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Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

CAHMI
The Child & Adolescent Health Measurement Initiative

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Sample Child Core

2011 & 2012 National Health Interview Survey (NHIS)

Guide to Topics & Questions Asked

The NHIS is a computer-assisted personal household interview of all child and adult family members in selected households. Using a multi-stage area probability sampling design, the NHIS is conducted continuously through each year (since 1957). Since 1997, the NHIS questionnaire has consisted of a Core and variable Supplements. The Core consists of four components: The Household Composition, the Family Core, the Sample Adult Core, and the Sample Child Core. One child from each family is randomly selected to be the Sample Child (SC) and an adult knowledgeable about the child's health is administered the full Sample Child Core.

This guide describes the topics and questions asked in the 2011 and 2012 NHIS Sample Child Core. Since the NHIS Sample Child data file can be linked to all other NHIS data files and to future year versions of the Medical Expenditures Panel Survey (MEPS), many other variables are possible to include in analyses of the Sample Child Core. Further information is available on the Data Resource Center for Child and Adolescent Health website (www.childhealthdata.org).

*Denotes that the item is asked only in the 2012 NHIS.

CHILD IDENTIFICATION

- Respondents relationship to the child **(CSRELTIV)**
- Confirm child's sex reported in the Family Core. **(CSPVERF_S)**
  - If Incorrect: Male or Female? **(NEWSEX)**
- Confirm child's age recorded in the Family core **(CSPVERF_A)**
  - If Incorrect: How old is the child? **(NEWAGE)**
- Confirm child's birthday recorded in the Family Core **(CSPVERF_D)**
  - If Incorrect: What is the child's birthday: month, day and year? **(NEWDOB_M NEWDOB_D NEWDOB_Y)**

CHILD HEALTH STATUS & LIMITATIONS

- Child's birth weight **(BWGT_LB)**: pounds **(BWGT_OZ)** or grams **(BWGTMGR)**
- Child's current height (without shoes) **(CHGT_FT)**: inches **(CHGT_IN)** meters **(CHGT_M)** centimeters **(CHGT_CM)**
- Child's current weigh (without shoes): pounds **(CWGT_LB)** kilograms **(CWGT_KG)**
- Has a doctor or health professional ever told you that [child's name] had:
  a) Intellectual disability, also known as mental retardation : **(ADD1_2)** (*<2 years)* **(ADD_2)** (*2-17 years)*
  b) Any other developmental delay: **(ADD1_3)** (*<2 years)* **(ADD_3)** **(***2-17 years)*
  c) Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) **(ADD_1)** (*2-17 years)*

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d) Down syndrome **(CONDL)**
e) Cerebral palsy **(CONDL)**
f) Muscular dystrophy **(CONDL)**
g) Cystic fibrosis **(CONDL)**
h) Sickle cell anemia **(CONDL)**
i) Autism/Autism spectrum disorder **(CONDL)**
j) Diabetes **(CONDL)**
k) Arthritis **(CONDL)**
l) Congenital heart disease **(CONDL)**
m) Other heart condition **(CONDL)**
n) Asthma **(CASHMEV)**
- Does [child's name] still have asthma? **(CASSTILL)**
- DURING THE PAST 12 MONTHS, has [child's name] had an episode of asthma or an asthma attack? **(CASHYR)**
- DURING THE PAST 12 MONTHS, did [child's name] have to visit an emergency room or urgent care center because of [his/her] asthma? **(CASMERYR)**

☐ Has [child's name] EVER had chickenpox? **(CPOX)**
- Has [child's name] had chickenpox DURING THE PAST 12 MONTHS? **(CPOX12MO)**

