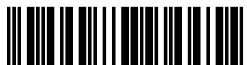




CHILD #1	CHILD #2	CHILD #3
<p>11. Which of the following contributed to not receiving regular check-ups:</p> <p>A) Your child had difficulty getting in to get a doctor's appointment?.....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B) Your child needed to see a doctor, but couldn't because of the cost?.....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C) You lacked transportation making it difficult/prevented your child from seeing a doctor or making a medical appointment? .....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D) You needed to purchase a medication for your child, but couldn't because of the cost?.....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F) Your child needed to see a doctor, but couldn't because office hours were inconvenient?.....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E) Your child needed to see a doctor, but couldn't because of language or cultural differences?.....&gt; <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>12. Within the last year, how many times has each child been to an emergency room for medical treatment?</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 7-8</p> <p><input type="checkbox"/> 3-4 <input type="checkbox"/> 9+</p> <p><input type="checkbox"/> 5-6 <input type="checkbox"/> Never</p>	<p><input type="checkbox"/> 1-2 <input type="checkbox"/> 7-8</p> <p><input type="checkbox"/> 3-4 <input type="checkbox"/> 9+</p> <p><input type="checkbox"/> 5-6 <input type="checkbox"/> Never</p>	<p><input type="checkbox"/> 1-2 <input type="checkbox"/> 7-8</p> <p><input type="checkbox"/> 3-4 <input type="checkbox"/> 9+</p> <p><input type="checkbox"/> 5-6 <input type="checkbox"/> Never</p>
<p>13. Is each child up-to-date on immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know</p>
<p>14. If your child is school age, how many days did they miss school due to illness or not being up-to-date on immunizations?</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 6-10</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 11+</p> <p><input type="checkbox"/> 3-5</p>	<p><input type="checkbox"/> 0 <input type="checkbox"/> 6-10</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 11+</p> <p><input type="checkbox"/> 3-5</p>	<p><input type="checkbox"/> 0 <input type="checkbox"/> 6-10</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 11+</p> <p><input type="checkbox"/> 3-5</p>
<p>15. Did your child have to remain in the hospital immediately following birth, due to birth complications or other medical concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>16. During pregnancy, did the mother of the child use any of the following: (check all that apply)</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Other drugs</p> <p><input type="checkbox"/> Tobacco (chew, snuff, cigarettes)</p> <p><input type="checkbox"/> None of the above</p>	<p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Other drugs</p> <p><input type="checkbox"/> Tobacco (chew, snuff, cigarettes)</p> <p><input type="checkbox"/> None of the above</p>	<p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Other drugs</p> <p><input type="checkbox"/> Tobacco (chew, snuff, cigarettes)</p> <p><input type="checkbox"/> None of the above</p>



CHILD #1	CHILD #2	CHILD #3
17. If you drive with a child that requires a car seat, do you always use a car seat? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. How often does each child use a helmet when he/she skate board, ride a bicycle/tricycle, scooter, etc.? <input type="checkbox"/> Always (100%) <input type="checkbox"/> Most of the time (more than 50%) <input type="checkbox"/> Some of the time (50%) <input type="checkbox"/> Seldom (less than 50%) <input type="checkbox"/> Never (0%) <input type="checkbox"/> Not applicable	<input type="checkbox"/> Always (100%) <input type="checkbox"/> Most of the time (more than 50%) <input type="checkbox"/> Some of the time (50%) <input type="checkbox"/> Seldom (less than 50%) <input type="checkbox"/> Never (0%) <input type="checkbox"/> Not applicable	<input type="checkbox"/> Always (100%) <input type="checkbox"/> Most of the time (more than 50%) <input type="checkbox"/> Some of the time (50%) <input type="checkbox"/> Seldom (less than 50%) <input type="checkbox"/> Never (0%) <input type="checkbox"/> Not applicable
19. On an average day, how many hours does each child watch television? <input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs
20. On an average day, how many hours does each child play video/computer games? <input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 0 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> Less than 1hr <input type="checkbox"/> 5+ hrs <input type="checkbox"/> 1-2 hrs
21. Has any child been diagnosed by a healthcare provider with asthma/chronic bronchitis? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Who takes care of each child when you or your spouse are at work? <input type="checkbox"/> A parent stays home <input type="checkbox"/> With other family member/nanny <input type="checkbox"/> Childcare center <input type="checkbox"/> Preschool <input type="checkbox"/> After-school program	<input type="checkbox"/> A parent stays home <input type="checkbox"/> With other family member/nanny <input type="checkbox"/> Childcare center <input type="checkbox"/> Preschool <input type="checkbox"/> After-school program	<input type="checkbox"/> A parent stays home <input type="checkbox"/> With other family member/nanny <input type="checkbox"/> Childcare center <input type="checkbox"/> Preschool <input type="checkbox"/> After-school program
23. Does your child take any of the following for dental care dental care purposes: (check all that apply) <input type="checkbox"/> Vitamin supplements with fluoride <input type="checkbox"/> Toothpaste with fluoride <input type="checkbox"/> Fluoride mouthwash <input type="checkbox"/> other: <input type="text"/>	<input type="checkbox"/> Vitamin supplements with fluoride <input type="checkbox"/> Toothpaste with fluoride <input type="checkbox"/> Fluoride mouthwash <input type="checkbox"/> other: <input type="text"/>	<input type="checkbox"/> Vitamin supplements with fluoride <input type="checkbox"/> Toothpaste with fluoride <input type="checkbox"/> Fluoride mouthwash <input type="checkbox"/> other: <input type="text"/>



	CHILD #1	CHILD #2	CHILD #3
24. When each child was drinking from a bottle, what did he/she drink? (check all that apply)	<input type="checkbox"/> Milk <input type="checkbox"/> Juice/sugary drinks/soda <input type="checkbox"/> Water <input type="checkbox"/> Formula <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Milk <input type="checkbox"/> Juice/sugary drinks/soda <input type="checkbox"/> Water <input type="checkbox"/> Formula <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Milk <input type="checkbox"/> Juice/sugary drinks/soda <input type="checkbox"/> Water <input type="checkbox"/> Formula <input type="checkbox"/> Other: <input type="text"/>
25. When did each child stop using a baby bottle?	<input type="checkbox"/> 12 mths or less <input type="checkbox"/> 13-15 mths <input type="checkbox"/> 16-24 mths <input type="checkbox"/> 25 mths or more <input type="checkbox"/> Didn't/Don't use bottle	<input type="checkbox"/> 12 mths or less <input type="checkbox"/> 13-15 mths <input type="checkbox"/> 16-24 mths <input type="checkbox"/> 25 mths or more <input type="checkbox"/> Didn't/Don't use bottle	<input type="checkbox"/> 12 mths or less <input type="checkbox"/> 13-15 mths <input type="checkbox"/> 16-24 mths <input type="checkbox"/> 25 mths or more <input type="checkbox"/> Didn't/Don't use bottle
26. How many times a week does each child eat <b>fast food</b> --i.e. McDonald's?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+
27. How many times a week does each child eat <b>vegetables</b> ?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+
28. How many times a week does each child consume <b>dairy products</b> (i.e. milk,cheese, ect.)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+
29. How many times a week does each child eat fruit?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+
30. How many times a week does each child drink <b>soda</b> ?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+
31. How many times a week does each child eat <b>junk food</b> --i.e. cookies, chips, candy?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8+

You have reached the end of the Children's Survey.  
Please continue with the adult survey.

