

Chapter 2

Reduced-Item PHDS for In-Office Administration

Reduced-Item PHDS for In-Office Administration

Survey for Parents of Children 3-9.99 Months Old

Your Child's Health Care

- ❖ This survey is about discussions you may have had with your child's doctors or other health providers since your child was born.
- ❖ By completing this survey, you are indicating that you have given your consent to participate.
- ❖ This survey is confidential. Do not write your name or your child's name on this survey.
- ❖ If you choose to not answer the survey, the decision will have no effect on the health care your child receives.
- ❖ If you begin to answer the questions and then change your mind, you may stop at any time. Also, if there are particular questions that you don't want to answer, you may skip them.

Instructions

1. Please use a BLUE or BLACK ink pen to complete this survey.
2. Answer all the questions by checking the box on top of your answer like this:

Yes No

YOUR CHILD'S HEALTH CARE

SECTION I: DISCUSSIONS WITH YOUR CHILD'S DOCTORS OR OTHER HEALTH PROVIDERS

A doctor or other health provider could be a general doctor, a specialist, a pediatrician, a nurse practitioner, a physician assistant, a nurse or any one else your child would see for health care.

	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
1. Since your child was born , did your child's doctors or other health providers talk with you about the following:				
a) Things you can do to help your child grow and learn	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) The kinds of behaviors you can expect to see in your child as he/she gets older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Breastfeeding	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Issues related to food such as the introduction of solid foods	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) The importance of placing your child on his or her back when going to sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Where your child sleeps (such as the location and type of crib of your child may sleep in)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Night waking and fussing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
2. Since your child was born , did your child's doctors or other health providers talk with you about the following:				
a) How your child communicates his/her needs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) What your child is able to understand	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) How your child responds to you, other adults, and caregivers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) How to avoid burns to your child, such as changing the hot water temperature in your home	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Using a car-seat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) How to make your house safe	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Importance of showing a picture book to or reading with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Issues related to childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

YOUR CHILD'S HEALTH CARE

SECTION II: EXPERIENCE OF CARE

The next questions ask about your overall experiences with the health care your child has received from his or her doctors or other health providers since your child was born.

3. Since your child was born , how often did your child's doctors or other health providers. . .	Never	Sometimes	Usually	Always
a) Take time to understand the specific needs of your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Respect you as an expert about your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Help you feel like a partner in your child's care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Explain things in a way that you can understand	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Show respect for your family's values, customs and how you prefer to raise your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION III: HEALTH CONCERNS ABOUT YOUR CHILD

The next few questions ask about concerns parents or guardians sometimes have about their child.

4.* Do you have any concerns about . . .	Yes	A little	Not at all
a) Your child's learning, development or behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) How your child talks and makes speech sounds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) How your child understands what you say	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) How your child uses his or her arms and legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) How your child behaves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) How your child gets along with others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

5. Since your child was born, did your child's doctors or other health providers ask if you have concerns about your child's learning, development or behavior?

1
Yes

2
No

3
I don't remember

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YOUR CHILD'S HEALTH CARE

6. Since your child was born, did your child's doctors or other health providers give you specific information to address your concerns?

1
Yes

2
No

3
I don't remember

4
I did not have any
concerns

7. Did your child's doctors or other health providers ever:

	Yes	No
a) Refer your child to another doctor or other health provider	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) Test your child's learning and behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) Note a concern about your child that should be watched carefully	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) Refer your child for speech-language or hearing testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION IV: QUESTIONS ABOUT YOUR FAMILY

A child's doctors or other health providers sometimes ask questions about a child's family. These questions help them provide the best care possible for your child. These questions can be asked in a survey that you fill out before the visit, in the waiting room or when you talked with your child's doctor or other health provider during your child's visit.

8. Since your child was born, did your child's doctors or other health providers ask you:

	Yes	No
a) If you or someone in your household smokes	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) If you or someone in your household drinks alcohol or uses other substances	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) If you ever feel depressed, sad or have crying spells	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) If you have any firearms in your home	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) To talk about any changes or stressors in your family or home	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION V: YOUR CHILD'S PERSONAL DOCTOR OR NURSE

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

1
Yes

2
No

10. Do you have more than one person you think of as your child's personal doctor or nurse?

1
Yes

2
No

YOUR CHILD'S HEALTH CARE

SECTION VI: YOUR CHILD, YOU, AND YOUR FAMILY

These last questions are about your child, you, and your family. We are asking these questions to better understand the children and families we care for so that we can improve our services. Remember this survey is **confidential** and results will be kept completely anonymous.

