

**FORM HIS-2 (1995)**  
(5-1-95)

U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
ACTING AS COLLECTING AGENT FOR THE  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL  
NATIONAL CENTER FOR HEALTH STATISTICS

**NATIONAL HEALTH INTERVIEW SURVEY**

**1995 SUPPLEMENT BOOKLET**

**I. IMMUNIZATION**

**II. DISABILITY**

**NOTICE** - Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to average 50 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA (0920-0214); Hubert H. Humphrey Building, Room 737-F, 200 Independence Avenue, SW; Washington, DC 20201.

|  |                           |                     |                         |  |                          |
|--|---------------------------|---------------------|-------------------------|--|--------------------------|
| <b>1. RO</b><br>9-10   | <b>2. Sample</b><br>11-13 | <b>Suffix</b><br>14 | <b>3. Week</b><br>15-16 | <b>4. Book</b> ___ of ___ books                                    | <b>RT 51</b><br>3-7<br>8 |
| <b>5. Control number</b>   |                           |                     |                         | <b>6. Family number</b> 32   |                          |
| PSU<br>17-21   | Segment<br>22-25          | Suffix<br>26-27     | Serial<br>28-29         | Suffix<br>30   | Check digit<br>31        |
| <b>7. Field Representative's name</b>                              |                           |                     |                         |  | <b>Code</b> 33-35        |
| <b>8. Beginning time</b>   |                           |                     | 40                      | <b>9. Ending time</b> 41-44 45                                     |                          |
| 1 <input type="checkbox"/> a.m.<br>2 <input type="checkbox"/> p.m. |                           |                     |                         | 1 <input type="checkbox"/> a.m.<br>2 <input type="checkbox"/> p.m. |                          |

**SAMPLE CHILD LIST**

**ITEM I1**

**Are there any nondeleted persons under 6 years old in this family?**

Yes (List by age, oldest to youngest)  
 No (Section II on page 12)

| RT 52    | 3-4        | 5-6 | 7   |           |            | 8                          | 9                          | 10       |
|----------|------------|-----|---|-----------|------------|----------------------------|----------------------------|----------|
| Line No. | Person No. | Age | Sex   | Last name | First name | SC                         | 19-35 months               | List No. |
| 1        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 2        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 3        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 4        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 5        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 6        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 7        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 8        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |
| 9        |            |     | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |           |            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1        |

Refer to the sample child selection label and circle as applicable. THEN, mark (X) the "SC" box in the column above for the selected sample child under 6.

**ITEM I2A**

**Are there any non-selected 2 year olds in the above list?**

Yes (Mark (X) box in "19-35 months" column for EACH, then I2B)  
 No (I2B)

**ITEM I2B**

**Are there any non-selected 1 year olds in the above list?**

Yes (Refer to Eligibility Chart below for EACH 1 year old)  
 No (Section I)

**ELIGIBILITY CHART**

If month of Interview is: Mark (X) box in "19-35 months" column if child's Date of Birth is Within:

|                |               |
|----------------|---------------|
| January 1995   | 02/92 - 06/93 |
| February 1995  | 03/92 - 07/93 |
| March 1995     | 04/92 - 08/93 |
| April 1995     | 05/92 - 09/93 |
| May 1995       | 06/92 - 10/93 |
| June 1995      | 07/92 - 11/93 |
| July 1995      | 08/92 - 12/93 |
| August 1995    | 09/92 - 01/94 |
| September 1995 | 10/92 - 02/94 |
| October 1995   | 11/92 - 03/94 |
| November 1995  | 12/92 - 04/94 |
| December 1995  | 01/93 - 05/94 |
| January 1996   | 02/93 - 06/94 |

