Cook Children’s Community-wide Children’s Health Assessment and Planning Survey [CCHAPS]

Please take time to complete this important survey. The results of this survey will be used to improve the quality of children’s health programs and services in the community where you live. If you have questions about the survey please go to www.cookhealthsurvey.com. THANK YOU in advance for your support of this important effort. Your answers will remain confidential.

Do you have any children under age 15 living in your home (this includes children who are not related to you)?
____ (1) Yes – continue  ____ (2) No - END THE SURVEY; this survey is intended for households with children under age 15

1. What are the ages of all children under age 15 who are currently living in your home? (Write the age of each child in your household (up to 6) in the spaces provided below; if a child is less than 1 year old, write “0”.)

   Child 1 _____  Child 2 _____  Child 3 _____  Child 4 _____  Child 5 _____  Child 6 ______

The remaining questions on this survey are intended to be about a specific child under age 15. In order for our survey to be representative of all children in the area where you live, we would like you to answer the following questions about the child in your household who is under age 15 and will celebrate their birthday next.

If you do not feel comfortable answering one or more questions, just leave the question(s) blank.
All of your responses will remain confidential.

2. How old is the child about whom you will be answering the following questions? _____ Years (Should be under age 15)

3. What is your relationship to this child?
   ____(1) Father  ____ (5) Grandmother  ____ (9) Foster parent
   ____ (2) Mother  ____ (6) Grandfather  ____ (0) Other: __________________
   ____ (3) Step-father  ____ (7) Aunt/Uncle
   ____ (4) Step-mother  ____ (8) Brother/Sister

4. What is this child’s gender? ____(1) Male  ____(2) Female

5. Is this child Hispanic or Latino?  ____(1) Yes  ____ (2) No

6. Which of the following describe this child’s race? (Check all that apply)
   ____ (1) Asian/Pacific Islander  ____ (3) American Indian/Alaskan Native  ____ (5) Other: __________________
   ____ (2) African American/Black  ____ (4) White/Caucasian

7. Does this child’s primary caregiver speak English fluently?  ____(1) Yes  ____ (2) No

PHYSICAL HEALTH

8. In general, how would you describe this child’s health?
   ____ (5) Excellent  ____ (4) Very Good  ____ (3) Good  ____ (2) Fair  ____ (1) Poor

9. Approximately, how tall is this child? _______ Inches  (or ________ Centimeters)

10. Approximately, how much does this child currently weigh? _________ Pounds  (or _________ Kilograms)

11. How many days did this child have at least 30 minutes of physical activity during the past 7 days?
    ____ (1) None  ____ (2) One to three days  ____ (3) Four to six days  ____ (4) Seven days