11. Is the child named in this survey your first child?

1

Yes

2

No

3

The question does not apply to me

12. How long did you breastfeed your child?

1

My child was not breastfed

2

Less than a month

3

A month or more

4

I am still breastfeeding

13. How many days in **a typical week** do you or other family members read a book with your child?

1

Everyday
(7 days)

2

5-6 days

3

3-4 days

4

1-2 days

5

No Days
(0 days)

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

1

8th grade
or less

2

Some high
school, but did
not graduate

3

High school graduate
or GED

4

Some college
or 2-year degree

5

4-year college
graduate

6

More than
a 4-year college
degree

15. In the **last 12 months**, have you had two weeks or more during which you felt sad, blue, depressed or lost pleasure in things you usually cared about or enjoyed?

1

Yes

2

No

16. How much trouble have you had paying for. . .

	A Lot of Trouble	Some Trouble	No Trouble
a) Child's health and medical expenses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Supplies like formula, food, diapers, clothes and shoes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) Healthcare for yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

YOU'RE DONE!!

Thank you for completing the survey. Please put the survey in the envelope provided and drop it off in the "completed survey" box before you leave.

You have helped make a difference.

Reduced-Item PHDS for In-Office Administration

Survey for Parents of Children 10-18.99 Months Old

Your Child's Health Care

- ❖ This survey is about discussions you may have had with your child's doctors or other health providers in the last 12 months.
- ❖ By completing this survey, you are indicating that you have given your consent to participate.
- ❖ This survey is confidential. Do not write your name or your child's name on this survey.
- ❖ If you choose to not answer the survey, the decision will have no effect on the health care your child receives.
- ❖ If you begin to answer the questions and then change your mind, you may stop at any time. Also, if there are particular questions that you don't want to answer, you may skip them.

Instructions

1. Please use a BLUE or BLACK ink pen to complete this survey.
2. Answer all the questions by checking the box on top of your answer like this:

Yes No

YOUR CHILD'S HEALTH CARE

SECTION I: DISCUSSIONS WITH YOUR CHILD'S DOCTORS OR OTHER HEALTH PROVIDERS

A doctor or other health provider could be a general doctor, a specialist, a pediatrician, a nurse practitioner, a physician assistant, a nurse or any one else your child would see for health care.

1. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) Things you can do to help your child grow and learn	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) The kinds of behaviors you can expect to see in your child as he/she gets older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Vitamins and foods your child should eat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Bed and naptime routines	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Words and phrases your child uses and understands	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Night waking and fussing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Whether your child sleeps with a bottle	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Weaning your child from a bottle	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

2. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) How your child may start to explore away from you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Guidance and discipline techniques to use with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Toilet training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) What you should do if your child swallows certain kinds of poisons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Using a car-seat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) How to make your house safe	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Importance of reading with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Issues related to childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

YOUR CHILD'S HEALTH CARE

SECTION II: EXPERIENCE OF CARE

The next questions ask about your overall experiences with the health care your child has received from his or her doctors or other health providers in the last 12 months.

3. In the last 12 months , how often did your child's doctors or other health providers . . .	Never	Sometimes	Usually	Always
a) Take time to understand the specific needs of your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Respect you as an expert about your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Help you feel like a partner in your child's care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Explain things in a way that you can understand	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Show respect for your family's values, customs and how you prefer to raise your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION III: HEALTH CONCERNS ABOUT YOUR CHILD

The next few questions ask about concerns parents or guardians sometimes have about their child.

4.* Do you have any concerns about . . .	Yes	A little	Not at all
a) Your child's learning, development or behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) How your child talks and makes speech sounds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) How your child understands what you say	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) How your child uses his or her arms and legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) How your child behaves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) How your child gets along with others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

5. In the **last 12 months**, did your child's doctors or other health providers ask if you have concerns about your child's learning, development or behavior?

1
Yes

2
No

3
I don't remember

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YOUR CHILD'S HEALTH CARE

6. In the **last 12 months**, did your child's doctors or other health providers give you specific information to address your concerns?

- ¹ Yes
 ² No
 ³ I don't remember
 ⁴ I did not have any concerns

7. Did your child's doctors or other health providers ever:

	Yes	No
a) Refer your child to another doctor or other health provider	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) Test your child's learning and behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) Note a concern about your child that should be watched carefully	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) Refer your child for speech-language or hearing testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION IV: QUESTIONS ABOUT YOUR FAMILY

A child's doctors or other health providers sometimes ask questions about a child's family. These questions help them provide the best care possible for your child. These questions can be asked in a survey that you fill out before the visit, in the waiting room or when you talked with your child's doctor or other health provider during your child's visit.

