

ADOLESCENT FAMILY LIFE CARE PROGRAMS CORE BASELINE QUESTIONNAIRE

FOR PARENTING TEENS

PRIVACY

We want you to know that:

1. Your answers to these questions will help us learn what people your age know, think, and do.
2. You may skip any questions you do not wish to answer. But we hope that you will answer as many questions as you can.
3. Your answers will be combined with those of other teens. We will keep your answers private.

PLEASE **DO NOT** WRITE YOUR NAME ANYWHERE ON THIS SURVEY!

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0290. The time required to complete this information collection is estimated to average 27 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

U.S. Department of Health & Human Services; OS/OIRM/PRA;
200 Independence Ave., S.W., Suite 531-H; Washington D.C. 20201
Attention: PRA Reports Clearance Officer

To be completed by project staff:

1. Client ID:						
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2. Site Number:						
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	M	M	D	D	Y	Y
3. Today's Date:						

4. Site Name: _____

Write the site name on page 4 for item #26, response options 9, 10, and 11.

After the survey has been completed and turned in, please complete page 9. You will need to make a copy of the immunization records provided by the adolescent. **Do not complete this section in front of the adolescent.**

GENERAL INSTRUCTIONS

- Read all the answers before marking your choice. If none of the printed answers exactly applies to you, black out the box beside the answer that best fits.
- Use a pencil to complete the survey.
- Completely black out in the box beside your answer choice.

INCORRECT CORRECT



- If you make an error, erase it cleanly and then mark the box beside your correct answer choice.
- Do not make any stray marks.
- **PLEASE READ EACH QUESTION CAREFULLY.**

Follow the directions for responding to each kind of question. These are:

1. MARK ONE

What is the color of your eyes?

Mark one

- 1 Brown
2 Blue
3 Green
4 Another color

If the color of your eyes is green, you would mark the third box as shown.

2. MARK ONE

What is the color of your hair?

Mark one

- 1 Brown
2 Black
3 Blonde
4 Red
5 Some other color (Describe)
 Purple

If your hair is purple, you would mark "Some other color." Then you would write "purple" in the blank.

GENERAL INSTRUCTIONS *(continued)*

3. BLANK BOX

If a question has only a blank box, write your answer in the space provided.

What is the name of the school you are currently attending?

Springfield Middle School

4. MARK ONE OR MORE

Do you plan to do any of the following next week?

Mark one or more

- ₁ Rent a video
- ₂ Go to a baseball game
- ₃ Study at a friend's house

If you plan to rent a video and go to a baseball game, you mark both.

5. QUESTION WITH A SKIP

1. Do you ever eat chocolate?

Mark one

- ₁ Yes
- ₀ No → GO to 3

2. Do you always brush your teeth after you eat chocolate?

Mark one

- ₁ Yes
- ₀ No

3. Did you do any of the following last week?

Mark one or more

- ₁ Saw a play
- ₂ Went to a movie
- ₃ Attended a sporting event

If you answered "Yes," you go to Question 2. After you answer Question 2, you go to Question 3.

If you answered "No" to Question 1, you skip Question 2. Then you go to Question 3.

ABOUT THE FUTURE

Think about the future and answer these questions:

1. How important is it to you to graduate high school? Or to graduate vocational or trade school?

MARK ONE

- ₁ Not important at all
₂ Somewhat important
₃ Very important
₄ Extremely important
₉₆ Already graduated

Answer the next question using a scale from 1 to 5. 1 is "not at all," and 5 is "a lot."

2. How much do you want to get more education or training? This could be college, vocational or technical school, or a nursing certification.

MARK ONE

**NOT
AT
ALL**

A LOT

**DON'T
KNOW**

- ₁ ₂ ₃ ₄ ₅ ₉₇

3. How important is it for you to get training to get the kind of job you want?

MARK ONE

**NOT
IMPORTANT**

**VERY
IMPORTANT**

**DON'T
KNOW**

- ₁ ₂ ₃ ₄ ₅ ₉₇

WHAT YOU THINK

4. Please mark how much you agree or disagree with this statement:

It is better for a person to get married than to go through life being single.

