

BMS Pediatric Proxy 0-7 Interview Form II: Research Staff Instructions

Instructions: This form is designed to aid in the interview process. If you are handing the form to the participant for them to fill out, use the mail version of this form instead. Instructions to the interviewer appear throughout the survey in italics, and scripts to read aloud to the participants appear using quotation marks. The scripts to read aloud are also boxed and shaded in light gray. Use these scripts as suggestions for how to move through the survey while establishing rapport with the participant.

Missing codes appear throughout this interview in small boxes. If a participant doesn't want to answer any item or doesn't know the answer, circle "88" (Declined to Answer/Refused) or "99" (Unknown) in that item's corresponding missing code box. Some items have missing codes built into their response options and therefore don't have those code boxes.

Remember to fill out the Medical Record Abstraction Form II. For the pain medication items, check the medical record to determine if there were any pain medications prescribed within the data collection window. Note on the Medical Record Abstraction Form II form and enter in the appropriate field during data entry.

Form II Administration:	
Who is responding to this questionnaire? (Select all that apply) <input type="checkbox"/> 1. Mother or stepmother <input type="checkbox"/> 2. Father or stepfather <input type="checkbox"/> 3. Guardian <input type="checkbox"/> 4. Other	Follow-up period <input type="checkbox"/> 1. 6-month follow-up <input type="checkbox"/> 2. 12 month follow-up <input type="checkbox"/> 3. 24 month follow-up <input type="checkbox"/> 4. 5 year follow-up
What is the method of administration of this form? <input type="checkbox"/> 1. In person interview <input type="checkbox"/> 3. Telephone interview <input type="checkbox"/> 5. Medical Record Review	What is the language of administration of this form? <input type="checkbox"/> 1. English <input type="checkbox"/> 2. Spanish
What is the status of this follow-up assessment? <input type="checkbox"/> 1. Some or all assessment done <input type="checkbox"/> 2. Death due to burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 3. Death due to non- burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 4. Unable to locate <input type="checkbox"/> 5. Refused this assessment <input type="checkbox"/> 6. Unable to test/med comp/incapable of responding <input type="checkbox"/> 7. Failed to respond <input type="checkbox"/> 8. Did not consent to future assessment/withdrew <input type="checkbox"/> 11. Incarcerated <input type="checkbox"/> 13. Still in hospital (not discharged yet) <input type="checkbox"/> 14. Unable to travel for assessment <input type="checkbox"/> 15. Death (unknown causes) (update date and cause of death on Patient Status Form)	If follow-up status is "unable to locate," mark the best reason, below: <input type="checkbox"/> 1. Homeless at previous data collection <input type="checkbox"/> 2. International place of residence <input type="checkbox"/> 3. Participant is child who was/is in CPS custody or foster care and no contact information is available <input type="checkbox"/> 4. No known current contact info <input type="checkbox"/> 5. Other reasons <input type="checkbox"/> 6. Unable to contact due to Shriners Hospital regulations

Burn Model System Follow-up Survey: Introduction

Introduction Script (replace this script with your personalized center introduction script if applicable or modify as needed to facilitate the flow and rapport of the interview):

“Hi my name is _____ and I am calling from _____ to ask you some questions about how your child has been doing (since your injury)... or (since we last spoke with you on (last follow-up date)).

Thank you for continuing to participate in our study. The aim of the study is to learn about how children do after a burn injury. Your answers will help us understand the experiences of all people with burn injury and I appreciate your willingness to share those experiences. I'll be asking questions about your child's burn injury, his/her health, and other questions about your child and people around him/her. I will guide you as we go along. You may notice that some questions are similar and feel repetitive. This is not a mistake and is part of the research process. All information will be kept confidential.

If you are unsure how to answer a question, please give the answer that fits you best. You can choose to skip any questions you don't want to answer or feel uncomfortable answering. Just tell me, “skip.” Please let me know at any time if you have any questions.”

Today's Date: ____ / ____ / ____

“As a reminder, your last research study questionnaire was completed on ____/____/____.”

“We're going to go ahead and get started.”

Section I

I. Since your last research study questionnaire, has your child spoken with other burn survivors to get support for problems related to his/her burn injury?

