

# Cook Children's Community-wide Children's Health Assessment and Planning Survey [CCHAPS] – Version 1

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](http://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)      \_\_\_\_\_ Months (if under the age of 1)

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 your marital status?

(1) Single, never married       (3) Widowed       (5) Separated  
 (2) Married or domestic partner       (4) Divorced

5. What is the child's gender?       (1) Male       (2) Female

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

7. Which of the following describe this child's race? (Check all that apply)

(1) Asian/Pacific Islander       (4) Hispanic/Latino  
 (2) African American/Black       (5) White/Caucasian  
 (3) American Indian/Alaskan Native       (6) Other: \_\_\_\_\_

## 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? \_\_\_\_\_ Ft.      \_\_\_\_\_ Inches

10. Approximately, how much does this child currently weigh? \_\_\_\_\_ Pounds

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 eats healthy meals most of the time? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

Asthma		Yes	No	Don't Know/NA
13. Has a doctor or health professional ever told you that the child you selected in Question #2 has asthma?		1	2	9
13a. If YES to #13: Does this child currently have asthma?		1	2	9
If YES to #13a, please answer #13a(1-6)	1. Does this child have an individualized asthma action plan?	1	2	9
	2. Does this child have asthma symptoms or take quick relief inhaler more than two times per week?	1	2	9
	3. Does this child awaken at night with asthma symptoms more than two times per month?	1	2	9
	4. Have you refilled this child's relief inhaler more than two times in the past year?	1	2	9
	5. Is this child able to participate in Physical Education at school or other physical activity?	1	2	9
	6. Has this child been in an emergency room in the past year because of asthma symptoms?	1	2	9

14. Has this child ever had allergies (e.g. hay fever, any kind of respiratory allergy not asthma, food/digestive allergy, skin rash/skin allergy)?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

15. Are this child's vaccinations up-to-date for a child of his/her age? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

16. Are you concerned that this child may be overweight? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

17. Are you concerned that this child may be underweight? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

18. How many 8 ounce servings of the following did this child drink yesterday?

(A) Water: \_\_\_ servings (B) Juice: \_\_\_ servings (C) Soda/pop: \_\_\_ servings (D) Milk: \_\_\_ servings

19. Was this child breastfed or did the child receive breast milk? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

19a. IF YES to #19: How long was this child breastfed or receive breast milk?

\_\_\_(1) Up to 6 weeks \_\_\_(2) 7 weeks – 6 months \_\_\_(3) 7-12 months \_\_\_(4) more than 12 months

19b. IF YES to #19: How old was this child when he/she was first fed anything other than breast milk?

\_\_\_\_\_ months

## DENTAL/ORAL HEALTH

20. 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

21. 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

22. Please answer the following questions YES or NO about the child you selected in Question #2. If you are not sure, circle "9".		Yes	No	Don't Know/NA
1.	Does this child have his/her own toothbrush?	1	2	9
2.	Did this child brush his/her teeth yesterday?	1	2	9
3.	Has this child visited a dentist for a dental exam during the past 12 months?	1	2	9
4.	Has this child had his/her teeth professionally cleaned during the past 12 months?	1	2	9
5.	Has this child had dental sealants placed on his/her teeth during the past 12 months?	1	2	9
6.	Has this child had fluoride varnish applied by a dental professional during the past 12 months?	1	2	9
7.	Has this child ever had any dental problems (toothache, decayed teeth or cavities, broken teeth, bleeding gums)?	1	2	9
8.	Has a dentist had to fix anything in this child's mouth during the past 12 months, such as fillings, crowns, etc.?	1	2	9

23. 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 \_\_\_(9) Don't know

24. 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 Q27a \_\_\_(9) Don't know

24a. [IF NO to #24] Why did this child not get all the dental care that he/she needed? (Check all that apply)

- |   |   |
|---|---|
| ___(01) Could not afford                    | ___(07) Lack of transportation                        |
| ___(02) Not covered by insurance            | ___(08) Could not find a dentist who accepts Medicaid |
| ___(03) Could not get in to see a dentist   | ___(09) Could not find a dentist who accepts CHIP     |
| ___(04) Did not know where to go            | ___(10) Child not old enough                          |
| ___(05) Dental facilities are not available | ___(11) Other: _____                                  |
| ___(06) Afraid to go to the dentist         |   |

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

26. Has this child ever missed school because of dental pain?

\_\_\_(1) Yes: How many days did he/she miss? \_\_\_\_\_ days

\_\_\_(2) No

### EMOTIONAL/BEHAVIORAL HEALTH

27. 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

28. Does this child regularly exhibit problematic social behaviors? \_\_\_(1) Yes \_\_\_(2) No

29. Has this child ever been arrested or in trouble with the police? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

30. Has this child ever had academic problems at school? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

31. Has this child ever had behavior problems at school? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

32. Has this child ever been suspended from daycare, school, or a program of activities due to "reported" behavioral problems?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

33. Has this child ever been bullied or teased a lot at school? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

34. Has this child ever bullied other children? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

35. Has this child ever been a victim of cyberbullying, sexting, or online child abuse?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

36. Has this child ever attempted suicide? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

37. Have you ever been told by a doctor or healthcare professional that this child has a mental illness or disorder? \_\_\_(1) Yes – answer Q39a \_\_\_(2) No \_\_\_(9) Don't know

37a. IF YES to #37: Which of following illnesses were you told that this child has (or used to have)?