12. Do you think this child typically eats healthy meals? ____ (1) Yes  ____ (2) No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has a doctor or health professional ever told you that the child you selected in Question #2 has asthma?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>13a. If YES to #13: Does this child currently have asthma?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Does this child have an individualized asthma action plan?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Does this child have asthma symptoms or take quick relief inhaler more than two times per week?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. Does this child awaken at night with asthma symptoms more than two times per month?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>E. Have you refilled this child's relief inhaler more than two times in the past year?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>F. Is this child able to participate in Physical Education at school or other physical activity?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>G. Has this child been in an emergency room in the past year because of asthma symptoms?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>14. Please indicate whether a doctor or health professional has ever told you that the child you selected in Question #2 has any of the following conditions:</td>
<td>Yes</td>
<td>No</td>
<td>Don't Know/NA</td>
</tr>
<tr>
<td>A. An iron deficiency</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>B. Blindness or other vision problems that cannot be corrected with glasses or contacts</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Bone, joint, or muscle problems</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. Hearing loss</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>E. Diabetes</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>15. Has this child ever had the following conditions? (If you are not sure, circle “9”.)</td>
<td>Yes</td>
<td>No</td>
<td>Don't Know/NA</td>
</tr>
<tr>
<td>A. Allergies (e.g., hay fever, any kind of respiratory allergy, food/digestive allergy, skin rash/skin allergy)</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>B. Frequent or severe headaches, including migraines</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Stuttering, stammering, or other speech problems</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. A chronic physical condition that has limited his/her activity</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>16. Please answer the following questions YES or NO about this child. If you are not sure, circle “9”.</td>
<td>Yes</td>
<td>No</td>
<td>Don’t Know/NA</td>
</tr>
<tr>
<td>A. Has this child had a vision screening during the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>B. Are this child’s vaccinations up-to-date for a child of his/her age?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Has this child’s blood pressure been checked during the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. Does this child receive free or discounted meals at school?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>E. Does this child receive assistance from WIC?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>F. Do you receive food stamps for this child?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>G. Are you concerned that this child may be overweight?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>H. Are you concerned that this child may be underweight?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>I. Has this child ever been pregnant?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>J. Has this child ever had a sexually transmitted disease?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>K. Has this child ever had a hearing screening?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>17. Was this child breastfed or receive breast milk?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____(1) Yes _____(2) No _____(9) Don’t Know/NA</td>
<td></td>
<td></td>
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<tr>
<td>17a. IF YES to #17: How long was this child breastfed or receive breast milk?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>_____(1) Up to 6 weeks _____(2) 7 weeks – 6 months _____(3) 7-12 months _____(4) more than 12 months</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17b. IF YES to #17: How old was this child when he/she was first fed anything other than breast milk?</td>
<td></td>
<td></td>
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<tr>
<td>_______ months</td>
<td></td>
<td></td>
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</tbody>
</table>
DENTAL/ORAL HEALTH

18. How much does this child’s dental health affect his/her overall health?
   ___(1) A lot   ___(2) Some   ___(3) Very little   ___(4) Not at all   ___(9) Don’t know

19. How important do you think dental check-ups, cleanings, and other preventive dental care services are to the overall health of this child?
   ___(1) Extremely important   ___(2) Very important   ___(3) Important   ___(4) Not Important   ___(5) Not important at all

20. Please answer the following questions YES or NO about the child you selected in Question #2. If you are not sure, circle “9”.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Does this child have his/her own toothbrush?</td>
<td>1</td>
</tr>
<tr>
<td>B.</td>
<td>Did this child brush his/her teeth yesterday?</td>
<td>1</td>
</tr>
<tr>
<td>C.</td>
<td>Has this child visited a dentist for a dental exam during the past 12 months?</td>
<td>1</td>
</tr>
<tr>
<td>D.</td>
<td>Has this child had his/her teeth professionally cleaned during the past 12 months?</td>
<td>1</td>
</tr>
<tr>
<td>E.</td>
<td>Has this child had dental sealants placed on his/her teeth during the past 12 months?</td>
<td>1</td>
</tr>
<tr>
<td>F.</td>
<td>Has this child had fluoride varnish applied by a dental professional during the past 12 months?</td>
<td>1</td>
</tr>
<tr>
<td>G.</td>
<td>Has a dentist had to fix anything in this child’s mouth during the past 12 months, such as fillings, crowns, etc.?</td>
<td>1</td>
</tr>
<tr>
<td>H.</td>
<td>To the best of your knowledge, has this child had a toothache during the past 6 months?</td>
<td>1</td>
</tr>
<tr>
<td>I.</td>
<td>To the best of your knowledge, has this child had decayed teeth or cavities during the past 6 months?</td>
<td>1</td>
</tr>
<tr>
<td>J.</td>
<td>To the best of your knowledge, has this child had broken teeth during the past 6 months?</td>
<td>1</td>
</tr>
<tr>
<td>K.</td>
<td>To the best of your knowledge, has this child had bleeding gums during the past 6 months?</td>
<td>1</td>
</tr>
</tbody>
</table>

21. Does this child have insurance, Medicaid or CHIP that helps pay for routine dental care including cleanings, X-rays, and examinations?
   ___(1) Yes   ___(2) No

22. During the past 12 months, did this child receive all the dental care that he/she needed or should have received?
   ___(1) Yes   ___(2) No - answer Q22a