88/Refused

- ☐ 1. Yes
- ☐ 2. No
- ☐ 77. Not applicable
- ☐ 99. I don't know

<p>2. To your knowledge, in the last year has your child had COVID-19?</p> <p><i>Or, since your last research study questionnaire if your child's burn was less than a year ago, has your child had COVID-19?</i></p> <p> <input type="checkbox"/> 1. Yes → <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know </p> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused</p>	<p>(If yes), What month and year did your child have COVID-19? (if your child has had COVID-19 more than once, provide the month and year of his/her <u>first</u> illness)</p> <p>Month: _____ Year: _____</p> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused 99/Unknown</p> <p>What level of care did your child receive for COVID-19?</p> <p> <input type="checkbox"/> 1. Did not seek medical care <input type="checkbox"/> 2. Received medical care but was not hospitalized <input type="checkbox"/> 3. Was hospitalized </p> <p style="padding-left: 40px;">In the hospital... (if applicable)</p> <p> <input type="checkbox"/> 1. He/she was NOT on a ventilator (breathing machine with tube down his/her throat) <input type="checkbox"/> 2. He/she was on a ventilator <input type="checkbox"/> 3. I don't know </p> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused</p>
<p>3. Since your last research study questionnaire, has your child received any of the following services at home or outpatient? (Choose all that apply)</p> <p> <input type="checkbox"/> 1. No services <input type="checkbox"/> 2. Occupational therapy <input type="checkbox"/> 3. Physical therapy <input type="checkbox"/> 4. Speech language pathology <input type="checkbox"/> 5. Social work <input type="checkbox"/> 6. Psychological services <input type="checkbox"/> 7. Vocational services or child life services <input type="checkbox"/> 99. I don't know </p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>If clarification is needed, say, "Examples of occupational therapy include helping with adjusting to a school environment after injury. Examples of physical therapy include range of motion and walking exercises."</i></p> </div> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused</p>	
<p>Interviewer Instructions: <i>If the child didn't receive any services OR if they didn't receive PT/OT, skip to #8 on page 4</i></p>	
<p>4. If yes to OT and/or PT, How many sessions of occupational and/or physical therapy has your child had in the past 4 weeks? (If you don't know exactly, use your best guess)</p> <p> <input type="checkbox"/> 1. One <input type="checkbox"/> 2. 2 to 4 <input type="checkbox"/> 3. 5 to 10 <input type="checkbox"/> 4. More than 10 <input type="checkbox"/> 77. Not applicable (no OT/PT received) → skip to #8 on page 4 <input type="checkbox"/> 99. I don't know </p> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused</p>	
<p><i>If yes to OT and/or PT, Since your last research study questionnaire, <u>where</u> did your child receive his/her outpatient occupational or physical burn therapy?</i></p>	
<p>5. At the burn center?</p> <p> <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know </p> <p style="text-align: right; border: 1px solid black; padding: 2px;">88/Refused</p>	

6. At any other facility? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know		88/Refused
7. Using telehealth? (for example, meeting with his/her therapist using video conferencing) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know		88/Refused
8. Since your last research study questionnaire, has your child had any burn related surgeries (such as surgeries for open wounds or scar management)? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know		(If your child <u>did</u> have burn related surgeries) Has your child had any burn-related surgeries outside of this clinical center? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know

Section 2

"Please answer each question with a "yes" or "no". If you answer "yes", then please indicate to what extent this problem affects your child's daily activities using these responses:"

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

1 Not at all	2 To a very small extent	3 To a small extent	4 To a moderate extent	5 To a fairly great extent	6 To a great extent	7 To a very great extent					
Does your child have problems...				Problem?	1	2	3	4	5	6	7
1. Seeing?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Learning and understanding?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Speaking or communicating in other ways (eg, signs, gestures, picture cards, or sounds that are not words)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Controlling emotions or behavior?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. with Seizures or epilepsy?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. involving the Mouth (eg, chewing, swallowing, and drooling)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. with Teeth and gums?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. with Digestion (eg reflux, vomiting, or constipation)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. with Type 1 or Type 2 diabetes?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. with Growth?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Sleeping?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child have problems...	Problem?	1	2	3	4	5	6	7
13. with Repeated infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. with Breathing (eg asthma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. with Chronic open skin areas (eg chronic open wounds)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. with other Skin problems (eg eczema)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. with the Heart (such as a birth defect)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. with Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Does your child have any other health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify problem:						

Section 3

For each of the following symptoms please rate how much of a problem they are for your child in general.

