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

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

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:		Yes	No	Don't Know/NA
A.	An iron deficiency	1	2	9
B.	Blindness or other vision problems that cannot be corrected with glasses or contacts	1	2	9
C.	Bone, joint, or muscle problems	1	2	9
D.	Hearing loss	1	2	9
E.	Diabetes	1	2	9

15. Has this child ever had the following conditions? (If you are not sure, circle "9".)		Yes	No	Don't Know/NA
A.	Allergies (e.g., hay fever, any kind of respiratory allergy, food/digestive allergy, skin rash/skin allergy)	1	2	9
B.	Frequent or severe headaches, including migraines	1	2	9
C.	Stuttering, stammering, or other speech problems	1	2	9
D.	A chronic physical condition that has limited his/her activity	1	2	9

16. Please answer the following questions YES or NO about this child. If you are not sure, circle "9".		Yes	No	Don't Know/NA
A.	Has this child had a vision screening during the past 12 months?	1	2	9
B.	Are this child's vaccinations up-to-date for a child of his/her age?	1	2	9
C.	Has this child's blood pressure been checked during the past 12 months?	1	2	9
D.	Does this child receive free or discounted meals at school?	1	2	9
E.	Does this child receive assistance from WIC?	1	2	9
F.	Do you receive food stamps for this child?	1	2	9
G.	Are you concerned that this child may be overweight?	1	2	9
H.	Are you concerned that this child may be underweight?	1	2	9
I.	Has this child ever been pregnant?	1	2	9
J.	Has this child ever had a sexually transmitted disease?	1	2	9
K.	Has this child ever had a hearing screening?	1	2	9

17. Was this child breastfed or receive breast milk?

____(1) Yes ____(2) No ____(9) Don't Know/NA

DENTAL/ORAL HEALTH

18. 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
A.	Does this child have his/her own toothbrush?	1	2	9
B.	Did this child brush his/her teeth yesterday?	1	2	9
C.	Has this child visited a dentist for a dental exam during the past 12 months?	1	2	9
D.	Has this child had his/her teeth professionally cleaned during the past 12 months?	1	2	9
E.	Has this child had dental sealants placed on his/her teeth during the past 12 months?	1	2	9
F.	Has this child had fluoride varnish applied by a dental professional during the past 12 months?	1	2	9
G.	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
H.	To the best of your knowledge, has this child had a **toothache** during the past 6 months?	1	2	9
I.	To the best of your knowledge, has this child had **decayed teeth or cavities** during the past 6 months?	1	2	9
J.	To the best of your knowledge, has this child had **broken teeth** during the past 6 months?	1	2	9
K.	To the best of your knowledge, has this child had a **bleeding gums** during the past 6 months?	1	2	9

19. 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

20. 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

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

22. 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

23. 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

24. Does this child regularly exhibit problematic social behaviors?
___(1) Yes ___(2) No

25. During the past month, how often have you felt that this child is much harder to care for than most other children [his/her] age?
___(1) Every day ___(2) Every other day ___(3) Once a week ____(4) Once ___(5) Never

26. During the past month, how often have you felt angry with this child?
___(1) Every day ___(2) Every other day ___(3) Once a week ____(4) Once ___(5) Never

27. Has this child ever done any of the following. If you don't know, circle "9".		Yes	No	Don't Know/NA
A.	Been arrested or in trouble with the police?	1	2	9
B.	Had academic problems at school?	1	2	9
C.	Had behavior problems at school?	1	2	9
D.	Been suspended from daycare, school, or a program of activities due to "reported" behavioral problems?	1	2	9
E.	Been bullied or teased a lot at school?	1	2	9
F.	Bullied other children?	1	2	9
G.	Do you believe this child has been a victim of cyberbullying, sexting or online child abuse?	1	2	9
H.	Attempted suicide?	1	2	9

28. Have you ever been told by a doctor or healthcare professional that this child has a mental illness or disorder?
___(1) Yes ___(2) No

29. Has this child ever needed mental healthcare but <u>not</u> received it? ___(1) Yes ___(2) No

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

31. Have you ever been told by a doctor or healthcare professional that this child has a developmental delay?
___(1) Yes
___(2) No