**Complete final status on Back Cover**

RT 32  
3-4

|   |                  |                        |                               |                               |   |   |   |
|---|------------------|------------------------|-------------------------------|-------------------------------|---|---|---|
| <p><b>ITEM X1</b></p> <p><i>Enter conditions reported in the Disability supplement in X1</i><br/><i>If insufficient space to enter multiple sources, continue in a footnote</i></p> | <p><b>X1</b></p> | <p><b>PERSON 1</b></p> |                               |                               |   |   |   |
|   |                  | A                      | C                             | D                             | E | F | G |
|   |                  | A                      | C                             | D                             | E | F | G |
|   |                  | A                      | C                             | D                             | E | F | G |
|   |                  | A                      | C                             | D                             | E | F | G |
|   |                  | A                      | C                             | D                             | E | F | G |
| <p><b>ITEM X2</b></p> <p><i>Indicate ADL Limitations in X2</i></p>  | <p><b>X2</b></p> | <p>Help/ Remind</p>    | <p>Spec. equip.</p>           | <p>Difficulty/ Doesn't do</p> |   |   |   |
|   |                  | Bathing                |                               |                               |   |   |   |
|   |                  | Dressing               |                               |                               |   |   |   |
|   |                  | Eating                 |                               |                               |   |   |   |
|   |                  | Bed/chair              |                               |                               |   |   |   |
|   |                  | Toilet                 |                               |                               |   |   |   |
| Getting around  |                  |                        |                               |                               |   |   |   |
| <p><b>ITEM X3</b></p> <p><i>Indicate IADL Limitations in X3</i></p>   | <p><b>X3</b></p> | <p>Help/ Supv.</p>     | <p>Difficulty/ Doesn't do</p> |                               |   |   |   |
|   |                  | Prep. meals            |                               |                               |   |   |   |
|   |                  | Shopping               |                               |                               |   |   |   |
|   |                  | Managing money         |                               |                               |   |   |   |
|   |                  | Telephone              |                               |                               |   |   |   |
|   |                  | Heavy work             |                               |                               |   |   |   |
| Light work  |                  |                        |                               |                               |   |   |   |
| <p>Notes</p>  |                  |                        |                               |                               |   |   |   |

**Section I - IMMUNIZATION - Continued**

RT 54

|                |  |                                      |     |
|----------------|--|--------------------------------------|-----|
| <b>ITEM 13</b> | <i>Enter person number and first name of sample child under 6.</i> | Person number _____ First name _____ | 3-4 |
|                | <i>Enter person number of respondent.</i>                          | Person number _____                  | 5-6 |

**These questions refer to (read name), and are about immunizations that -- may have received. It would be helpful if we could refer to -- shot record.**

|                |                              |  |   |
|----------------|------------------------------|--|---|
| <b>ITEM 14</b> | <i>Refer to shot record.</i> | 1 <input type="checkbox"/> Available (2)     | 7 |
|                |                              | 2 <input type="checkbox"/> Not available (1) |   |

|  |  |   |
|--|--|---|
| <b>1.</b> Ask only on initial interview. On callback, skip to 9. We will need the shot record to complete this section of the interview. If I called you within the next few days, would you be able to have --'s shot record available? | 1 <input type="checkbox"/> Yes (Arrange callback, then 15 on page 6)<br>2 <input type="checkbox"/> No } (9)<br>9 <input type="checkbox"/> DK } | 8 |
|--|--|---|

**2.** Transcribe from shot record - If telephone ask: Looking at the shot record, please tell me how many times -- has received (names of vaccines)? Record number of times for each vaccine. What is the date on the record for (first) (vaccine)? Repeat for second, third -- shots.