22a. [IF NO to #22] Why did this child not get all the dental care that he/she needed? (Check all that apply)
   ___(01) Could not afford   ___(06) Afraid to go to the dentist
   ___(02) Not covered by insurance   ___(07) Lack of transportation
   ___(03) Could not get in to see a dentist   ___(08) Could not find a dentist who accepts Medicaid
   ___(04) Did not know where to go   ___(09) Could not find a dentist who accepts CHIP
   ___(05) Dental facilities are not available   ___(10) Other: ________________________

23. Has this child ever gone to the Emergency Room because of dental pain? ___(1) Yes  ___(2) No

24. Has this child ever missed school because of dental pain?
   ___(1) Yes: How many days did he/she miss? ________ days
   ___(2) No

25. At what age do you think a child should first visit a dentist?
   ___(1) 1 year   ___(2) 2 years   ___(3) 3 years   ___(4) When permanent teeth come in   ___(9) Don’t know

EMOTIONAL/BEHAVIORAL HEALTH

26. During the past week, how many days did this child play with other children [his/her] age?
   ___(1) Every day   ___(2) Every other day   ___(3) Once a week   ___(4) Once a month   ___(5) Less than once/month

27. Does this child regularly exhibit problematic social behaviors?
   ___(1) Yes   ___(2) No
28. Has this child ever done any of the following. If you don’t know, circle “9”.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't Know/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Been arrested or in trouble with the police?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>B. Had academic problems at school?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Had behavior problems at school?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. Been suspended from daycare, school, or a program of activities due to “reported” behavioral problems?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>E. Been bullied or teased a lot at school?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>F. Bullied other children?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>G. Do you believe this child has been a victim of cyberbullying, sexting or online child abuse?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>H. Attempted suicide?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

29. Have you ever been told by a doctor or healthcare professional that this child has a mental illness or disorder?

   ___(1) Yes – answer #29a  ___(2) No

29a. IF YES to #29: Which of following illnesses were you told that this child has (or used to have)? (Check all)

   ___(01) ADD or ADHD (Attention Deficit Disorder or Attention Deficit Hyperactive Disorder)
   ___(02) Anxiety problems including Obsessive-Compulsive Disorder
   ___(03) Autism Spectrum Disorders (Autism, Asperger’s Syndrome, etc.)
   ___(04) Bipolar Disorder
   ___(05) Conduct Disorder, Oppositional-Defiant Disorder, or Intermittent Explosive Disorder
   ___(06) Eating Disorder (such as anorexia, bulimia, binge or night eating syndrome).
   ___(07) Learning Disorder
   ___(08) Major or Severe Depression
   ___(09) Schizophrenia
   ___(10) Other Mood Disorder
   ___(11) Alcohol or Drug Abuse or Dependence
   ___(12) Post-traumatic stress disorder
   ___(13) Other: ___________________________

30. Has this child ever needed mental healthcare but not received it?  ___(1) Yes – answer Q30a  ___(2) No

30a. IF YES to #30: Why did this child not get all the mental healthcare that he/she needed? (Check all that apply)

   ___(01) Could not afford
   ___(02) Not covered by insurance
   ___(03) Could not get in to see a doctor/healthcare professional
   ___(04) Did not know where to get help
   ___(05) Mental health facilities are not available
   ___(06) Child is afraid to go to a mental health professional
   ___(07) Did not want others to know about the child’s problem
   ___(08) Afraid that services might not be confidential or that providers might report you to other agencies
   ___(09) You or another caregiver did not think the child really needed help at the time
   ___(10) You or others did not think anything could be done to help the child
   ___(11) Lack of transportation
   ___(12) Could not find a mental health professional who accepts Medicaid/CHIP
   ___(13) Inability to access during convenient (i.e., evening or weekend) hours
   ___(14) Unacceptably long waiting list
   ___(15) Other: ___________________________

31. Has this child ever done any of the following. If you don’t know, circle “9”.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't Know/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Deliberately Cut or hurt him/herself?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>B. Been in more than one fight during the past year?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>C. Had self-esteem problems?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>D. Had sleep problems?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>E. Experienced something traumatic such as a natural disaster, accident, violence, neglect, or abuse?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>F. Had negative, obsessive thoughts?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>G. Had problems with eating such as overeating or refusing to eat enough?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>H. Been cruel to animals?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>I. Frequently wetted the bed after age 5?</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>
32. Have you ever been told by a doctor or healthcare professional that this child has a developmental delay?
   ___(1) Yes  ___(2) No