8. In the **last 12 months**, did your child's doctors or other health providers **ask** you:

	Yes	No
a) If you or someone in your household smokes	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) If you or someone in your household drinks alcohol or uses other substances	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) If you ever feel depressed, sad or have crying spells	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) If you have any firearms in your home	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) To talk about any changes or stressors in your family or home	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION V: YOUR CHILD'S PERSONAL DOCTOR OR NURSE

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

- ¹ Yes
 ² No

10. Do you have more than one person you think of as your child's personal doctor or nurse?

- ¹ Yes
 ² No

YOUR CHILD'S HEALTH CARE

SECTION VI: YOUR CHILD, YOU, AND YOUR FAMILY

These last questions are about your child, you, and your family. We are asking these questions to better understand the children and families we care for so that we can improve our services. Remember this survey is **confidential** and results will be kept completely anonymous.

11. Is the child named in this survey your first child?

1
Yes

2
No

3
The question does not
apply to me

12. How long did you breastfeed your child?

1
My child was not breastfed

2
Less than a month

3
A month or more

4
I am still breastfeeding

13. How many days in **a typical week** do you or other family members read a book with your child?

1
Everyday
(7 days)

2
5-6 days

3
3-4 days

4
1-2 days

5
No Days
(0 days)

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

1
8th grade
or less

2
Some high
school, but did
not graduate

3
High school graduate
or GED

4
Some college
or 2-year degree

5
4-year college
graduate

6
More than
a 4-year college
degree

15. In the **last 12 months**, have you had two weeks or more during which you felt sad, blue, depressed or lost pleasure in things you usually cared about or enjoyed?

1
Yes

2
No

16. How much trouble have you had paying for . . .

	A Lot of Trouble	Some Trouble	No Trouble
a) Child's health and medical expenses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Supplies like formula, food, diapers, clothes and shoes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) Healthcare for yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

YOU'RE DONE!!

Thank you for completing the survey. Please put the survey in the envelope provided and drop it off in the "completed survey" box before you leave.

You have helped make a difference.

Reduced-Item PHDS for In-Office Administration

Survey for Parents of Children 19-46.99 Months Old

Your Child's Health Care

- ❖ This survey is about discussions you may have had with your child's doctors or other health providers in the last 12 months.
- ❖ By completing this survey, you are indicating that you have given your consent to participate.
- ❖ This survey is confidential. Do not write your name or your child's name on this survey.
- ❖ If you choose to not answer the survey, the decision will have no effect on the health care your child receives.
- ❖ If you begin to answer the questions and then change your mind, you may stop at any time. Also, if there are particular questions that you don't want to answer, you may skip them.

Instructions

1. Please use a BLUE or BLACK ink pen to complete this survey.
2. Answer all the questions by checking the box on top of your answer like this:

Yes No

YOUR CHILD'S HEALTH CARE

SECTION I: DISCUSSIONS WITH YOUR CHILD'S DOCTORS OR OTHER HEALTH PROVIDERS

A doctor or other health provider could be a general doctor, a specialist, a pediatrician, a nurse practitioner, a physician assistant, a nurse or any one else your child would see for health care.

1. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) Things you can do to help your child grow and learn	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) The kinds of behaviors you can expect to see in your child as he/she gets older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Issues related to food and feeding	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Bedtime routines and how many hours of sleep your child needs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Toilet training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Words and phrases your child uses and understands	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) How your child is learning to get along with other children	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

2. In the last 12 months , did your child's doctors or other health providers talk with you about the following:	YES, and my questions were answered	YES, but my questions were not answered completely	NO, but I wish we had talked about that	NO, but I already had information about this topic and did not need to talk about it any more
a) Guidance and discipline techniques to use with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Ways to teach your child about dangerous situations, places and objects	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Using a car-seat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) How to make your house safe	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) What you should do if your child swallows certain kinds of poisons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Importance of reading with your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Issues related to childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

YOUR CHILD'S HEALTH CARE

SECTION II: EXPERIENCE OF CARE

The next questions ask about your overall experiences with the health care your child has received from his or her doctors or other health providers in the last 12 months.

