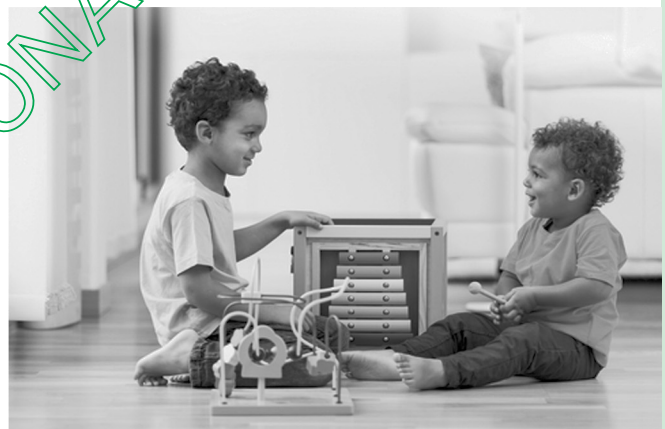




# National Survey of Children's Health

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



INFORMATIONAL COPY

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

Any information you provide will be shared for the work-related purposes identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

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

**NSCH-T1**  
(05/09/2019)



## Start Here

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

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

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

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

The survey should be completed by an adult who is familiar with this child's health and health care.

Your participation is important. Thank you.

## A. This Child's Health

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

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

**A3** How often...

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

**A4** DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

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

**A5** Does this child have any of the following?

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



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

**A6** Allergies (including food, drug, insect, or other)?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A7** Arthritis?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A8** Asthma?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A9** Brain injury, concussion or head injury?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A10** Cerebral Palsy?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A11** Diabetes?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

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

**A12** Epilepsy or Seizure Disorder?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A13** Heart Condition?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A14** Frequent or severe headaches, including migraine?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A15** Tourette Syndrome?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A16** Anxiety Problems?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A17** Depression?

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



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

**A18 Down Syndrome?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A19 Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

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

Yes  No

↳ If yes, was this child diagnosed with:

Sickle Cell Disease?  Yes  No

Thalassemia?  Yes  No

Hemophilia?  Yes  No

Other Blood Disorders?  Yes  No

**A20 Cystic Fibrosis?**

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

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

Yes  No

**A21 Other genetic or inherited condition?**

Yes  No

↳ If yes, specify: ↴

↳ Is it:

Mild  Moderate  Severe

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

Yes  No

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

*Examples of educators are teachers and school nurses.*

**A22 Behavioral or Conduct Problems?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A23 Developmental Delay?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A24 Intellectual Disability (formerly known as Mental Retardation)?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A25 Speech or other language disorder?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A26 Learning Disability?**

Yes  No

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe



**A27** Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Yes  No → **SKIP to question A32**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A28** How old was this child when a doctor or other health care provider FIRST told you that he or she had Autism, ASD, Asperger's Disorder or PDD?

Age in years  Don't know

**A29** What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD? Mark (X) ONE box.

Primary Care Provider

Specialist

School Psychologist/Counselor

Other Psychologist (Non-School)

Psychiatrist

Other, specify:

Don't know

**A30** Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

Yes  No

**A31** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with his or her behavior?

Yes  No

**A32** Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?

Yes  No → **SKIP to question A35**

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

Yes  No

↳ If yes, is it:

Mild  Moderate  Severe

**A33** Is this child CURRENTLY taking medication for ADD or ADHD?

Yes  No

**A34** At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with his or her behavior?

Yes  No

**A35** DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected his or her ability to do things other children his or her age do?

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

Never

Sometimes

Usually

Always

**A36** To what extent do this child's health conditions or problems affect his or her ability to do things?

Very little

Somewhat

A great deal



## B. This Child as an Infant

**B1** Was this child born more than 3 weeks before his or her due date?

Yes

No

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

Birth Month / 4-Digit Birth Year

/ 20

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

pounds AND   ounces

OR

kilograms AND    grams

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

Age in years

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

Yes

No → **SKIP to question B7**

**B6** If yes, how old was this child when he or she COMPLETELY stopped breastfeeding or being fed breast milk?

days

OR

weeks

OR

months

OR

Check this box if child is still breastfeeding

**B7** How old was this child when he or she was FIRST fed formula?

Check this box if child has never been fed formula

OR

At birth

OR

days

OR

weeks

OR

months

**B8** 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 anything else that your child might have been given, even water.