☐ DURING THE PAST 12 MONTHS, has a doctor or other health professional told you that [child's name] had
a) Hypertension, also called high blood pressure **(CHPYR)** *(6-17 years)* *
- Does [child's name] take prescription medication to control [his/her] blood pressure? **(CHYPMED)*****

b) High cholesterol **(CCHLYR)** *(6-17 years)**
c) Influenza or pneumonia **(CFLUPNYR)** *(4-17 years)**
d) Constipation severe enough to require medication **(CCONMED)** *(4-17 years)**
e) Sinusitis **(CSINYR)** *(4-17 years)**
f) Strep throat or tonsillitis **(CSTREPYR)** *(4-17 years)**
g) Depression **(CDEPRSYR)** *(6-17 years)**

☐ DURING THE PAST 12 MONTHS, has [child's name] had any of the following conditions:
a) Hay fever: **(CCONDT1_1)** *(0-2 years)* **(CCONDT_1)** *(3-17 years)*
b) Any kind of respiratory allergy **(CCONDT1_2)** *(0-2 years)* **(CCONDT_2)** *(3-17 years)*
c) Any kind of food or digestive allergy **(CCONDT1_3)** *(0-2 years)* **(CCONDT_3)** *(3-17 years)*
d) Eczema or any kind of skin allergy **(CCONDT1_4)** *(0-2 years)* **(CCONDT_4)** *(3-17 years)*
e) Frequent or repeated diarrhea or colitis **(CCONDT1_5)** *(0-2 years)* **(CCONDT_5)** *(3-17 years)*
f) Anemia **(CCONDT1_6)** *(0-2 years)* **(CCONDT_6)** *(3-17 years)*
g) Three or more ear infections **(CCONDT1_8)** *(0-2 years)* **(CCONDT_8)** *(3-17 years)*
h) Seizures **(CCONDT1_9)** *(0-2 years)* **(CCONDT_9)** *(3-17 years)*
i) Frequent or severe headaches, including migraines **(CCONDT_7)** *(3-17 years)*
j) Stuttering or stammering **(CCONDT_10)** *(3-17 years)*
k) Recurring headache, other than migraine **(CHEADYR)** *(6-17 years)**
l) Abdominal pain **(CABDOMYR)** *(6-17 years)**
m) Neck pain **(CPAINECK)** *(6-17 years)**
n) Low back pain **(CPAINLB)** *(6-17 years)**
o) Other muscle or bone pain **(CMUSCLYR)** *(6-17 years)**

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p) Any severe sprains or strains **(CSPNYR)** *(6-17 years)**

q) Dental pain **(CDENYR)** *(6-17 years)**

r) Other chronic pain? **(CPNOTHYR)** *(6-17 years)**

s) Problems with being overweight **(COVRWTYR)** *(6-17 years)**

t) Sore throat other than strep or tonsillitis **(CTHOTHYR)** *(4-17 years)**

u) Fever more than one day **(CFEVRYR)** *(4-17 years)**

v) A head or chest cold **(CCOLDYR)** *(4-17 years)**

w) Nausea and/or vomiting **(CNAUSYR)** *(4-17 years)**

x) Fatigue or lack of energy more than three days **(CFATIGYR)** *(4-17 years)**

y) Regularly had excessive sleepiness during the day **(CFATYR)** *(4-17 years)**

z) Regularly had insomnia or trouble sleeping **(CINSYR)** *(4-17 years)**

aa) Frequently felt anxious, nervous, or worried **(CANXNWYR)** *(6-17 years)**

bb) Frequently felt stressed **(CSTRESYR)** *(6-17 years)**

cc) Menstrual problems such as heavy bleeding, bothersome cramping, or premenstrual syndrome (also called PMS)? **(MENSTYR)** *(girls 10-17 years)**

dd) Gynecologic problems such as vaginal infection **(CGYNYR)** *(girls 10-17 years)**

