Never
- Some days
- Most days
- Every day

F2 In a typical week during the school year, how often does this child do exercises to strengthen or tone their muscles, such as sit-ups, push-ups, or weight lifting?

- Never
- Some days
- Most days
- Every day

F3 In a typical week during the school year, how often does this child nap or fall asleep during the day, such as in school, watching TV, or riding in a car?

- Never
- Some days
- Most days
- Every day

F4 How tall is this child without shoes? Answer in feet and inches OR meters and centimeters. Your best estimate is fine.

feet AND inches

OR

meters AND centimeters

F5 How much does this child weigh? Answer in pounds OR kilograms. Your best estimate is fine.

pounds

OR

kilograms



F6 On most weekdays, how many hours does this child spend a day in front of a TV, computer, cellphone, or other electronic device watching programs, playing games, accessing the Internet, or using social media? Do not include time spent doing schoolwork.

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

G. About You and This Child

G1 Do you consider this child to be Hispanic or Latino?

- Yes
- No

G2 What race or races do you consider this child to be? Mark (X) for all that apply.

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

G3 What is your relationship to this child?

- Parent (biological, step, adoptive, or foster)
- Grandparent
- Uncle or aunt
- Other family member
- Unrelated household member

G4 How many of this child's parents live at this address? Include biological, adoptive, step, or foster parents.

- Two
- One
- Zero

G5 How many of this child's parents at this address are currently working? Include biological, adoptive, step, or foster parents.

- Two
- One
- Zero

G6 Including yourself and this child, how many of the people in your household are members of your family? For this survey, family refers to everybody living together who are related by birth, marriage, or adoption, as well as any unrelated children who are cared for by the family, such as foster children. Family also includes any people living together as a couple and their children.

Number of family members in household

The next questions are about your total family income in 2025.

G7 In 2025, did you or any family member 18 or older receive income from any of the following sources? Mark (X) yes or no for each item.

	Yes	No
a. Wages, salaries, commissions, bonuses, tips, or self-employment	<input type="checkbox"/>	<input type="checkbox"/>
b. Interest-bearing accounts or investments	<input type="checkbox"/>	<input type="checkbox"/>
c. Dividends from stocks or mutual funds	<input type="checkbox"/>	<input type="checkbox"/>
d. Net rental income, royalty income, or income from estates and trusts	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Security or Railroad Retirement	<input type="checkbox"/>	<input type="checkbox"/>
f. Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>
g. Any public assistance or welfare payments from the state or local welfare office	<input type="checkbox"/>	<input type="checkbox"/>
h. Retirement income, pensions, survivors or disability income	<input type="checkbox"/>	<input type="checkbox"/>
i. Any other sources of income received regularly such as Veterans' VA payments, unemployment compensation, child support, or alimony	<input type="checkbox"/>	<input type="checkbox"/>

G8 What is your best estimate of the total income of all family members from all sources in 2025? Report amount before taxes. Report net income after business expenses if self-employed.

\$.00



Mailing Instructions

→ **Please print today's date.** *This should be the date this form was completed.*

Month

Day

Year

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

Your answers to this survey will provide better information for health policies and decisions that affect millions of people across the United States.

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

DIRECTOR
U.S. Census Bureau
P.O. Box 5000
Jeffersonville, IN 47199-5000