MARK ONE

- ₁ Strongly agree
₂ Agree
₃ Neither agree nor disagree
₄ Disagree
₅ Strongly disagree
₉₇ Don't know

5. How much do you stay away from people who might get you into trouble?

MARK ONE

- ₁ Almost never
₂ Some of the time
₃ Usually
₄ Almost always

Please mark how much the following statements sound like you.

6. I think I should work to get something, if I really want it.

MARK ONE

- ₁ Not at all like me
₂ A little like me
₃ Mostly like me
₄ Very much like me
₉₇ Don't know

7. I make decisions to help me reach my goals.

MARK ONE

- ₁ Not at all like me
- ₂ A little like me
- ₃ Mostly like me
- ₄ Very much like me
- ₉₇ Don't know

8. Some young women feel they are not ready to be a parent. For these women, I think adoption is a good choice.

MARK ONE

- ₁ Not at all like me
- ₂ A little like me
- ₃ Mostly like me
- ₄ Very much like me
- ₉₇ Don't know

The next question is about your mother or father. Or a person like a mother or father to you.

9. How often do you talk to your mother or father about your problems?

MARK ONE

- ₁ Almost never
- ₂ Some of the time
- ₃ Usually
- ₄ Almost always
- ₉₆ There is no person who is like a mother or father to me

These next questions are about how you feel about being a parent. How much do the following statements apply to you?

10. In the last month, I have felt trapped by the things I have to do as a parent.

MARK ONE

- ₁ Strongly agree
- ₂ Agree
- ₃ Neither agree nor disagree
- ₄ Disagree
- ₅ Strongly disagree

11. I consider being a parent a good thing in my life.

MARK ONE

- ₁ Strongly agree
- ₂ Agree
- ₃ Neither agree nor disagree
- ₄ Disagree
- ₅ Strongly disagree

12. I find that taking care of my child(ren) is much more work than pleasure.

MARK ONE

- ₁ Strongly agree
- ₂ Agree
- ₃ Neither agree nor disagree
- ₄ Disagree
- ₅ Strongly disagree

13. I enjoy spending time with my child(ren).

MARK ONE

- ₁ Strongly agree
- ₂ Agree
- ₃ Neither agree nor disagree
- ₄ Disagree
- ₅ Strongly disagree

ABOUT YOUR CHILD

These next questions are about your child. (If you have more than one child, think about your youngest child).

14. When was this child born? ____ / ____ / ____
MONTH / YEAR

15. An early birth is one that occurs at 36 weeks or earlier in pregnancy. As far as you know, did you have an early birth?

- ₁ Yes
₀ No
₉₇ Don't know

16. How much did this child weigh at birth?

MARK ONE

- ₁ 5½ pounds or more
₂ Less than 5½ pounds
₉₇ Don't know

17. This next question is about after the birth of this child. About how many times has this child had a regular check up or "well-baby" visit? This is a visit to a doctor or nurse when this child is not sick, but to get checked out or to get shots. Would you say . . .

MARK ONE

- ₁ Never **(SKIP TO #19)**
₂ 1-3 times
₃ 4 or more times
₉₇ Don't know

18. When was this child's last "well baby" visit?

MARK THE MOST RECENT

- ₁ Within the past 3 months
₂ Within the past 6 months
₃ Within the past 12 months
₄ More than a year ago
₉₇ Don't know

19. Did you breastfeed this child at all?

- ₁ Yes
₀ No **(SKIP TO #21)**

20. How old was this child when you completely stopped breastfeeding him or her?

MARK ONE

- ₁ I am still breastfeeding
₂ Younger than 1 month old
₃ 1 month old to 2 months old
₄ 3 months old or older

21. Does this child live with you?

MARK ONE

- ₂ Yes
₁ Sometimes
₀ No
- (SKIP TO # 23 ON PAGE 4)**

22. Where does this child live now?

MARK ONE

- ₁ With the child's father
₂ With other relatives
₃ With adoptive family
₄ Other (Describe _____)
₉₇ Don't know

23. Is this child 3 months old or older?

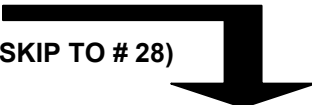
- ₁ Yes 
- ₀ No (SKIP TO # 25)