- Has a representative from a school or a health professional ever told you that [child's name] had a learning disability? **(LEARND)** *(3-17 years)*
- DURING THE PAST 30 DAYS, has [child's name] had any symptoms of pain, aching, or stiffness in or around a joint? **(CJNTSYMP)** *(6-17 years)**
- Compared with 12 months ago, would you say [child's name]'s health is now better, worse, or about the same? **(CHSTATYR)**
- DURING THE PAST 12 MONTHS about how many days did [child's name] miss school because of illness or injury? **(SCHDAYR)** *(5-17 years)*
- Did [child's name] have any of the following health problems that started DURING THE LAST 2 WEEKS?
  a) head cold or chest cold **(CCOLD2W)**
  b) stomach or intestinal illness with vomiting or diarrhea **(CINTIL2W)**
- Which statement best describes [child's name]'s hearing without a hearing aid: Excellent, good, a little trouble hearing, moderate trouble, a lot of trouble, or is [child's name] deaf? **(CHEARST1)**
- Does [child's name] have any trouble seeing [even when wearing glasses or contact lenses]? **(CVISION)**
  - Is [child's name] blind or unable to see at all? **(CBLIND)**
- Does [child's name] have any impairment or health problem that requires [he/she] to use special equipment, such as a brace, a wheelchair, or a hearing aid (excluding ordinary eyeglasses or corrective shoes)? **(IHSPEQ)**
- Does [child's name] have an impairment or health problem that limits [his/her] ability to (crawl), walk, run, or play? **(IHMOB)**
  - Is this an impairment or health problem that has lasted, or is expected to last, 12 months or longer? **(IHMOBYR)**
- Does [child's name] NOW have a problem for which [he/she] has regularly taken prescription medication for at least three months? **(PROBRX)**
- I am going to read a list of items that describe children. For each one, tell me if it has been NOT TRUE, SOMETIMES TRUE, or OFTEN TRUE, of [child's name] DURING THE PAST TWO MONTHS

  For male children 2-3 years:

  a) Has been uncooperative **(CMHAGM11_1)**

  b) Has trouble getting to sleep **(CMHAGM11_2)**

  c) Has speech problems **(CMHAGM11_3)**

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d) Has been unhappy, sad, or depressed **(CMHAGM11_4)**

For female children 2-3 years:

a) Has temper tantrums or a hot temper? **(CMHAGF11_1)**

b) Has speech problems **(CMHAGF11_2)**

c) Has been nervous or high-strung **(CMHAGF11_3)**

d) Has been unhappy, sad, or depressed? **(CMHAGF11_4)**

CHILD ACCESS TO HEALTH CARE & UTILIZATION

- Is there a place that [child's name] USUALLY goes when [he/she] is sick or you need advice about [his/her] health? **(CUSUALPL)**
  - [What kind of place is it / What kind of place does [child's name] go to most often] - a clinic, doctor's office, emergency room, or some other place? **(CPLKIND)**
    - Is that [fill1: CPLKIND/CAU.030] the same place [child's name] USUALLY goes when [he/she] needs routine or preventive care, such as a physical examination or (well baby/child) check-up? **(CHCPLROU)**