33. In your opinion, does the child you selected in Question #2 have any behavioral, emotional, or developmental problems outside of what you would consider typical for a child his or her age?
   ___(1) Yes  ___(2) No

34. Has this child ever received assistance for a mental illness or a behavioral, emotional, or developmental problem?  ___(1) Yes – answer #34a  ___(2) No

34a. IF YES to #34: Which of following types of treatment has this child received?  (Check all that apply)
   ___(1) Counseling or Therapy  
   ___(2) Medication  
   ___(3) Special services at school including school counseling, individual education plans (IEP), 504 plans, etc.  
   ___(4) Hospitalization  
   ___(5) Support from friends, extended family, church members, or other community members  
   ___(6) Case management, wraparound, multi-systemic therapy (MST), or service coordination  
   ___(7) Other: _____________________________

HEALTH INSURANCE

35. Does the child you selected in Question #2 have any kind of healthcare coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicaid or CHIP?
   ___(1) Yes - answer Q35a  
   ___(2) No

36. During the past 12 months was there any time that this child was NOT covered by health insurance?
   ___(1) Yes  ___(2) No

ACCESS TO CARE

37. During the past 12 months, did this child see a doctor, nurse, or other healthcare professional for any kind of medical care, including sick-child care, well-child care checkups, etc.?
   ___(1) Yes – answer #37a  
   ___(2) No

37a. [IF YES to #37] How many times did this child visit a doctor, nurse, or other healthcare professional for any reason during the past 12 months?  
   ________ Times

38. Does this child have any specialized healthcare needs for a child his/her age?
   ___(1) Yes – what type of needs does this child have? ________________________________  
   ___(2) No

39. At which of the following places has this child received healthcare services during the past year?
   ___(1) School  
   ___(2) Family doctor  
   ___(3) Pediatrician  
   ___(4) Emergency room  
   ___(5) Community health clinic  
   ___(6) Urgent care centers – (excludes hospital emergency rooms)  
   ___(7) Chiropractor  
   ___(8) Friend/Family member  
   ___(9) Other: _______________________________

40. Does this child have a doctor that you would consider to be this child’s primary doctor?  ___(1) Yes  ___(2) No

41. How many days did this child spend in the hospital during the past 12 months?  ________ Days

41a. If #41 is more than “0”, for which of the following reasons did this child spend the night in the hospital?  (Check all that apply)
   ___(1) Illness  ___(2) Surgery  ___(3) Asthma  ___(4) Injury  ___(5) other: ________________________________
42. During the past 12 months, did this child receive all the medical care that he/she needed?
   ___(1) Yes   ___(2) No - answer Q42a

42a. [IF NO to #42] Why did this child not get all the medical care that he/she needed? (Check all that apply)
   ___(1) Could not afford
   ___(2) Not covered by insurance
   ___(3) Could not get in to see a doctor/healthcare professional
   ___(4) Did not know where to go
   ___(5) Health facilities are not available
   ___(6) Child is afraid to go to the doctor
   ___(7) Lack of transportation
   ___(8) Could not find a doctor who accepts Medicaid/CHIP
   ___(9) Other: __________________________

43. Approximately how many days of school did this child miss last year due to illness of health problems?
   _______ Days

44. During the past 12 months, did this child receive all the medication that was prescribed for him/her?
   ___(1) Yes   ___(2) No - answer Q44a

44a. [IF NO to #44] Why did this child not get all of his/her medication? (Check all that apply)
   ___(1) Could not afford
   ___(2) Could not get in to see a doctor/healthcare professional to get a prescription
   ___(3) Parent unable to administer medication
   ___(4) Lack of transportation
   ___(5) Other: __________________________