24. Has this child had any of the following vaccinations/shots?

<i>Mark one for each</i>		Yes	No	Don't know
a.	Diphtheria, Tetanus, Pertussis (DTaP)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
b.	Inactivated Poliovirus (IPV)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
c.	<i>Haemophilus influenzae</i> type b (Hib)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
d.	Hepatitis B (HepB)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
e.	Pneumococcal (PCV)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
f.	Rotavirus (Rota)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇

IF THIS CHILD DOES NOT LIVE WITH YOU, PLEASE SKIP TO QUESTION #28 ON THE NEXT PAGE

25. This next question is about the past four weeks. Has this child received any regular child care? This could be a day care, nursery school, play group, babysitter, after school care, relative, or some other child care plan. ("Regular" means at least once a week for a month or more.)

- ₁ Yes 
- ₀ No (SKIP TO # 28)

26. Which of these has been your main child care provider in the past four weeks?

MARK ONE

- ₁ Child's father/stepfather
- ₂ My brother/sister aged 13 years old or older
- ₃ My brother/sister younger than 13 years old
- ₄ Child's grandparent
- ₅ Other relative
- ₆ Non-relative or babysitter
- ₇ Nursery/preschool
- ₈ Family day care
- ₉ _____
- ₁₀ Day care center referred by _____
- ₁₁ Day care center **not** referred by _____
- ₁₂ Other (Describe _____)
- ₁₃ Child has not received regular child care in past four weeks

27. How many hours a week is this child in child care? This includes all the different plans that you use.

Hours

₉₇ **MARK HERE IF YOU DON'T KNOW**

28. Which of these statements best describes your relationship with this child's father?

MARK ONE

- ₁ We do not see or talk to each other
- ₂ We hardly ever see or talk to each other
- ₃ We are just friends
- ₄ We are involved in an on-again, off-again relationship
- ₅ We are romantically involved on a steady basis but are not married
- ₆ We are married (**SKIP TO # 33**)
- ₇ Don't know

IF YOU ARE MARRIED TO THE FATHER OF THIS CHILD, SKIP TO #33

29. Do you and this child's father have a legal agreement for child support, alimony, custody, visitation, or where the child will live?

- ₁ Yes
- ₀ No

30. Does this child's father give you money or buy clothes for the child? Or pay for doctor visits or provide other kinds of support?

- ₁ Yes
- ₀ No

31. Does this child's father help you in other ways, such as watching the child or helping with chores?

- ₁ Yes
- ₀ No

32. What is your marital status?

MARK ONE

- ₁ Single, never married (including living with someone or engaged)
- ₂ Married
- ₃ Separated or divorced
- ₄ Widowed
- ₅ Other (Describe _____)

33. Who do you live with now?

MARK ALL THAT APPLY

- a. I live alone
- b. With husband
- c. With my mother (include stepmother)
- d. With my father (include stepfather)
- e. With this child's father
- f. With this child's father's mother
- g. With this child's father's father
- h. With partner
- i. With other relatives
- j. With friends
- k. In a group home/institution
- l. In a foster home
- m. Other (Describe _____)

ABOUT YOUR HEALTH

34. These are some ways people try to avoid sexually transmitted diseases. What way(s) did you try this month?

MARK ONE OR MORE

- ₁ No method used this month
- ₂ Abstinence (did not have sex this month)
- ₃ Condom
- ₄ Female condom, vaginal pouch
- ₅ Other method (Describe _____)

35. These are some ways people try to avoid pregnancy. What way(s) did you try this month?

MARK ONE OR MORE

- ₁ No method used this month
- ₂ Abstinence (did not have sex this month)
- ₃ Birth control pills
- ₄ Condom
- ₅ Withdrawal, pulling out
- ₆ Depo-Provera, injectables (the shot)
- ₇ Natural family planning (rhythm or safe period by calendar, temperature or cervical mucus test)
- ₈ Diaphragm
- ₉ Female condom, vaginal pouch
- ₁₀ Foam
- ₁₁ Jelly or cream
- ₁₂ Cervical cap
- ₁₃ Suppository
- ₁₄ Sponge
- ₁₅ IUD
- ₁₆ "Morning after" pills or emergency contraception
- ₁₇ Contraceptive patch
- ₁₈ NuvaRing (vaginal ring)
- ₁₉ Implanon
- ₂₀ Other method (Describe _____)

36. How many times have you been pregnant in your life?

MARK ONE

- ₁ Once
- ₂ Twice
- ₃ Three times
- ₄ More than three times

ABOUT YOU

These questions ask about you.