      If No: What kind of place does [child's name] USUALLY go to when [he/she] needs routine or preventive care, such as a physical examination or (well baby/child) check-up? **(CHCPLKND)**
  - If child has one or more place to go when sick/need advice [or who reported same place as usual source of routine/preventive care]
  - At any time IN THE PAST 12 MONTHS did you CHANGE the place(s) to which the child USUALLY goes for health care? **(CHCCHGYR)**
    - Was this change for a reason related to health insurance? **(CHCCHGHI)**
  - If child does not have a usual place of care:
    - Why doesn't the child have a usual source of medical care? **(CNOUSLPL)**
- DURING THE PAST 12 MONTHS, did you have any trouble finding a general doctor or provider who would see the child? **(CPRVTRYR)**
  - Were you able to find a general doctor or provider who could see the child? **(CPRVTRFD)**
- DURING THE PAST 12 MONTHS, were you told by a doctor's office or clinic that they would not accept the child as a new patient? **(CDRNANP)**
- DURING THE PAST 12 MONTHS, were you told by a doctor's office or clinic that they did not accept the child's health care coverage? **(CDRNAI)**
- Have you delayed getting care for the child for any of the following reasons IN THE PAST 12 MONTHS:
  - You couldn't get through on the telephone **(CHCDLYR1_1)**
  - You couldn't get an appointment soon enough **(CHCDLYR1_2)**
  - Once you get there, the child has to wait too long to see the doctor **(CHCDLYR1_3)**
  - The (clinic/doctor's office) wasn't open when you could get there **(CHCDLYR1_4)**
  - You didn't have transportation **(CHCDLYR1_5)**
- DURING THE PAST 12 MONTHS, was there any time when the child NEEDED any of the following, but didn't get it because you couldn't afford it:
  - Prescription medicines? **(CHCAFYR)** *(<2 years)* **CHCAFYR1_1)** *(3-17 years)*
  - To see a specialist **(CHCAFYRN)** *(<2 years)* **(CHCAFYR1_5)** *(3-17 years)*
  - Follow-up care **(CHCAFYRF)** *(<2 years)* **(CHCAFYR1_6)** *(3-17 years)*
  - Mental health care or counseling **(CHCAFYR1_2)** *(2-17 years)*

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- Dental care (including check-ups) **(CHCAFYR1_3)** *(2-17 years)*
- Eyeglasses **(CHCAFYR1_4)** *(2-17 years)*

- About how long has it been since the child last saw a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. **(CDENLONG)** *(1-17 years)*
- DURING THE PAST 12 MONTHS, that is since [12 month reference date], has anyone in the family (0-1 year)/ have you (2-17 or 0-17 years) seen or talked to any of the following health care providers about child's health?
  - An optometrist, ophthalmologist, or eye doctor (someone who prescribes eyeglasses)? **(CHCSYR1_2)** *(<2 years)* **(CHCSYR2)** *(3-17 years)*
  - A foot doctor **(CHCSYR1_3)** *(<2 years)* **(CHCSYR_3)** *(3-17 years)*
  - A physical therapist, speech therapist, respiratory therapist, audiologist, or occupational therapist **(CHCSYR1_5)** *(<2 years)* **(CHCSYR_5)** *(3-17 years)*
  - A nurse practitioner, physician assistant or midwife **(CHCSYR1_6)** *(<2 years)* **(CHCSYR_6)** *(3-17 years)*
  - A mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker **(CHCSYR_1)** *(2-17 years)*
  - A chiropractor **(CHCSYR_4)** *(2-17 years)*
  - A doctor who specializes in women's health (an obstetrician/gynecologist) **(CHCSYR7)** *(girls 15-17 years)*
  - A medical doctor who specializes in a particular medical disease or problem (other than obstetrician/ gynecologist, psychiatrist or ophthalmologist? /other than psychiatrist or ophthalmologist)? **(CHCSYR8_1)**
  - A general doctor who treats a variety of illnesses (a doctor in general practice, pediatrics, family medicine, or internal medicine)? **(CHCSYR8_2)**
    - Does that doctor treat children and adults (a doctor in general practice or family medicine)? **(CHCSYR10)**
    - Did you see or talk to this general doctor because of an emotional or behavioral problem that the child may have? **(CHCSYREM)**
- DURING THE PAST 12 MONTHS, did the child receive a well-child check-up, that is a general check-up, when [he/she] was not sick or injured? **(CHPEXYR)**
- DURING THE PAST 12 MONTHS, HOW MANY TIMES has the child gone to a HOSPITAL EMERGENCY ROOM about [his/her] health? (This includes emergency room visits that resulted in a hospital admission.) **(CHERNOYR)**
  - If child had 1 or more ER visits:
    - Thinking about [child's name]'s most recent emergency room visit, did [he/she] go to the emergency room either at night or on the weekend? **(CERVISND)**
    - Did this emergency room visit result in a hospital admission? **(CERHOS)**
  - If No to **CERHOS** (1st quarter of the survey) OR child had 1 or more ER visits not regarding admission status (2-4 Quarter): NOTE: In Quarters 2-4, the universe for the flowing questions was changed (for more information go to Layout document of the Sample Child file)
    - Tell me which of these apply to the child's last emergency room visit?
      - Did not have another place to go **(CERREAS1)**
      - Doctor's office or clinic was not open **(CERREAS2)**
      - Health provider advised that [he/she] go **(CERREAS3)**
      - The problem was too serious for the doctor's office or clinic **(CERREAS4)**
      - Only hospital could help **(CERREAS5)**
      - The emergency room is [child's name]'s closest provider **(CERREAS6)**
      - [Child's name] gets most of [his/her] care at the emergency room **(CERREAS7)**