	Not at all = 0	A little bit = 1	Some- what = 2	Quite a bit = 3	Very much = 4	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	88/Refused
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	99/Unknown
						88/Refused
						99/Unknown

Section 4

1. Is your child **currently** taking prescription medication for pain on a regular basis?

88/Refused

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

2. Is your child **currently** taking prescription medication for itch on a regular basis?

88/Refused

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

3. In the **past 12 months**, did your child take medication for being, worried, tense, or anxious?

88/Refused

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

4. In the **past 12 months**, did your child take medication for being sad, empty, or depressed?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

5. Since your last research study questionnaire, has your child received psychological therapy or counseling due to his/her burn injury?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

Section 5

1. What is your child's current weight? (lbs) _____ ☐ I don't know

88/Refused

2. What is your child's current height? (feet/inches) _____ ☐ I don't know

88/Refused

3. Where is your child currently living? (Choose only one)

- ☐ 1. Private residence
☐ 2. Nursing home
☐ 4. Correctional institution
☐ 5. Hotel/motel
☐ 6. Homeless
☐ 7. Hospital

88/Refused

99/Unknown

4. What is your child's current zip code? ____-____-____

- ☐ Not applicable (not living in U.S.) ☐ Not applicable (homeless)
(code 99999 for unknown)

5. Who is your child currently living with? (Choose all that apply)

- ☐ 4. Parent or step-parent
☐ 5. Other relative (siblings, grandparents)
☐ 6. Others, not part of family
☐ 7. Guardian

88/Refused

99/Unknown

<p>6. What is your child's current school status?</p> <p><input type="checkbox"/> 1. In school</p> <p><input type="checkbox"/> 2. Not in school </p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">99/Unknown</div>	<p><i>If your child isn't going to school, why not?</i></p> <p><input type="checkbox"/> Not school age</p> <p><input type="checkbox"/> Burn related</p> <p><input type="checkbox"/> Other medical problems</p> <p><input type="checkbox"/> Emotional/social reasons</p> <p><input type="checkbox"/> Personal choice</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Not applicable (going to school)</p> <p><input type="checkbox"/> I don't know</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; float: right;">88/Refused</div>
<p>7. <u>Interviewer instructions:</u> <i>If the child hadn't already returned to school before their last research study questionnaire, but the child is in school now, say:</i></p> <p>"What was your child's first date to return to school since his/her injury? (Please take your best guess if you don't know the exact date):" ____/____/____</p>	
<p>8. How many years of education has your child completed?</p> <p><input type="checkbox"/> 0. Preschool completed</p> <p><input type="checkbox"/> 1. 1 year or less</p> <p><input type="checkbox"/> 2. 2 years</p> <p><input type="checkbox"/> 3. 3 years</p> <p><input type="checkbox"/> 4. 4 years</p> <p><input type="checkbox"/> 77. Not applicable (child is too young for school)</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; float: right;">88/Refused</div> <div style="border: 1px solid black; padding: 2px; width: fit-content; float: right;">99/Unknown</div>	
<p>9. Is your child currently receiving <u>disability</u> income such as Social Security Disability? (Choose all that apply)</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> </div> <div> <p><input type="checkbox"/> 1. My child is not receiving disability income</p> <p><input type="checkbox"/> 2. Social Security Disability</p> <p><input type="checkbox"/> 4. Supplemental security income (SSI)</p> <p><input type="checkbox"/> 6. Other (please specify) _____</p> <p><input type="checkbox"/> 99. I don't know</p> </div> <div style="margin-left: 10px;"> </div> </div> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">88/Refused</div>	<p><i>If yes, is your child receiving disability income due to his/her burn injury?</i></p> <p><input type="checkbox"/> 1. Yes, my child is receiving disability income due to his/her burn injury</p> <p><input type="checkbox"/> 2. No, my child is not receiving disability income due to his/her burn injury</p> <p><input type="checkbox"/> 77. Not applicable (not receiving disability income)</p> <p><input type="checkbox"/> 99. I don't know</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; float: right;">88/Refused</div>
<p>10. Does your child currently have any physical problems, such as a mobility impairment (difficulty moving his/her arms, legs or body)?</p> <p><input type="checkbox"/> 1. Yes</p> <p><input type="checkbox"/> 2. No</p> <p><input type="checkbox"/> 99. I don't know</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; float: right;">88/Refused</div>	

“The following question asks about your income. We appreciate this information because income is often related to health. For instance, we’d like to know if families with lower reported income have more trouble accessing health care, such as dental care or physical therapy. Having this information helps us advocate for better programs that serve people with burn injuries.”

