MY CHILD'S HEALTH

These questions ask about your child's health and well-being. Answer the questions by circling the best number response. Certain questions may look alike, but each one is different. Some questions ask about problems your child may not have. It's important for us to know about problems your child does not
have as well as those your child does have. Please answer each question. There are no right or wrong answers. If you are unsure how to answer a question, please give the best response.

1. In general, would you say your child's health is: circle one.

1. Poor 2. Fair 3. Good 4. Very good 5. Excellent

The following questions ask about physical activities your child might do during a day.

2. During the last 4 weeks, has your child been limited in any of the following activities due to health problems?

	No, not limited	Yes, limited a little	Yes, limited some	Yes, very limited
a. Doing things that require a lot of energy, such as playing soccer or running	1	2	3	4
b. Doing things that require some energy, such as riding a bike or skating	1	2	3	4
c. Bending, lifting, or stooping	1	2	3	4

	None of the Time	Once or Twice	A few Times	Fairly Often	Very Often	Every/ Almost Every Day
3. During the last 4 weeks, how often has your child had bodily pain or discomfort?	1	2	3	4	5	6

4. How true or false is the statement for your child?

	Definitely False	Mostly False	Don't Know	Mostly True	Definitely True
a. My child seems to be less healthy than other children I know	1	2	3	4	5
b. My child has never been seriously ill	1	2	3	4	5
c. I worry about my child's health more than other people worry about their children's health	1	2	3	4	5

5. Compared to one year ago, how would you rate your child's health now? Circle one

Much Worse	Somewhat Worse	About the Same	Somewhat Better	Much Better
1	2	3	4	5

The following questions ask about you and your family.

6. During the last 4 weeks, how MUCH emotional concern or worry did the following cause YOU?

	None at all	A Little bit	Some	Quite a bit	A lot
Your child's physical health	1	2	3	4	5

7. During the last 4 weeks, were you LIMITED in the amount of time YOU have for your own needs because of:

	No, Not Limited	Yes, Limited a Little	Yes, Limited Some	Yes, Limited A lot
Your child's physical health?	1	2	3	4

8. During the last 4 weeks, how often has your child's health or behavior:

	Never	Almost Never	Sometimes	Fairly Often	Very Often
a. Limited the type of activities you can do as a family?	1	2	3	4	5
b. Interrupted various everyday family activities (eating meals, watchingT.V.)	1	2	3	4	5

9. Have you ever been told by a doctor, nurse, or other health professional that your child has any of the following conditions? Circle yes or no for each item.

a. Anemia……1 yes……..0 no
b. Arthritis or any joint disease or joint problem……1 yes……..0 no
c. Asthma ……1 yes ……..0 no
d. Cancer ……1 yes……0 no
e. Chronic allergies, hay fever, or sinus trouble……1 yes……..0 no
f. Chronic respiratory, lung, or breathing trouble (NOT asthma)…… ……1 yes……..0 no
g. Chronic rheumatic disease or heart disease……1 yes……..0 no
h. Epilepsy or seizure disorder……1 yes……..0 no
i. Hepatitis ……1 yes……..0 no
j. Migraine headaches……1 yes……..0 no
k. Obesity……1 yes……..0 no
l. Serious acne, eczema, or other allergic rashes……1 yes……..0 no
m. Sexually transmitted diseases (STD)…… ……1 yes……..0 no
n. Sickle cell anemia……1 yes……..0 no

10. Have you ever been told by a teacher, school official, doctor, nurse or other health professional that your child has any of the following conditions? Circle yes or no for each item.

a. Anxiety problems ……1 yes ……..0 no
b. Attention Deficit Hyperactivity Disorder ……1 yes ……..0 no
c. Autism, Asperger syndrome, or pervasive developmental disorder...1 yes ……0 no
d. Behavioral problems ……1 yes ……..0 no

e. Depression ……..……1 yes …….....……0 no
f. Developmental delay or mental retardation (NOT autism) ……1 yes ……..……...0 no
g. Drug or alcohol dependency ……..…1 yes……....……...0 no
h. Eating disorder like anorexia or bulimia …….....1 yes ……..…….,....0 no
i. Hearing impairment or deafness ……1 yes …….....…..…..0 no
j. Learning disability ……..…1 yes……...……....….0 no
k. Manic depression ……..…1 yes ……...…..……...0 no
l. Obsessive compulsive disorder ……..…..1 yes …….....….…….0 no
m. Panic attacks …….....…1 yes …….....….…….0 no
n. Sleep problems ……..……...…….1 yes……....…..…….0 no
o. Speech problems ……....1 yes …..…...…..…….0 no
p. Vision problems …….……....1 yes ……...…….0 no

11. Does your child have any other problem that affects what your child does or how your child feels? (If yes, please describe below)……...1 yes ……....0 no

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