(Check all that apply)

\_\_\_(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) Severe Behavior Problems/Disruptive Behavior problems

\_\_\_(05) Eating Disorder (such as anorexia, bulimia, binge or night eating syndrome).

\_\_\_(06) Learning Disorder

\_\_\_(07) Depression

\_\_\_(08) Mood Disorder

\_\_\_(09) Post-traumatic stress disorder

\_\_\_(10) Adjustment disorder

\_\_\_(11) Other: \_\_\_\_\_

38. Has this child ever needed mental healthcare but not received it?

\_\_\_(1) Yes – answer Q41a \_\_\_(2) No \_\_\_(9) Don't know

38a. IF YES to #38: 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: \_\_\_\_\_

39. Has this child ever done any of the following. If you don't know, circle "9".		Yes	No	Don't Know/NA
1.	Deliberately cut or hurt him/herself?	1	2	9
2.	Been in more than one fight during the past year?	1	2	9
3.	Had self-esteem problems?	1	2	9
4.	Had sleep problems?	1	2	9
5.	Experienced something traumatic such as a natural disaster, accident, violence, neglect, or abuse?	1	2	9
6.	Had negative, obsessive thoughts?	1	2	9
7.	Had problems with eating such as overeating or refusing to eat enough?	1	2	9
8.	Been cruel to animals?	1	2	9
9.	Frequently wetted the bed after age 5?	1	2	9

40. Have you ever been told by a doctor or healthcare professional that this child has a developmental delay?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

41. In your opinion, does the child you selected in Question #2 have any behavioral or emotional problems outside of what you would consider typical for a child his or her age?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

42. In your opinion, does the child you selected in Question #2 have any developmental problems outside of what you would consider typical for a child his or her age?

\_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

43. Has this child ever received assistance for a mental illness or behavioral, emotional, or developmental problem? \_\_\_(1) Yes \_\_\_(2) No \_\_\_(9) Don't know

43a. IF YES to #43: Which of following types of treatment has this child received? (Check all that apply)

- |  |   |
|--|---|
| ___(1) Counseling or Therapy   | ___(5) Support from friends, extended family, church members, or other community members  |
| ___(2) Medication  | ___(6) Case management, wraparound, multi-systemic therapy (MST), or service coordination |
| ___(3) Special services at school including school counseling, individual education plans (IEP), 504 plans, etc. | ___(7) Other: _____   |
| ___(4) Hospitalization   |   |

### HEALTH INSURANCE

44. 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 \_\_\_(2) No

45. 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

46. 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 Q48a \_\_\_(2) No

46a. [IF YES to #46] How many times did this child visit a doctor, nurse, or other healthcare professional for any reason during the past 12 months? \_\_\_\_\_ Times

47. 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

48. At which of the following places has this child received healthcare services during the past year?

- |                                |  |
|--------------------------------|--|
| ___(1) School                  | ___(6) Urgent care centers – (excludes hospital emergency rooms) |
| ___(2) Family doctor           | ___(7) Chiropractor  |
| ___(3) Pediatrician            | ___(8) Friend/Family member                                      |
| ___(4) Emergency room          | ___(9) Other: _____  |
| ___(5) Community health clinic |  |

49. Does this child have a doctor that you would consider to be this child's primary doctor? \_\_\_(1) Yes \_\_\_(2) No

50. During the past 12 months, did this child receive all the medical care that he/she needed?

\_\_\_(1) Yes \_\_\_(2) No - answer Q53a

50a. [IF NO to #50] Why did this child not get all the medical care that he/she needed? (Check all that apply)

- |   |  |
|---|--|
| ___(1) Could not afford   | ___(5) Health facilities are not available               |
| ___(2) Not covered by insurance                                 | ___(6) Child is afraid to go to the doctor               |
| ___(3) Could not get in to see a doctor/healthcare professional | ___(7) Lack of transportation                            |
| ___(4) Did not know where to go                                 | ___(8) Could not find a doctor who accepts Medicaid/CHIP |
|   | ___(9) Other: _____                                      |