|            | (1) A DTP/DT shot (some times called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)?             | (2) A polio vaccine by mouth (pink drops) or a polio shot?   | (3) A measles or MMR (Measles - Mumps - Rubella) shot?<br><i>If telephone ask: Was each shot measles only or MMR?</i>            | RT 55       | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) | (5) A Hepatitis B shot?   |
|------------|---|--|--|-------------|---|---|
|            | 9-10<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK } | 59-60<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK } | 5-6<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK } | 3-4<br>5-6  | 35-36<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK }    | 61-62<br>Shots (Record dates, then 3)<br>(Number)<br>00 <input type="checkbox"/> None } (3)<br>99 <input type="checkbox"/> DK } |
|            | DTP/DT (Shot)   | Polio (Drops or shots)   | Measles/MMR (Shots)  |             | HIB (Shot)  | Hepatitis B   |
| <b>1st</b> | 11-16<br>____/____/19<br>MO DAY YR  | 61-66<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR     | 7<br>8-13   | 37-42<br>____/____/19<br>MO DAY YR  | 63-68<br>____/____/19<br>MO DAY YR  |
| <b>2nd</b> | 17-22<br>____/____/19<br>MO DAY YR  | 67-72<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR     | 14<br>15-20 | 43-48<br>____/____/19<br>MO DAY YR  | 69-74<br>____/____/19<br>MO DAY YR  |
| <b>3rd</b> | 23-28<br>____/____/19<br>MO DAY YR  | 73-78<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR     | 21<br>22-27 | 49-54<br>____/____/19<br>MO DAY YR  | 75-80<br>____/____/19<br>MO DAY YR  |
| <b>4th</b> | 29-34<br>____/____/19<br>MO DAY YR  | 79-84<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR     | 28<br>29-34 | 55-60<br>____/____/19<br>MO DAY YR  | 81-86<br>____/____/19<br>MO DAY YR  |
| <b>5th</b> | 35-40<br>____/____/19<br>MO DAY YR  | 85-90<br>____/____/19<br>MO DAY YR   |  |             |   |   |
| <b>6th</b> | 41-46<br>____/____/19<br>MO DAY YR  | 91-96<br>____/____/19<br>MO DAY YR   |  |             |   |   |
| <b>7th</b> | 47-52<br>____/____/19<br>MO DAY YR  | 97-102<br>____/____/19<br>MO DAY YR  |  |             |   |   |
| <b>8th</b> | 53-58<br>____/____/19<br>MO DAY YR  | 103-108<br>____/____/19<br>MO DAY YR   |  |             |   |   |

**Section I - IMMUNIZATION - Continued**

|  |  |           |
|--|--|-----------|
| <p><b>3. Are all the immunizations that -- ever received included on this shot record?</b></p>   | <p>1 <input type="checkbox"/> Yes (11)<br/>                 2 <input type="checkbox"/> No } (4)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>87</p> |
| <p><b>4a. Has -- ever received an additional DTP shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis shot, baby shot, or three-in-one-shot)?</b></p>                         | <p>1 <input type="checkbox"/> Yes (4b)<br/>                 2 <input type="checkbox"/> No } (5)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>88</p> |
| <p><b>b. How many additional DTP shots has -- received?</b></p>  | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                |           |
| <p><b>5a. Has -- ever received an additional polio vaccine by mouth (pink drops) or a polio shot?</b></p>  | <p>1 <input type="checkbox"/> Yes (5b)<br/>                 2 <input type="checkbox"/> No } (6)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>90</p> |
| <p><b>b. How many additional polio vaccines has -- received?</b></p>   | <p>_____ Vaccines<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>             |           |
| <p><b>6a. Has -- ever received an additional measles or MMR (Measles-Mumps-Rubella) shot?</b></p>  | <p>1 <input type="checkbox"/> Yes (6b)<br/>                 2 <input type="checkbox"/> No } (7)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>92</p> |
| <p><b>b. How many additional measles or MMR shots has -- received?</b></p>   | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                |           |
| <p><b>7a. Has -- ever received an additional HIB shot? This shot is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI), HIB vaccine or H. flu vaccine.</b></p> | <p>1 <input type="checkbox"/> Yes (7b)<br/>                 2 <input type="checkbox"/> No } (8)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>94</p> |
| <p><b>b. How many additional HIB shots has -- received?</b></p>  | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                |           |