Check this box if child has never been fed anything other than breast milk or formula

OR

At birth

OR

days

OR

weeks

OR

months



## C. Health Care Services

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

Yes

No → **SKIP to question C4**

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

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

0 visits

1 visit

2 or more visits

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

Less than 10 minutes

10-20 minutes

More than 20 minutes

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

Yes, it's too high

Yes, it's too low

No, I am not concerned

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

Yes

No

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

Yes

No

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

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

Yes  No

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

Did the questionnaire ask about your concerns or observations about: Mark (X) ALL that apply.

How this child talks or makes speech sounds?

How this child interacts with you and others?

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

Did the questionnaire ask about your concerns or observations about: Mark (X) ALL that apply.

Words and phrases this child uses and understands?

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

**C8** Is there a place you or another caregiver USUALLY take this child when he or she is sick or you need advice about his or her health?

Yes

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

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

Doctor's Office

Hospital Emergency Room

Hospital Outpatient Department

Clinic or Health Center

Retail Store Clinic or "Minute Clinic"

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

Some other place



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

- Yes
- No → **SKIP to question C12**

**C11** If yes, is this the same place this child goes when he or she is sick?

- Yes
- No

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

- Yes
- No → **SKIP to question C14**

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

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

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

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

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

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

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

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

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

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

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

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

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

- Yes
- No

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

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





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

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

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

- Yes
- No

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

- Yes
- No → **SKIP to question C26**

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

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

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

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

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

- Never
- Sometimes
- Usually
- Always

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

- None
- 1 time
- 2 or more times

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

- Yes
- No

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

- Yes
- No → **SKIP to question C32**

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

Years AND  Months

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

- Yes
- No

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

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

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

Years AND  Months

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

- Yes
- No

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

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

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

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

- Yes
- No → **SKIP to question D4**

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

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

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

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

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

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

- Yes
- No → **SKIP to question D7**

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

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

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

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

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

- Yes
- No → **SKIP to question D10**

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

- Usually
- Sometimes
- Never

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

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



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

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

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

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

## E. This Child's Health Insurance Coverage

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

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

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

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

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

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

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

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

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

- Always
- Usually
- Sometimes
- Never

**E6** How often does this child's health insurance allow him or her to see the health care providers he or she needs?

- Always
- Usually
- Sometimes
- Never

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

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



## F. Providing for This Child's Health

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

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

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

- Always
- Usually
- Sometimes
- Never

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

- Yes
- No

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

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

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

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

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

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

## G. This Child's Learning

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

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

Mark (X) Yes or No for each item.

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



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

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

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

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

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

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

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

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

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

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

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

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

**G8** Can this child rhyme words?

- Yes
- No

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

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

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

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

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

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

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

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



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

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

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

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

**G15** How often does this child keep working at something until he or she is finished?

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

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

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

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

- Uses fingers to hold the pencil
- Grips the pencil in his or her fist
- This child cannot hold a pencil

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

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

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

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

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

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

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

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

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

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

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

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



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

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

## H. About You and This Child

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

- Yes → **SKIP to question H3**
- No

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

Years AND  Months

**H3** How many times has this child moved to a new address since he or she was born?

Number of times

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

- Always
- Usually
- Sometimes
- Rarely
- Never

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

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

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

In which position do you most often lay this baby down to sleep now? Mark (X) **ONE** box.