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- [Child's name] arrived by ambulance or other emergency vehicle **(CERREAS8)**

- DURING THE PAST 12 MONTHS, did [child's name] receive care AT HOME from a nurse or other health care professional? **(CHCHYR)**
  - DURING THE PAST 12 MONTHS, how many months did the child receive care AT HOME? **(CHCHMOYR)**
  - What was the total number of home visits received for [child's name] during [that month/those months]? **(CHCHNOYR)**
- DURING THE PAST 12 MONTHS, HOW MANY TIMES has [child's name] seen a doctor or other health care professional about [his/her] health at A DOCTOR'S OFFICE, A CLINIC, OR SOME OTHER PLACE? Do not include times [child's name] was hospitalized overnight, visits to hospital emergency rooms, home visits, dental visits or telephone calls. **(CHCNOYR)**
- DURING THE PAST 12 MONTHS has [child's name] had SURGERY or other surgical procedures either as an inpatient or outpatient? **(CSRGYR)**
  - Including any times you may have already told me about, HOW MANY DIFFERENT TIMES has [child's name] had surgery? **(CSRGNOYR)**
- About how long has it been since anyone in the family last saw or talked to a doctor or other health care professional about [child's name] 's health? Include doctors seen while [he/she] was a patient in a hospital. **(CMDLONG)**

CHILD COMMUNICATION DISORDERS*

- How old was [child's name] when [he/she] spoke [his/her] first words other than "ma-ma" or "da-da"? **CVSLWRD)** *(3-17 years)*
- DURING THE PAST 12 MONTHS, has [child's name] had any problems or difficulties with [his/her] VOICE, such as too weak, hoarse, or strained that lasted for a week or longer? **(CVSLVYR)** *(3-17 years)*
- DURING THE PAST 12 MONTHS, has [child's name] had a problem swallowing food or beverages that lasted for a week or longer? **(CVSLSWYR)** *(3-17 years)*
- DURING THE PAST 12 MONTHS, has [child's name] had a problem speaking, such as making speech sounds correctly or stuttering that lasted for a week or longer? **(CVSLSPYR)** *(3-17 years)*
- DURING THE PAST 12 MONTHS, has [child's name] had a problem learning, using, or understanding words or sentences that lasted for a week or longer? **(CVSLLGYR)** *(3-17 years)*

➢ If NO to **ALL** items: **CVSLVYR, CVSLSWYR, CVSLSPYR, and CVSLLGYR**

- Has [child's name] EVER had a voice, swallowing, speech, or language problem that lasted a week or longer? **(CVSLEVER)**

➢ IF YES to **ANY** items: **CVSLVYR, CVSLSWYR, CVSLSPYR, and CVSLLGYR**

- Did a health or education professional EVER tell you a diagnosis or reason for [child's name]'s voice, swallowing, speech, or language problem? **(CVSLDG)**