11. Approximately what was your family’s total income for the last full year (total income of all family members living with you in your household)? (in U.S. dollars)

99/Unknown

- ☐ 1. Less than \$25,000
- ☐ 2. \$25,000-\$49,999
- ☐ 3. \$50,000-\$99,999
- ☐ 4. \$100,000-\$149,999
- ☐ 5. \$150,000-\$199,999
- ☐ 6. \$200,000 or more
- ☐ 7. Living outside the United States
- ☐ 77. Not applicable (e.g., living in an institution)
- ☐ 88. Prefer not to answer

12. How many people are in your household? _____

88/Refused

99/Unknown

13. Who is the primary sponsor of your child’s care currently? That is, who is paying for the majority of your child’s burn care costs? (Choose only one)

88/Refused

- ☐ 1. Medicare
- ☐ 2. Medicaid (DSHS)
- ☐ 3. Private insurance/HMO/PPO/Pre-paid/Managed
- ☐ 4. Worker’s compensation (L&I)
- ☐ 6. Champus/Tri-Care
- ☐ 7. Self-pay or indigent (public support)
- ☐ 9. VA
- ☐ 10. Other
- ☐ 11. Philanthropy (private support or private foundation or Shriners hospital)
- ☐ 77. Not applicable (no burn care costs)
- ☐ 99. I don’t know

Section 6 *Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.*

The following questions ask about this child’s appearance:

	Definitely true = 1	Mostly true = 2	Not sure = 3	Mostly false = 4	Definitely false = 5
1. This child feels that the burn is unattractive to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. This child thinks that people would not want to touch him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. This child feels unsure of himself/herself among strangers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Changes in this child’s appearance have interfered with his/her relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 7

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Below is a list of activities. Please choose which response best describes your child's ability in those activities.

Unable = Can't do, doesn't know how, or is too young = 1

Hard = Does with a lot of help, extra time, or effort = 2

A little Hard = Does with a little help, extra time or effort = 3

Easy=Does with no help, extra time or effort, or child's skills are past this level= 4

(Please do not consider use of walking devices (walker, crutches or canes) unless specified.)

Please choose which answer best describes your child's abilities in the following activities.

	Unable	Hard	A little hard	Easy
1. When lying on belly, turns head to both sides	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Sits on floor without support of pillow or couch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Walks while holding onto furniture or walls	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Walks outdoors on grass, mulch or gravel	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. When running, is able to go around people and objects	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

*Instructions: If the child is younger than 3 you are finished with the interview after asking the next question below. If the child is **between the ages of 3 and 7**, continue with the rest of the survey on the last page.*

Length of interview: _____

If the child is under 3 years old, say,
"Is there anything else you would like to tell us?"

You're done with the survey. Thank you very much for sharing your experiences with us."

Section 8 (for children ages 3-7)*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.***Please indicate how often or true the behavior is of your child.**

	0=Never or not true	1=Sometimes or somewhat true	2=Often or very true
1. Has temper tantrums or hot temper.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Argues a lot with adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Gets back at people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate how often or true the behavior is of your child.

	0=Never or not true	1=Sometimes or somewhat true	2=Often or very true
1. Is unhappy, sad or depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cries a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seems lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Withdraws from peer activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 9 (for children ages 3-7)*Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.*

Indicate how much you agree or disagree:	1= Strongly disagree	2= Disagree	3= Neither agree nor disagree	4= Agree	5= Strongly agree
1. My child's life is going well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My child's life is just right.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My child has a good life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My child has what he/she wants in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Length of interview: _____

Is there anything else you would like to tell us? _____

Thank you very much for sharing your experiences with us!