37. How old are you?

MARK ONE

- ₁ 12 years old or younger
- ₂ 13 years old
- ₃ 14 years old
- ₄ 15 years old
- ₅ 16 years old
- ₆ 17 years old
- ₇ 18 years old
- ₈ 19 years old or older

38. Think about any children who may live with you. How many are under your care?

MARK ONE

- ₀ Zero (**SKIP TO #40**)
- ₁ One
- ₂ Two
- ₃ Three or more

39. How many of these children were born to you?

MARK ONE

- ₀ Zero
- ₁ One
- ₂ Two
- ₃ Three or more

40. Are you Hispanic or Latino?

- ₁ Yes
- ₀ No

41. Mark the box or boxes to describe your race.

MARK ONE OR MORE

- ₁ White
- ₂ Black or African American
- ₃ Asian
- ₄ Native Hawaiian or Other Pacific Islander
- ₅ American Indian or Alaska Native
- ₆ Other
(Describe _____)

42. What is your current school status?

MARK ONE

- ₁ In school or GED program
- ₂ Graduated from high school or completed GED (**SKIP TO # 44**)
- ₃ Dropped out of school
- ₄ Other (Describe _____)

IF YOU HAVE NOT FINISHED HIGH SCHOOL OR COMPLETED YOUR GED:

43. Do you want to have another baby before you finish high school?

- ₁ Yes
- ₀ No
- ₉₇ Don't know

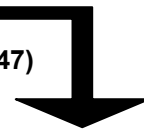
44. What is the highest grade you have completed?

MARK ONE

- ₁ 8th grade or below
- ₂ 9th grade
- ₃ 10th grade
- ₄ 11th grade
- ₅ 12th grade
- ₆ Some college
- ₇ College degree or more
- ₉₇ Don't know

45. Have you ever been in a job training program?

- ₁ Yes
- ₀ No (**SKIP TO #47**)



46. Did you ever complete a job training program?

MARK ONE

- ₁ Yes
- ₂ No and not now in a job training program
- ₃ No and now in a job training program

47. How many hours do you work per week?

WRITE 00 IF YOU DO NOT WORK

Hours per week

48. Do you receive money or aid from any of the following sources?

MARK ALL THAT APPLY

- a. Medicaid
- b. Food stamps
- c. WIC (Women, Infants, and Children) Program
- d. TANF (Temporary Aid to Needy Families)
- e. Social Security
- f. Unemployment or Workers' Compensation
- g. Other public aid
- h. Child support
- i. My job
- j. Husband or partner
- k. Parent(s)
- l. Other (Describe _____)

49. What is your main source of financial support?

MARK ONE

- ₁ My job
- ₂ Husband or partner
- ₃ Parents
- ₄ Public aid
- ₅ Other relatives
- ₆ Other (Describe _____)

That's all!
**Thank you so very much for your
time.**

TO BE COMPLETED BY SURVEY ADMINISTRATION STAFF

After the survey has been completed and turned in, please complete this page. You will need to make a copy of the immunization records provided by the adolescent. **Do not complete this section in front of the adolescent.**

1. Child's birth date (can be copied from item #14):

____ / ____ MONTH / YEAR

2. Do you have access to this child's immunization record?

- ₁ Yes
₂ No (**SKIP TO PAGE 10**)

3. Using the child's immunization records, mark whether or not the child has received at least one dose of each of the immunizations listed below.

<i>Mark one for each</i>		Yes	No	Unknown/ not mentioned
a.	Diphtheria, Tetanus, Pertussis (DTaP)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
b.	Inactivated Poliovirus (IPV)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
c.	<i>Haemophilus influenzae</i> type b (Hib)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
d.	Hepatitis B (HepB)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
e.	Pneumococcal (PCV)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇
f.	Rotavirus (Rota)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	<input type="checkbox"/> ₉₇

SURVEY ADMINISTRATOR:
YOU HAVE COMPLETED THIS RECORD ABSTRACTION.
THANK YOU FOR YOUR TIME!