  If Yes: For which problem(s)? **(CVSLDGTP)**

  - What diagnoses or reasons were you told caused [child's name]'s
    - voice problems? **(CVSLVDG)**
    - problems swallowing? **(CVSLSWDG)**
    - speech problems? **(CVSLSPDG)**
    - problems learning, using, or understanding words or sentences? **(CVXLLGDG)**
- At what age did [child's name] FIRST begin to have any
  - voice problems? **(CVSLVAG)**
  - problems swallowing? **(CVSLSWAG)**
  - speech problems? **(CVSLSPAG)**
  - problems learning, using, or understanding words or sentences? **(CVSLLGAG)**

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- DURING THE PAST 12 MONTHS, how much of a problem did [child's name] have with [his/her]
  - Voice? **(CVSLVPB)**
  - Swallowing? **(CVSLSWPB)**
  - speech? **(CVSLSPPB)**
  - learning, using or understanding words or sentences? **(CVSLLGPB)**
- DURING THE PAST 12 MONTHS, did [child's name] receive speech language therapy or other intervention services for [his/her]
  - voice problems? **(CVSLVSP)**
  - problems swallowing? **(CVSLSWSP)**
  - speech problems? **(CVSLSPSP)**
  - problems using, learning or understanding words or sentences? **(CVSLLGSP)**

➢ If No:

- Did [child's name] EVER receive speech language therapy or other intervention services for [his/her]
  - voice problems? **(CVSLVPE)**
  - problems swallowing? **(CVSLSWPE)**
  - speech problems? **(CVSLSPPE)**
  - problems learning, using, or understanding words or sentences? **(CVSLLGPE)**

➢ If child EVER (ever and during the past 12 months) received speech language therapy or other intervention services:

- Who provided this (for [child's name]'s
  - voice problems)? **(CVSLVHP)**
  - problems swallowing)? **(CVSLSWHP)**
  - speech problems)? **(CVSLSPHP)**
  - problems learning, using, or understanding words or sentences)? **(CVSLLGHP)**

CHILD BALANCE*

- At what age did [child's name] take [his/her] first steps without support? **(CBALWLK)** *(3-17 years)*
- Does [child's name] have any problem standing, walking, or using [his/her] arms or legs? **(CBALLIMB)** *(3-17 years)*
- DURING THE PAST 12 MONTHS, has [child's name] been bothered by episodes of any of the following dizziness or balance problems? *(3-17 years)*
  a) Vertigo, a spinning sensation like a Merry-Go-Round? **(CBALVRTG)**
  b) Poor balance, an unsteady or woozy feeling that makes it difficult to stand up or walk? **(CBALSTED)**
  c) Problems with body or motor coordination or clumsiness? **(CBALMOTR)**
  d) Frequent falls? **(CBALFALL)**
  e) Light-headedness, fainting, or feeling [he/she] is about to pass out? **(CBALPASS)**
  f) Any other type of balance or dizziness problems? **(CALOTH)**

➢ If YES to ANY of the above :

- Did a doctor or other health professional EVER tell you a diagnosis or reason for [child's name]'s dizziness or balance problems? **(CBALDGHP)**
  - What diagnoses or reasons were you told caused [child's name]'s balance or dizziness problems? **(CBALDIGN)**
- Did any of these episodes of dizziness or balance problems keep [child's name] from participating in home, school, work, or recreational activities? **(CBALPART)**
- DURING THE PAST 12 MONTHS, how much of a problem were these episodes of dizziness or imbalance for [child's name]?

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(CBALPROB)

- DURING THE PAST 12 MONTHS, has [child's name] seen a doctor, physical or occupational therapist, or other health care professional about these episodes of dizziness or balance problems? Include visits to the Emergency Room, hospital, or health clinics. **(CBALHPYR)**
- DURING THE PAST 12 MONTHS, has [child's name] tried methods recommended by a doctor, physical or occupational therapist, or other health care professional for treating [his/her] episodes of dizziness or balance problems? **(CBALTRET)**

