SECTION F: MATERNAL AND CHILD HEALTH

F1. And now I have some questions about health issues. How would you rate your overall physical health--excellent, very good, good, fair, or poor?

1. EXCELLENT	2. VERY GOOD	3. GOOD	4. FAIR	5. POOR

F1a. Are you currently pregnant?

1. YES	5. NO

NEXT PAGE, F2

F1b. Have you been pregnant since (W1 IW DATE)?

1. YES	5. NO

F2. (RB, P. 17) The following items are about activities you might do during a typical day. How much does your health limit you in...

	A LOT (1)	A LITTLE (2)	NOT AT ALL (3)
a. vigorous activities, such as running or lifting heavy objects--a lot, a little, or not at all?			**GO TO F2c**
b. lifting or carrying groceries?			
c. moderate activities, such as moving a table or pushing a vacuum cleaner?			
d. (How much does your health limit you in) climbing several flights of stairs (a lot, a little, or not at all)?			**GO TO F2f**
e. climbing one flight of stairs?			
f. bending, kneeling, or stooping?			
g. walking more than one mile?			**GO TO F2k**
h. walking several blocks?			**GO TO F2k**
j. walking one block?			
k. sitting or standing for long periods of time?			
m. bathing or dressing yourself?			

F3. Do you have any chronic health or medical conditions that prevent you from attending work, affect your work performance, or prevent you from doing regular activities?

1. YES

5. NO → GO TO F6

F4. Do you have one of the following conditions?

	YES (1)	NO (5)
a. asthma or breathing problem?		
b. hypertension or heart problems?		
c. diabetes or sugar?		
d. arthritis, bone or joint problems?		

[F5. Not used in this Wave]

F6. Since (W1 IW DATE) have you applied for disability benefits from the Social Security Disability program, SSI program, Veteran's Administration, Worker's Compensation, State Disability Assistance, or another program for yourself?

1. YES

5. NO

F6a. Are you currently receiving disability benefits for yourself?

1. YES

5. NO

F7. Since (W1 IW DATE) was there a time that you did not receive needed emergency or routine medical care?

1. YES

5. NO → GO TO F8

F7a. What was the main reason you did not receive care? (DO NOT READ - CHECK ALL THAT APPLY)

A. COST/INSURANCE PROBLEMS

B. CHILD CARE PROBLEMS

C. TRANSPORTATION PROBLEMS

D. FEAR OF TREATMENT/DIAGNOSIS

E. DON'T BELIEVE IN TREATMENT

F. DIDN'T NEED TREATMENT; NOT SERIOUS

G. DIDN'T HAVE TIME

Z. OTHER (SPECIFY):

_____

F8. Do you smoke cigarettes now at all?

1. YES

5. NO → NEXT PAGE, F9

F8a. How many cigarettes do you usually smoke per day?

_____ # CIGARETTES OR _____ # PACKS

F9. How many hours of sleep do you usually get over a 24 hour period, including naps?

_____ # HOURS

F10. Have you ever had a concern about having a mental health problem?

1. YES

5. NO → TURN TO P. 60, F16

F11. Now I am going to ask you a few questions about mental health services. Services might include a stay in the hospital, treatment center, or halfway house. It could also consist of seeing a counselor, participating in a support group, or receiving medication.

Have you ever received mental health services?

1. YES

5. NO → NEXT PAGE, F14

F12. Have you received any services since (W1 IW DATE)?

1. YES

5. NO → NEXT PAGE, F14

F12a. What type of care have you received?
(CHECK ALL THAT APPLY)

- A. HOSPITAL, TREATMENT CENTER, HALFWAY HOUSE
- B. EMERGENCY TREATMENT
- C. MEDICATION
- D. COUNSELING, THERAPY (INCL. GROUP)
- Z. OTHER CARE

F13. Are you currently receiving mental health services?

1. YES

5. NO

F14. Was there a time since (W1 IW DATE) when you wanted treatment and didn't get it?