32. 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

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

HEALTH INSURANCE

34. 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 Q34a
___(2) No

34a. What kind of health insurance does this child currently have? (Check all that apply)
___(1) Medicaid
___(2) CHIP
___(3) Insurance provided by the legal guardian's employer
___(4) Private insurance purchased directly by a parent or legal guardian
___(5) Insurance provided by the child's school
___(6) Other: _____

35. 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

36. 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 #36a ___(2) No

36a. [IF YES to #36] How many times did this child visit a doctor, nurse, or other healthcare professional for any reason during the past 12 months?
_____ Times

37. 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

38. 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: _____

38a. Of the places listed above, which ONE would you prefer to visit when this child is injured or not well?
(Write the number for your top choice from the list in Question 38 in the space below)

Preferred Place to Visit: _____

39. Using a scale of 1 to 5 where 5 means "very easy" and 1 means "very difficult" please rate how easy/difficult you think it is to get access to the following types of children's health services in the community where you live.

How easy is it for you to get the following types of health care services for the child you selected in Question #2?		Very Easy	Easy	Neutral	Difficult	Very Difficult	Don't Know
A.	Preventive healthcare (well-child check-ups, physicals)	5	4	3	2	1	9
B.	Immunizations	5	4	3	2	1	9
C.	Care for short-term illnesses, such as a cold or flu	5	4	3	2	1	9
D.	Care for long-term conditions, such as diabetes and asthma	5	4	3	2	1	9
E.	Treatment for injuries, such as cuts, broken bones, etc.	5	4	3	2	1	9
F.	Mental healthcare or counseling for behavioral or emotional problems	5	4	3	2	1	9
G.	Preventive dental care (dental cleanings, check-ups, etc.)	5	4	3	2	1	9
H.	Treatment for oral or dental problems and pain, such as cavities, black spots on teeth, pain while chewing, loss of appetite, etc.	5	4	3	2	1	9
I.	Specialized care for specific conditions, injuries, or illnesses	5	4	3	2	1	9

40. Which THREE of the children's health services listed above do you think are needed most in the community where you live? [Write in the letters from the list in Question 39 for your top 3 choices below.]

1st _____ 2nd _____ 3rd _____

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

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

43. During the past 12 months, did this child receive all the medical care that he/she needed?
___(1) Yes ___(2) No

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

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

SAFETY/COMMUNITY SURROUNDINGS

46. Please answer the following questions YES or NO. Please continue to answer the questions about the child you selected in Question #2. If you don't know, circle "9".		Yes	No	Don't Know/NA
A.	Was this child buckled up properly (car seat, booster seat, or seat belt) for his/her age the last time he/she rode in a car with you?	1	2	9
B.	Does this child ride on an ATV (All Terrain Vehicle)?	1	2	9
C.	Has this child ever been brought to an Emergency Room because he/she nearly drowned?	1	2	9
D.	Has this child had an accidental injury that needed medical attention during the past 12 months?	1	2	9
E.	Does this child **always** wear a helmet when biking/rollerblading/or riding a scooter more than 1 block from your home?	1	2	9
F.	Does this child **always** wear a helmet when biking/rollerblading/or riding a scooter in your driveway or within 1 block from your home?	1	2	9

47. **Please answer the following questions YES or NO.** Please continue to answer the questions about the child you selected in Question #2. If you don't know, circle "9".		Yes	No	Don't Know/NA
A.	Has there ever been an investigation by CPS related to this child?	1	2	9
B.	Do you think this child has ever been physically abused?	1	2	9
C.	Do you think this child has ever been neglected?	1	2	9
D.	Do you think this child has ever been sexually abused?	1	2	9
E.	Do you think this child has ever been psychologically abused or mistreated?	1	2	9
F.	Do you think this child has ever been threatened or hurt by gang members?	1	2	9
G.	Do you think this child has ever been taken to a family violence shelter?	1	2	9
H.	Has this child ever been in foster care or in a voluntary placement (such as a relative)?	1	2	9
I.	Has this child ever lived in an emergency shelter or with other friends/family because of homelessness?	1	2	9