**Section I - IMMUNIZATION - Continued**

|  |  |
|--|--|
| <b>8a. Has -- ever received an additional Hepatitis B shot?</b>  | <input type="checkbox"/> Yes (8b) <span style="float:right">96</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (11)                 |
| <b>b. How many additional Hepatitis B shots has -- received?</b> | <div style="text-align: right;">         _____ Shots<br/>         (Number)       </div> <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (11) |

|   |   |
|---|---|
| <b>9. Has -- ever received an immunization (that is a shot or drops)?</b> | <input type="checkbox"/> Yes (10) <span style="float:right">98</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (Item 15 on page 6) |
|---|---|

|   |   |   |  |  |
|---|---|---|--|--|
| <b>10a. Has -- ever received:</b>   |   |   |  |  |
| <b>(1) A DTP/DT shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three- in-one shot)?</b><br><br><input type="checkbox"/> Yes (10b) <span style="float:right">99</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (Next vaccine) | <b>(2) A polio vaccine by mouth (pink drops) or a polio shot?</b><br><br><input type="checkbox"/> Yes (10b) <span style="float:right">102</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (Next vaccine) | <b>(3) A measles or MMR (Measles - Mumps - Rubella) shot?</b><br><br><input type="checkbox"/> Yes (10b) <span style="float:right">105</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (Next vaccine) | <b>(4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine)</b><br><br><input type="checkbox"/> Yes (10b) <span style="float:right">108</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (Next vaccine) | <b>(5) A Hepatitis B shot?</b><br><br><input type="checkbox"/> Yes (10b) <span style="float:right">111</span><br><input type="checkbox"/> No }<br><input type="checkbox"/> DK } (11) |

|   |   |   |   |   |
|---|---|---|---|---|
| <b>10b. How many (vaccine) shots did -- ever receive?</b>   |   |   |   |   |
| (1) DTP/DT  | (2) Polio   | (3) Measles or MMR  | (4) HIB   | (5) Hepatitis B   |
| <div style="border: 1px solid black; width: 40px; margin: 0 auto; padding: 2px;">100-101</div><br>_____ Shots<br>(Number) | <div style="border: 1px solid black; width: 40px; margin: 0 auto; padding: 2px;">103-104</div><br>_____ Shots<br>(Number) | <div style="border: 1px solid black; width: 40px; margin: 0 auto; padding: 2px;">106-107</div><br>_____ Shots<br>(Number) | <div style="border: 1px solid black; width: 40px; margin: 0 auto; padding: 2px;">109-110</div><br>_____ Shots<br>(Number) | <div style="border: 1px solid black; width: 40px; margin: 0 auto; padding: 2px;">112-113</div><br>_____ Shots<br>(Number) |
| <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (Next vaccine)  | <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (Next vaccine)  | <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (Next vaccine)  | <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (Next vaccine)  | <input type="checkbox"/> All }<br><input type="checkbox"/> DK } (11)  |

|  |   |
|--|---|
| <b>11. Are you the person who took -- for most of -- shots? (Most means at least 1/2 of the shots)</b> | <input type="checkbox"/> Yes <span style="float:right">114</span><br><input type="checkbox"/> No<br><input type="checkbox"/> DK |
|--|---|

|  |   |
|--|---|
| <b>12. In your opinion, has -- received all of the recommended shots for -- age?</b> | <input type="checkbox"/> Yes <span style="float:right">115</span><br><input type="checkbox"/> No<br><input type="checkbox"/> DK |
|--|---|