1. YES

5. NO → NEXT PAGE, F16

F15. What were the reasons you didn't get help? (CHECK ALL THAT APPLY)

A. COST/INSURANCE PROBLEMS

B. CHILD CARE PROBLEMS

C. TRANSPORTATION PROBLEMS

D. FEAR OF TREATMENT/DIAGNOSIS

E. DON'T BELIEVE IN TREATMENT

F. DIDN'T NEED TREATMENT; NOT SERIOUS

G. DIDN'T HAVE TIME

H. WAIT LIST TOO LONG

J. DIDN'T KNOW WHERE TO GO FOR HELP

Z. OTHER (SPECIFY):

_____

F16. INTERVIEWER CHECKPOINT

SEE COVERSHEET, P. 3, Item 16
CHECK FIRST BOX THAT APPLIES

☐ 1. R HAS **ONLY OWN** CHILD(REN) UNDER 18 IN HH → F16a. Now let's talk about the health of your own child(ren) living with you. (Does this child/Do any of these children) have a physical, learning, or mental health condition that limits their regular activities?

1. YES → NEXT PAGE, F17
5. NO → TURN TO P. 62, F21

☐ 2. R HAS **ONLY CAREGIVEN** CHILD(REN) UNDER 18 IN HH → F16a. Now let's talk about the health of the child(ren) living with you for whom you are the primary caregiver. (Does this child/Do any of these children) have a physical, learning, or mental health condition that limits their regular activities?

1. YES → NEXT PAGE, F17
5. NO → TURN TO P. 62, F21

☐ 3. R HAS **BOTH OWN AND CAREGIVEN** CHILDREN UNDER 18 IN HH → F16a. Now let's talk about the health of your own child(ren) living with you and the child(ren) living with you for whom you are the primary caregiver. Do any of these children have a physical, learning, or mental health condition that limits their regular activities?

1. YES → NEXT PAGE, F17
5. NO → TURN TO P. 62, F21

☐ 4. ALL OTHERS → TURN TO P. 65, SECTION GA

F17. How many of the children have these problems?

1. ONE	2. TWO	3. THREE	4. FOUR OR MORE

F18. How old (is this child/are these children)? (DO NOT READ-CHECK ALL THAT APPLY)

1. UNDER 1 YR OLD	2. 1-4 YRS OLD	3. 5-9 YRS OLD	4. 10-14 YRS OLD	5. 15-17 YRS OLD

F19. (Does this child/Do these children) receive SSI benefits?

1. YES	5. NO

F20. (Does this child's/Do the children's) physical, learning or mental health conditions interfere with your work or regular activities?

1. YES	5. NO

F20a. The next questions ask about any of your own children and the children you care for that live with you.

F21. In the past month, has any child had any routine health problems such as ear infections, sore throats, colds, stomach flu, fever or rashes that have required him or her to be cared for at home?

1. YES	5. NO → NEXT PAGE, F22

F21a. Do these routine health problems interfere with your work or regular activities?

1. YES	5. NO

F21b. IF MORE THAN ONE CHILD READ:
(Again) The next questions ask about any of your own children and the children you care for that live with you.

F22. Since (W1 IW DATE) was there a time that any child did not receive needed emergency or routine medical care?

1. YES	5. NO → GO TO F23

F22a. What was the main reason they did not receive care? (CHECK ALL THAT APPLY)

- A. COST/INSURANCE PROBLEMS
- B. CHILD CARE PROBLEMS
- C. TRANSPORTATION PROBLEMS
- D. FEAR OF TREATMENT/DIAGNOSIS
- E. DON'T BELIEVE IN TREATMENT
- F. DIDN'T NEED TREATMENT; NOT SERIOUS
- G. DIDN'T HAVE TIME
- Z. OTHER (SPECIFY): _____

F23. Since (W1 IW DATE), has any child had an accident or injury, including burn or accidental poisoning, that required a doctor’s or nurse's care?

1. YES	5. NO

F24. (RB, P. 18) Now I want to ask you some questions about feelings you may have in your role as a mother or caretaker for the (child/children) now living with you, and how often you experience these feelings.

	ALMOST ALWAYS (1)	OFTEN (2)	SOME-TIMES (3)	RARELY (4)	NEVER (5)
a. How often do you feel that you have too little time to spend by yourself--almost always, often, sometimes, rarely, or never?					
b. How often do you wish you didn't have so many responsibilities?					
c. How often would you say that your (child gets/ children get) on your nerves?					
d. How often do you feel that your (child is/children are) making too many demands on you--(almost always, often, sometimes, rarely, or never)?					
e. Many women feel that they are not as good a mother as they would like to be. How often do you feel this way?					
f. How often do you find that being a mother is much more work than pleasure?					
g. How often do you feel tired, worn out or exhausted from raising a family?					