CHILD MENTAL HEALTH BRIEF QUESTIONNAIRE

- I am going to read a list of items that describe children. For each item, please tell me if it has been NOT TRUE, SOMEWHAT TRUE, or CERTAINLY TRUE for [child's name] DURING THE PAST SIX MONTHS... *(4-17 years)*
  - is generally well behaved, usually does what adults request. **(CMHMF_1)**
  - has many worries, or often seems worried. **(CMHMF_2)**
  - is often unhappy, depressed or tearful. **(CMHMF_3)**
  - gets along better with adults than with other [children/youth]. **(CMHMF_4)**
  - has good attention span, sees chores or homework through to the end. **(CMHMF_5)**
- Overall, do you think that [child's name] has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people? **(CMHDIFF)**

CHILD MENTAL HEALTH SERVICES

- Has [child's name] had any difficulties with emotions, concentration, behavior, or getting along with others DURING THE PAST 6 MONTHS? **(DIFF6M)** *(4-17 years)*
  - ➢ If child had at least minor difficulties:
  - Did the difficulties interfere with or limit [child's name] being able to get along in your family, in school, or in daily activities? **(DIFFINTF)**
    - How much did these difficulties interfere with [child's name] being able to get along in your family, in school, or in daily activities? **(DIFFDEG)**
  - How long have these difficulties been present? **(DIFFLNG)**
  - DURING THE PAST 6 MONTHS, did [child's name] receive any treatment or counseling FROM A SCHOOL SOCIAL WORKER, SCHOOL PSYCHOLOGIST, SCHOOL NURSE, SCHOOL COUNSELOR, SPECIAL ED TEACHER, OR SCHOOL SPEECH, OCCUPATIONAL OR PHYSICAL THERAPIST? **(NSDUH21)**
  - At any time DURING THE PAST 6 MONTHS did [child's name] attend a school for students with difficulties with emotions, concentration, behavior, or being able to get along with others? **(NSDUH3)**
    - Was it a day school or school where [child's name] stayed overnight or longer? **(NSDUH31)**
    - Who provided the treatment or counseling? **(NSDUH32)**
  - DURING THE PAST 6 MONTHS, did [child's name] participate in a school program that was just for students with these kinds of difficulties? **(NSDUH4)**
    - Who provided the treatment or counseling? **(NSDUH5)**
  - DURING THE PAST 6 MONTHS, did [child's name] receive treatment or counseling for these difficulties *(4-6 years)*
    - At daycare, child care, or play group **(TRETWHR1)**
      Who provided the treatment or counseling? **(TRETWHO1)** Type of mental health care providers **(TRTMHP1)**
    - In an office, clinic or center in your community **(TRETWHR2)**
      Who provided the treatment or counseling? **(TRETWHO2)** Type of mental health care providers **(TRTMHP2)**

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- In your home, for example, from a visiting teacher or counselor **(TRETWHR3)**
  Who provided the treatment or counseling? **(TRETWHO3)** Type of mental health care providers **(TRTMHP3)**
- In a hospital emergency room, crisis center, or emergency shelter **(TRETWHR4)**
  Who provided the treatment or counseling? **(TRETWHO4)** Type of mental health care providers **(TRTMHP4)**
- At a day treatment program in a hospital or in your community **(TRETWHR5)**
  Who provided the treatment or counseling? **(TRETWHO5)** Type of mental health care providers **(TRTMHP5)**
- Any other place **(TRETWHR6)**
  Who provided the treatment or counseling? **(TRETWHO6)** Type of mental health care providers **(TRTMHP6)**