- On his or her side
- On his or her back
- On his or her stomach

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

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

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

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

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

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

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

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



# I. About Your Family and Household

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

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

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

0 days

1-3 days

4-6 days

Every day

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

Yes

No → **SKIP to question H14**

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

Yes

No → **SKIP to question I4**

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

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

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

Yes

No

**H14** 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.*

Yes

No

**I4** DURING THE PAST 12 MONTHS, how often were pesticides used inside your residence to control for insects? *If the frequency changed throughout the year, report the highest frequency.*

More than once a week

Once a week

Once a month

Once every 2-5 months

Once every 6 months

Once during the past 12 months

Never

Don't know

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

Yes

No

**I5** DURING THE PAST 12 MONTHS, other than in a shower or bathtub, have you seen any mold, mildew or other signs of water damage on walls or other surfaces inside your home?

Yes

No





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

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

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

Never

Rarely

Somewhat often

Very often

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

We could always afford to eat good nutritious meals.

We could always afford enough to eat but not always the kinds of food we should eat.

Sometimes we could not afford enough to eat.

Often we could not afford enough to eat.

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

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

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

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

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

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

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

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

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



## J. Child's Caregivers

→ Complete the questions for UP TO TWO ADULTS in the household who are this child's primary caregivers.

### CAREGIVER 1 (You)

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

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

**J2** What is your sex?

- Male
- Female

**J3** What is your age?

Age in years

**J4** Where were you born?

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

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

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

4-Digit Year

**J6** What is the highest grade or level of school you have completed? Mark (X) ONE box.

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

**J7** What is your marital status?

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

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

- Excellent
- Very good
- Good
- Fair
- Poor

**J10** Were you employed at least 50 out of the past 52 weeks?

- Yes
- No

**J11** Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard? Mark (X) ONE box.

- Never served in the military → **SKIP to question J13 on page 19**
- Only on active duty for training in the Reserves or National Guard → **SKIP to question J13 on page 19**
- Now on active duty
- On active duty in the past, but not now

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

- Yes
- No



→ If this child has another primary adult caregiver who lives in this household, complete Questions J13 - J24. Otherwise, skip to Question K1 on page 20.

## CAREGIVER 2

**J13** How is Caregiver 2 related to this child?  
 There is only one primary adult caregiver in the household for this child → **SKIP to question K1 on page 20**

Biological or Adoptive Parent

Step-parent

Grandparent

Foster Parent

Other: Relative

Other: Non-Relative

**J14** What is Caregiver 2's sex?

Male

Female

**J15** What is Caregiver 2's age?

Age in years

**J16** Where was Caregiver 2 born?

In the United States → **SKIP to question J18**

Outside of the United States

**J17** When did Caregiver 2 come to live in the United States? Indicate the 4-digit year in which Caregiver 2 came to live in the United States.

4-Digit Year

**J18** What is the highest grade or level of school Caregiver 2 has completed? Mark (X) ONE box.

8th grade or less

9th-12th grade; No diploma

High School Graduate or GED Completed

Completed a vocational, trade, or business school program

Some College Credit, but no Degree

Associate Degree (AA, AS)

Bachelor's Degree (BA, BS, AB)

Master's Degree (MA, MS, MSW, MBA)

Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

**J19** What is Caregiver 2's marital status?

Married

Not married, but living with a partner

Never Married

Divorced

Separated

Widowed

**J20** In general, how is Caregiver 2's physical health?

Excellent

Very good

Good

Fair

Poor

**J21** In general, how is Caregiver 2's mental or emotional health?

Excellent

Very good

Good

Fair

Poor

**J22** Was Caregiver 2 employed at least 50 out of the past 52 weeks?

Yes

No

**J23** Has Caregiver 2 ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard? Mark (X) ONE box.

Never served in the military → **SKIP to question K1 on page 20**

Only on active duty for training in the Reserves or National Guard → **SKIP to question K1 on page 20**

Now on active duty

On active duty in the past, but not now

**J24** Was Caregiver 2 deployed at any time during this child's life?

Yes

No



## K. Household Information

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

Number of people

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

Number of people

**K3** Income in 2018

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

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

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

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

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

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

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

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

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

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

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

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

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

- K4** The following question is about your 2018 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.

\$ .00  
 TOTAL AMOUNT in the last calendar year

## Mailing Instructions

### Thank you for your participation.

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

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

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

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

You may also call 1-800-845-8241 to request a replacement envelope.

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