**Section I - IMMUNIZATION - Continued**

|  |  |  |                 |                   |  |  |
|--|--|--|-----------------|-------------------|--|--|
| <b>ITEM<br/>15</b>   | <i>Refer to Sample Child List on Cover.</i>  | 1 <input type="checkbox"/> Additional 19-35 month old child ( <i>Item 18 on page 7</i> )<br>2 <input type="checkbox"/> No additional 19-35 month old child ( <i>16</i> )   |                 |                   |  |  |
| <b>ITEM<br/>16</b>   | <i>Refer to questions 2 and 10 for SC.<br/>Mark (X) first appropriate box.</i>   | 1 <input type="checkbox"/> Callback required } ( <i>Fill HIS-2A if appropriate, then 17</i> )<br>2 <input type="checkbox"/> Any immunizations }<br>3 <input type="checkbox"/> No immunizations ( <i>Section II on page 12</i> )  |                 |                   |  |  |
| <b>ITEM<br/>17</b>   | <i>Status of HIS-2A for SC.<br/>Mark (X) one in each column.</i>   | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px dashed black; text-align: center;"><u>Provider</u></td> <td style="width: 50%; text-align: center;"><u>Permission</u></td> </tr> <tr> <td style="border-right: 1px dashed black; vertical-align: top;">                     0 <input type="checkbox"/> Not required<br/>                     1 <input type="checkbox"/> Complete<br/>                     2 <input type="checkbox"/> Refused<br/>                     3 <input type="checkbox"/> Other (<i>Explain in notes</i>)                 </td> <td style="vertical-align: top;">                     0 <input type="checkbox"/> Not required<br/>                     1 <input type="checkbox"/> Complete<br/>                     2 <input type="checkbox"/> Refused<br/>                     3 <input type="checkbox"/> Other (<i>Explain in notes</i>)                 </td> </tr> </table> | <u>Provider</u> | <u>Permission</u> | 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other ( <i>Explain in notes</i> ) | 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other ( <i>Explain in notes</i> ) |
| <u>Provider</u>  | <u>Permission</u>  |  |                 |                   |  |  |
| 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other ( <i>Explain in notes</i> ) | 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other ( <i>Explain in notes</i> ) |  |                 |                   |  |  |
| Notes  |  | 1 Sample child   |                 |                   |  |  |

**Section I – IMMUNIZATION – Continued**

RT 54

|                |  |                     |                  |     |
|----------------|--|---------------------|------------------|-----|
| <b>ITEM 18</b> | Enter person number and first name of other 19-35 month old child. | Person number _____ | First name _____ | 3-4 |
|                | Enter person number of respondent.                                 | Person number _____ |                  | 5-6 |

**These questions refer to (read name), and are about immunizations that -- may have received. It would be helpful if we could refer to -- shot record.**

|                |                       |   |   |   |
|----------------|-----------------------|---|---|---|
| <b>ITEM 19</b> | Refer to shot record. | 1 <input type="checkbox"/> Available (14) | 2 <input type="checkbox"/> Not available (13) | 7 |
|----------------|-----------------------|---|---|---|

|   |   |   |
|---|---|---|
| <b>13.</b> Ask only on initial interview. On callback, skip to 21.<br><b>We will need the shot record to complete this section of the interview.</b><br>If I called you within the next few days, would you be able to have --'s shot record available? | 1 <input type="checkbox"/> Yes (Arrange callback, then 110 on page 10)<br>2 <input type="checkbox"/> No } (21)<br>9 <input type="checkbox"/> DK } | 8 |
|---|---|---|

**14.** Transcribe from shot record – If telephone ask: **Looking at the shot record, please tell me how many times -- has received (names of vaccines)?** Record number of times for each vaccine. **What is the date on the record for (first) (vaccine)?** Repeat for second, third -- shots.