FAMILY ACTIVITY

48. **Please indicate how often the following items occur:**		Daily	Weekly	Monthly	A few times per year	Seldom or Never	Don't Know
A.	Talk to the child you selected in Question 2 about healthy eating habits	5	4	3	2	1	9
B.	Talk to this child about his/her friends or companions	5	4	3	2	1	9
C.	Talk to this child about his/her interests (school, sports)	5	4	3	2	1	9
D.	Talk to this child about drugs and alcohol	5	4	3	2	1	9
E.	Talk to this child about his/her problems and concerns	5	4	3	2	1	9
F.	Talk to this child about sexual activity	5	4	3	2	1	9
G.	People smoke cigarettes in your home	5	4	3	2	1	9
H.	Alcoholic beverages are consumed in your home	5	4	3	2	1	9

49. How many minutes did this child watch television or play video games yesterday? _____ Minutes (Enter "0" if none)

50. During the past week, how many times did all members of your family eat a meal together? _____ Times

51. How many servings of vegetables did this child eat yesterday? [if none write "0"] _____ servings

52. How many servings of fruit did this child eat yesterday? [if none write "0"] _____ servings

53. During the past 30 days, how many times has this child gone to bed hungry because there was not enough food for him/her to eat? [if never write "0"] _____ times

PARENTAL QUESTIONS

54. Prior to becoming pregnant with this child was the mother's health…

____(5) Excellent ___(4) Very Good ___(3) Good ____(2) Fair ___(1) Poor

55. When the mother of this child was pregnant with him/her, did she…(Check all that apply.)

____(1) regularly visit an OB/GYN doctor
____(2) have pre-term labor
____(3) consume alcohol
____(4) smoke
____(5) get admitted to a hospital to deliver the child
____(6) gain too much weight
____(7) experience other unusual circumstances (if so, please explain: _____)
____(9) don't know

AWARENESS/EDUCATION

56. Do you think this child's personal doctor or nurse explains things in a way that you can understand?

____(1) Yes ____(2) No

57. Using a scale of 1 to 5 where 5 means "very familiar" and 1 means "not familiar at all" please rate your level of familiarity with the following items in the community where you live:

How familiar are you with the following:		Very Familiar	Familiar	Some-what Familiar	Not Very Familiar	Not Familiar at All	Don't Know
A.	The types of healthcare services that are available in your community	5	4	3	2	1	9
B.	Where you can get information about health issues that affect this child	5	4	3	2	1	9
C.	The types of mental health services that are available in your community	5	4	3	2	1	9
D.	The types of social services that are available in your community	5	4	3	2	1	9
E.	The types of dental services available in your community	5	4	3	2	1	9
F.	The types of injury prevention programs available in your community	5	4	3	2	1	9

58. Overall, how well informed do you think you are about health issues that affect this child?

___(1) very well informed
___(2) well informed
___(3) somewhat well informed
___(4) not well informed
___(5) not well informed at all

DEMOGRAPHICS AND NEIGHBORHOOD CHARACTERISTICS

59. Are there grocery stores in your neighborhood that have fresh fruit and vegetables?

___(1) Yes ___(2) No

60. Are there safe parks/outdoor areas for this child to play in the neighborhood where you live?

___(1) Yes ___(2) No

61. Are there organizations located in your neighborhood that help children?

___(1) Yes ___(2) No

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

____(1) Spanish ____(2) English ____(3) Other (identify language: _____)

63. Did you participate in the 2008 Cook Children's Health Survey? ____(1) Yes ____(2) No

64. How many years have you lived in community where you currently live? _____ years

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

____(1) Less than high school graduate
____(2) High school graduate
____(3) Some college
____(4) 2-Year college/Technical certification program
____(5) 4-Year college degree
____(6) more than 4-years of college

66. What is your total annual household income?

____(01) Less $14,000
____(02) $14,000-$20,999
____(03) $21,000-$27,999
____(04) $28,000-$34,999
____(05) $35,000-$49,999
____(06) $50,000-$59,999
____(07) $60,000-$69,999
____(08) $70,000-$79,999
____(09) $80,000-$89,999
____(10) $90,000-$99,999
____(11) $100,000 or more
____(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