SAFETY/COMMUNITY SURROUNDINGS

45. How many hours of sleep did this child get yesterday? _________ Hours

46. Please rate your level of agreement with each of the following statements.   If you do not know, circle “9”.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. I feel that this child is safe in our neighborhood</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>B. I feel that this child is safe at school</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>C. I feel that this child is safe at home</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

47. How many times did this child visit an Emergency Room (ER) during the past 12 months? _____ Times

47a. If this child visited an Emergency Room for an injury during the past 12 months, how did the injury occur? (Check all that apply)
   ___(1) from skate boarding, roller blading or non-powered scooter
   ___(2) from biking
   ___(3) from a fall (excluding falls from skate boards, bikes, etc., which are covered above)
   ___(4) a motor vehicle crash
   ___(5) a physical assault
   ___(6) a sexual assault
   ___(7) a burn
   ___(8) from farm-related equipment or a farm animal
   ___(9) other: __________________________

48. If #48 is more than “0”, for which of the following reasons did this child visit the emergency room?
   ___(1) high fever/illness
   ___(2) poisoning/overdose
   ___(3) gun shot
   ___(4) injury (other than a gunshot)
   ___(5) asthma or breathing difficulty
   ___(6) abdominal pain
   ___(7) head pain
   ___(8) other: __________________________
FAMILY ACTIVITY
49. During the past month, how many times did you or any family member take this child on an outing, such as to the park, library, zoo, sporting event, shopping, religious activity, or family gathering? _______ times

50. How many days did someone in your household read to this child during the past week? _______ Days

51. How many minutes did someone in your household read to this child yesterday? ______ Minutes (Enter “0” if none)

52. During the past 12 months has this child done any volunteer work in the community? ___(1) Yes ___(2) No

PARENTAL QUESTIONS
53. Overall, how important do you think it is for this child to have routine well visits and other preventive medical care?
   ___(1) Extremely Important ___(4) Not Very Important
   ___(2) Very Important ___(5) Not Important at All
   ___(3) Important

54. Would you describe your relationship with the child you selected in Question #2 as:
   ___(4) Very close ___(3) Somewhat close ___(2) Not very close ___(1) Not close at all

55. In general, how well do you think you are coping with the day-to-day demands of parenthood?
   ___(4) Very well ___(3) Somewhat well ___(2) Not very well ___(1) Not well at all

56. Is there someone you can really rely on for day-to-day emotional help and support with parenting?
   ___(1) Yes ___(2) No

AWARENESS/EDUCATION
57. From which of the following sources do you typically get information about issues that affect the health of this child?
   ___(01) this child’s personal doctor ___(06) your insurance company
   ___(02) local hospitals ___(07) non-profit organizations
   ___(03) the Internet ___(08) this child’s school
   ___(04) media (TV, radio, newspaper) ___(09) friends/relatives
   ___(05) books ___(10) other: _______________________________

DEMOGRAPHICS AND NEIGHBORHOOD CHARACTERISTICS
58. What is the primary language spoken in your household?
   ___(1) Spanish ___(2) English ___(3) Other (identify language: _______________________________

59. Did you participate in the 2008 Cook Children’s Health Survey? ___(1) Yes ___(2) No

60. How many years have you lived in community where you currently live? _______ years

61. What is the highest level of education you have completed?
   ___(1) Less than high school graduate ___(4) 2-Year college/Technical certification program
   ___(2) High school graduate ___(5) 4-Year college degree
   ___(3) Some college ___(6) more than 4-years of college

62. What is your total annual household income?
   ___(01) Less $14,000 ___(05) $35,000-$49,999 ___(09) $80,000-$89,999
   ___(02) $14,000-$20,999 ___(06) $50,000-$59,999 ___(10) $90,000-$99,999
   ___(03) $21,000-$27,999 ___(07) $60,000-$69,999 ___(11) $100,000 or more
   ___(04) $28,000-$34,999 ___(08) $70,000-$79,999 ___(99) Prefer not to disclose

THANK YOU. THIS CONCLUDES THE SURVEY.
Please return your survey in the postage-paid envelope addressed to
ETC Institute, 725 W Frontier, Olathe KS 66061

Your responses will remain completely confidential