|            | (1) A DTP/DT shot (some times called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)?             | (2) A polio vaccine by mouth (pink drops) or a polio shot?   | (3) A measles or MMR (Measles – Mumps – Rubella) shot?<br><i>If telephone ask: Was each shot measles only or MMR?</i>              | RT 55       | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) | (5) A Hepatitis B shot?   |
|------------|---|--|--|-------------|---|---|
|            | 9-10<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK } | 59-60<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK } | Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK }          | 3-4<br>5-6  | 35-36<br>Shots (Record dates)<br>(Number)<br>00 <input type="checkbox"/> None } (Next vaccine)<br>99 <input type="checkbox"/> DK }    | 61-62<br>Shots (Record dates, then 15)<br>(Number)<br>00 <input type="checkbox"/> None } (15)<br>99 <input type="checkbox"/> DK } |
|            | DTP/DT (Shot)   | Polio (Drops or shots)   | Measles/MMR (Shots)  |             | HIB (Shot)  | Hepatitis B   |
| <b>1st</b> | 11-16<br>____/____/19<br>MO DAY YR  | 61-66<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles    2 <input type="checkbox"/> MMR    9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR | 7<br>8-13   | 37-42<br>____/____/19<br>MO DAY YR  | 63-68<br>____/____/19<br>MO DAY YR  |
| <b>2nd</b> | 17-22<br>____/____/19<br>MO DAY YR  | 67-72<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles    2 <input type="checkbox"/> MMR    9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR | 14<br>15-20 | 43-48<br>____/____/19<br>MO DAY YR  | 69-74<br>____/____/19<br>MO DAY YR  |
| <b>3rd</b> | 23-28<br>____/____/19<br>MO DAY YR  | 73-78<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles    2 <input type="checkbox"/> MMR    9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR | 21<br>22-27 | 49-54<br>____/____/19<br>MO DAY YR  | 75-80<br>____/____/19<br>MO DAY YR  |
| <b>4th</b> | 29-34<br>____/____/19<br>MO DAY YR  | 79-84<br>____/____/19<br>MO DAY YR   | 1 <input type="checkbox"/> Measles    2 <input type="checkbox"/> MMR    9 <input type="checkbox"/> DK<br>____/____/19<br>MO DAY YR | 28<br>29-34 | 55-60<br>____/____/19<br>MO DAY YR  | 81-86<br>____/____/19<br>MO DAY YR  |
| <b>5th</b> | 35-40<br>____/____/19<br>MO DAY YR  | 85-90<br>____/____/19<br>MO DAY YR   |  |             |   |   |
| <b>6th</b> | 41-46<br>____/____/19<br>MO DAY YR  | 91-96<br>____/____/19<br>MO DAY YR   |  |             |   |   |
| <b>7th</b> | 47-52<br>____/____/19<br>MO DAY YR  | 97-102<br>____/____/19<br>MO DAY YR  |  |             |   |   |
| <b>8th</b> | 53-58<br>____/____/19<br>MO DAY YR  | 103-108<br>____/____/19<br>MO DAY YR   |  |             |   |   |

**Section I - IMMUNIZATION - Continued**

|   |  |           |
|---|--|-----------|
| <p><b>15. Are all the immunizations that -- ever received included on this shot record?</b></p>   | <p>1 <input type="checkbox"/> Yes (23)<br/>                 2 <input type="checkbox"/> No } (16)<br/>                 9 <input type="checkbox"/> DK }</p>  | <p>87</p> |
| <p><b>16a. Has -- ever received an additional DTP shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis shot, baby shot, or three-in-one-shot)?</b></p>                         | <p>1 <input type="checkbox"/> Yes (16b)<br/>                 2 <input type="checkbox"/> No } (17)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>88</p> |
| <p><b>b. How many additional DTP shots has -- received?</b></p>   | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                  | <p>89</p> |
| <p><b>17a. Has -- ever received an additional polio vaccine by mouth (pink drops) or a polio shot?</b></p>  | <p>1 <input type="checkbox"/> Yes (17b)<br/>                 2 <input type="checkbox"/> No } (18)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>90</p> |
| <p><b>b. How many additional polio vaccines has -- received?</b></p>  | <p>_____ Vaccines<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>               | <p>91</p> |
| <p><b>18a. Has -- ever received an additional measles or MMR (Measles-Mumps-Rubella) shot?</b></p>  | <p>1 <input type="checkbox"/> Yes (18b)<br/>                 2 <input type="checkbox"/> No } (19)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>92</p> |
| <p><b>b. How many additional measles or MMR shots has -- received?</b></p>  | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                  | <p>93</p> |
| <p><b>19a. Has -- ever received an additional HIB shot? This shot is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI), HIB vaccine or H. flu vaccine.</b></p> | <p>1 <input type="checkbox"/> Yes (19b)<br/>                 2 <input type="checkbox"/> No } (20)<br/>                 9 <input type="checkbox"/> DK }</p> | <p>94</p> |
| <p><b>b. How many additional HIB shots has -- received?</b></p>   | <p>_____ Shots<br/>                 (Number)</p> <p>8 <input type="checkbox"/> All<br/>                 9 <input type="checkbox"/> DK</p>                  | <p>95</p> |