	Never	Sometimes	Usually	Always
3. In the last 12 months , how often did your child's doctors or other health providers. . .				
a) Take time to understand the specific needs of your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Respect you as an expert about your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Help you feel like a partner in your child's care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Explain things in a way that you can understand	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Show respect for your family's values, customs and how you prefer to raise your child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION III: HEALTH CONCERNS ABOUT YOUR CHILD

The next few questions ask about concerns parents or guardians sometimes have about their child.

	Yes	A little	Not at all
4.* Do you have any concerns about . . .			
a) Your child's learning, development or behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) How your child talks and makes speech sounds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) How your child understands what you say	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) How your child uses his or her arms and legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) How your child behaves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) How your child gets along with others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

5. In the **last 12 months**, did your child's doctors or other health providers ask if you have concerns about your child's learning, development or behavior?

1
Yes

2
No

3
I don't remember

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YOUR CHILD'S HEALTH CARE

6. In the **last 12 months**, did your child's doctors or other health providers give you specific information to address your concerns?

- 1** Yes
 2 No
 3 I don't remember
 4 I did not have any concerns

7. Did your child's doctors or other health providers ever:

	Yes	No
a) Refer your child to another doctor or other health provider	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) Test your child's learning and behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) Note a concern about your child that should be watched carefully	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) Refer your child for speech-language or hearing testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION IV: QUESTIONS ABOUT YOUR FAMILY

A child's doctors or other health providers sometimes ask questions about a child's family. These questions help them provide the best care possible for your child. These questions can be asked in a survey that you fill out before the visit, in the waiting room or when you talked with your child's doctor or other health provider during your child's visit.

8. In the **last 12 months**, did your child's doctors or other health providers **ask** you:

	Yes	No
a) If you or someone in your household smokes	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) If you or someone in your household drinks alcohol or uses other substances	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) If you ever feel depressed, sad or have crying spells	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) If you have any firearms in your home	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) To talk about any changes or stressors in your family or home	1 <input type="checkbox"/>	2 <input type="checkbox"/>

SECTION V: YOUR CHILD'S PERSONAL DOCTOR OR NURSE

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

- 1** Yes
 2 No

10. Do you have more than one person you think of as your child's personal doctor or nurse?

- 1** Yes
 2 No

SECTION VI: YOUR CHILD, YOU, AND YOUR FAMILY

These last questions are about your child, you, and your family. We are asking these questions to better understand the children and families we care for so that we can improve our services. Remember this survey is **confidential** and results will be kept completely anonymous.

11. Is the child named in this survey your first child?

1
Yes

2
No

3
The question does not
apply to me

12. How long did you breastfeed your child?

1
My child was not breastfed

2
Less than a month

3
A month or more

4
I am still breastfeeding

13. How many days in **a typical week** do you or other family members read a book with your child?

1
Everyday
(7 days)

2
5-6 days

3
3-4 days

4
1-2 days

5
No Days
(0 days)

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

1
8th grade
or less

2
Some high
school, but did
not graduate

3
High school graduate
or GED

4
Some college
or 2-year degree

5
4-year college
graduate

6
More than
a 4-year college
degree

15. In the **last 12 months**, have you had two weeks or more during which you felt sad, blue, depressed or lost pleasure in things you usually cared about or enjoyed?

1
Yes

2
No

16. How much trouble have you had paying for . . .

	A Lot of Trouble	Some Trouble	No Trouble
a) Child's health and medical expenses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Supplies like formula, food, diapers, clothes and shoes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) Healthcare for yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

YOU'RE DONE!!

Thank you for completing the survey. Please put the survey in the envelope provided and drop it off in the "completed survey" box before you leave.

You have helped make a difference.

--IMPORTANT NOTE--

If health care provider-level information is desired then health care provider level sampling is conducted.

However, in some practices, this is not possible due to office-level approaches to care that do not make health care provider level sampling feasible (for example: person who prepares the charts does so for all patients who come to the office that day and not for individual health care providers).

If this is the case, then a question should be added to ~~after~~ question 10 that asks parents report which doctor or other health care providers are their child's personal doctor or nurse. The health care providers in the office are then listed, including physicians and nurses that provide well-child care.

Health care provider-level analyses is performed only for those parents who noted that health care provider as their child's personal doctor or nurse.

Below is an example of a question that can inserted in to the survey to allow for health care provider-level analysis.

12. Which of these people do you think of as your child's personal doctor or nurse? **Please mark one or more.**

1 2 3 4 5 6
Doctor A Doctor B Doctor C Nurse D Nurse E Nurse F

7
Other Person (Name Not Listed Above)