51. Approximately how many days of school did this child miss last year due to illness or health problems?

\_\_\_\_\_ Days

52. Approximately how many days of work did you miss last year due to illness or health problems of this child?

\_\_\_\_\_ Days

53. During the past 12 months, did this child receive all the medication that was prescribed for him/her?

\_\_\_(1) Yes      \_\_\_(2) No - answer Q56a

53a. [IF NO to #53] 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) Given to another child
- \_\_\_(6) Saved for another time
- \_\_\_(7) Other: \_\_\_\_\_

### SAFETY/COMMUNITY SURROUNDINGS

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

Statement	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Don't Know
1. I feel that this child is safe in our neighborhood	5	4	3	2	1	9
2. I feel that this child is safe at school	5	4	3	2	1	9
3. I feel that this child is safe at home	5	4	3	2	1	9

### FAMILY ACTIVITY

55. How many hours of sleep did this child get yesterday? \_\_\_\_\_ Hours

56. 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

57. How many days did someone in your household read to this child or did the child read to him/herself during the past week? \_\_\_\_\_ Days

### PARENTAL QUESTIONS

58. Overall, how important do you think it is for this child to have routine well visits and other preventive medical care?

- \_\_\_(1) Extremely Important
- \_\_\_(2) Very Important
- \_\_\_(3) Important
- \_\_\_(4) Not Very Important
- \_\_\_(5) Not Important at All

59. 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

60. 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

61. Is there someone you can really rely on for day-to-day emotional help and support with parenting?

- \_\_\_(1) Yes
- \_\_\_(2) No

62. How often do you do the following to discipline your child?		Often	Sometimes	Rarely	Never	Don't Know
1.	Raising your voice or yelling	4	3	2	1	9
2.	Spanking	4	3	2	1	9
3.	Taking away a toy or treat	4	3	2	1	9
4.	Giving a time out (making your child take a break from an activity he/she is involved in)	4	3	2	1	9
5.	Explaining why a behavior is not appropriate	4	3	2	1	9

**AWARENESS/EDUCATION**

63. From which of the following sources do you typically get information about issues that affect the health of this child?

- |  |  |
|--|--|
| <input type="checkbox"/> (01) this child's personal doctor | <input type="checkbox"/> (06) your insurance company   |
| <input type="checkbox"/> (02) local hospitals              | <input type="checkbox"/> (07) non-profit organizations |
| <input type="checkbox"/> (03) the Internet                 | <input type="checkbox"/> (08) this child's school      |
| <input type="checkbox"/> (04) media (TV, radio, newspaper) | <input type="checkbox"/> (09) friends/relatives        |
| <input type="checkbox"/> (05) books                        | <input type="checkbox"/> (10) other: _____             |

**DEMOGRAPHICS AND NEIGHBORHOOD CHARACTERISTICS**

64. How many children under age 18 currently live in your household? \_\_\_\_\_ Children

65. How many adults age 18 and older currently live in your household? \_\_\_\_\_ Adults

66. What is the primary language spoken in your household?

- (1) Spanish     (2) English     (3) Other (identify language: \_\_\_\_\_)

67. Did you participate in any of the previous health assessment surveys sponsored by Cook Children's? (check all that apply)

- (1) 2009  
 (2) 2012  
 (3) 2015

68. How many years have you lived in the community where you currently live? \_\_\_\_\_ years

69. What is the highest level of education you have completed?

- |   |   |
|---|---|
| <input type="checkbox"/> (1) Less than high school graduate | <input type="checkbox"/> (4) 2-Year college/Technical certification program |
| <input type="checkbox"/> (2) High school graduate           | <input type="checkbox"/> (5) 4-Year college degree                          |
| <input type="checkbox"/> (3) Some college                   | <input type="checkbox"/> (6) more than 4 years of college                   |

70. What is your total annual household income?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> (01) Less than \$14,000 | <input type="checkbox"/> (05) \$35,000-\$49,999 | <input type="checkbox"/> (09) \$80,000-\$89,999      |
| <input type="checkbox"/> (02) \$14,000-\$20,999  | <input type="checkbox"/> (06) \$50,000-\$59,999 | <input type="checkbox"/> (10) \$90,000-\$99,999      |
| <input type="checkbox"/> (03) \$21,000-\$27,999  | <input type="checkbox"/> (07) \$60,000-\$69,999 | <input type="checkbox"/> (11) \$100,000 or more      |
| <input type="checkbox"/> (04) \$28,000-\$34,999  | <input type="checkbox"/> (08) \$70,000-\$79,999 | <input type="checkbox"/> (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**

The address information on the label to the right will only be used to identify needs in different areas of the county where you live. If the information is not correct, please provide the correct information. If you do not want us to record your address, please leave the county name, the city and the zip code visible.