- DURING THE PAST 6 MONTHS, in addition to a school you may have told me about, did [child's name] stay overnight or longer in a hospital, any type of group home, any type of juvenile detention center, sometimes called juvie, or juvenile hall, youth prison, training school or jail, foster care home, or another special type of center or shelter to receive counseling or treatment for these difficulties? **(OVERNT6M)**
  - Which ones **(OVERWHCH)**
    1. Hospital
    2. Residential treatment center
    3. Foster care or therapeutic foster care home
    4. In any type of juvenile detention center, sometimes called "juvie", prison, or jail
    5. Group home
    6. Homeless shelter
    7. In another place
- DURING THE PAST 6 MONTHS, did [child's name] take part in a self-help group for children and youth with these difficulties? **(SH1)**
- DURING THE PAST 6 MONTHS, did [child's name] use the Internet to seek treatment or counseling for these difficulties? **(SH2)**
- DURING THE PAST 6 MONTHS, did you or [child's name] receive help with care coordination or case management (see introduction) from any individual or agency? **(CASEM6M)**
  - Who provides help arranging or coordinating [child's name]'s care? **(CASEMWHO)**
- DURING THE PAST 6 MONTHS, did [child's name] need treatment or counseling for these difficulties but didn't get it? **(TRTNEED1)**
  - Reasons that kept [child's name] from getting treatment or counseling:
    - Help was too expensive **(NTRTCOST)**
    - Didn't know where to go **(NTRTLOC)**
    - had a negative experience with professionals **(NTRTNEXP)**
    - Afraid or you don't like professionals **(NTRTFEAR)**
    - Afraid [child's name] would be taken from your home or that you would lose your parental rights or custody **(NTRTLOSE)**
    - Afraid of what your family or friends would say **(NTRTSAY)**
    - Had to wait a long time for an appointment **(NTRTWAIT)**
    - Had no way to get there **(NTRTTRAN)**
    - Services were too inconvenient to use **(NTRTINCV)**
    - Services were too far away **(NTRTFAR)**
    - [Child's name] did not want to go **(NTRTCHNO)**

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- Some other reason **(NTRTOTH)**

➢ If child received treatment or counseling:

- How much has this treatment or counseling helped [child's name]? **(TRETHELP)**
- Who pays or paid for [child's name]'s treatment or counseling during the past 6 months.

  - Private health insurance, such as insurance that comes with a job **(TRPAYPHI)**
  - School system **(TRPAYSCH)**
  - You or your family (sometimes called out of pocket or co-payment) **(TRPAYSLF)**
  - Medicaid **(TRPAYMED)**
  - A state CHIP/SCHIP program [STNAME1] **(TRPAYCHP)**
  - Military health care **(TRPAYMIL)**
  - Some other state or county sponsored health plan, Medicare or other government program **(TRPAYSHP)**
  - Indian Health Service **(TRPAYIHS)**
  - Some other source **(TRPAYOTH)**

- Was ALL OF THE treatment or counseling [child's name] RECEIVED during the past 6 months free **(TRETFREE)**

- DURING THE PAST 6 MONTHS, was [child's name] prescribed medication or taking prescription medication for difficulties with emotions, concentration, behavior, or being able to get along with others? **(PRESCP6M)** *(4-17 years)*
  - How much has this prescription medication helped? **(PRESHELP)**
  - Who FIRST prescribed the medication?
    - A pediatrician or other family doctor **(PMEDPED)**
    - A psychiatrist, psychologist or other mental health professional? **(PMEDPSY)**
    - A neurologist **(PMEDNEU)**
    - Someone else **(PMEDOTH)**

CHILD INFLUENZA IMMUNIZATION

- DURING THE PAST 12 MONTHS, has [child's name] had a flu vaccination? A flu vaccination is usually given in the fall and protects against influenza for the flu season. **(CH1N1_1)**
- How many vaccinations has [child's name] received? **(CH1N1_2)**
- During what month and year did [child's name] receive [his/her] most recent flu vaccine? **(CH1N1_3M)**
- Year of most recent flu vaccine **(CH1N1_4Y)**
- Was this a shot, or was it a vaccine sprayed in the nose? **(CH1N1_5)**

➢ IF child received >1 vaccine doses:

- During what month and year did [child's name] receive [his/her] next most recent flu vaccine? **(CH1N1_6M)**
- Year of most recent flu vaccine **(CH1N1_7Y)**
- Was this a shot, or was it a vaccine sprayed in the nose? **(CH1N1_8)**

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