**Section I - IMMUNIZATION - Continued**

|  |   |
|--|---|
| <b>20a. Has -- ever received an additional Hepatitis B shot?</b> | <input type="checkbox"/> Yes (20b) <span style="float:right">96</span><br><input type="checkbox"/> No } (23)<br><input type="checkbox"/> DK } |
| <b>b. How many additional Hepatitis B shots has -- received?</b> | <div style="text-align: right;">Shots } (23)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK                    |

|  |  |
|--|--|
| <b>21. Has -- ever received an immunization (that is a shot or drops)?</b> | <input type="checkbox"/> Yes (22) <span style="float:right">98</span><br><input type="checkbox"/> No } (Item 110)<br><input type="checkbox"/> DK } |
|--|--|

**22a. Has -- ever received:**

|   |   |   |  |  |
|---|---|---|--|--|
| <b>(1) A DTP/DT shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three- in-one shot)?</b><br><br><input type="checkbox"/> Yes (22b) <span style="float:right">99</span><br><input type="checkbox"/> No } (Next vaccine)<br><input type="checkbox"/> DK } | <b>(2) A polio vaccine by mouth (pink drops) or a polio shot?</b><br><br><input type="checkbox"/> Yes (22b) <span style="float:right">102</span><br><input type="checkbox"/> No } (Next vaccine)<br><input type="checkbox"/> DK } | <b>(3) A measles or MMR (Measles - Mumps - Rubella) shot?</b><br><br><input type="checkbox"/> Yes (22b) <span style="float:right">105</span><br><input type="checkbox"/> No } (Next vaccine)<br><input type="checkbox"/> DK } | <b>(4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine)</b><br><br><input type="checkbox"/> Yes (22b) <span style="float:right">108</span><br><input type="checkbox"/> No } (Next vaccine)<br><input type="checkbox"/> DK } | <b>(5) A Hepatitis B shot?</b><br><br><input type="checkbox"/> Yes (22b) <span style="float:right">111</span><br><input type="checkbox"/> No } (23)<br><input type="checkbox"/> DK } |
|---|---|---|--|--|

**22b. How many (vaccine) shots did -- ever receive?**

| (1) DTP/DT   | (2) Polio  | (3) Measles or MMR   | (4) HIB  | (5) Hepatitis B  |
|--|--|--|--|--|
| 100-101  | 103-104  | 106-107  | 109-110  | 112-113  |
| <div style="text-align: right;">Shots } (Next vaccine)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK | <div style="text-align: right;">Shots } (Next vaccine)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK | <div style="text-align: right;">Shots } (Next vaccine)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK | <div style="text-align: right;">Shots } (Next vaccine)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK | <div style="text-align: right;">Shots } (23)</div> (Number)<br><input type="checkbox"/> All<br><input type="checkbox"/> DK |

|  |   |
|--|---|
| <b>23. Are you the person who took -- for most of -- shots? (Most means at least 1/2 of the shots)</b> | <input type="checkbox"/> Yes <span style="float:right">114</span><br><input type="checkbox"/> No<br><input type="checkbox"/> DK |
|--|---|

|  |   |
|--|---|
| <b>24. In your opinion, has -- received all of the recommended shots for -- age?</b> | <input type="checkbox"/> Yes <span style="float:right">115</span><br><input type="checkbox"/> No<br><input type="checkbox"/> DK |
|--|---|

**Section I – IMMUNIZATION – Continued**

|  |  |   |                            |            |                   |            |  |  |   |                            |  |
|--|--|---|----------------------------|------------|-------------------|------------|--|--|---|----------------------------|--|
| <b>ITEM<br/>I10</b>  | Refer to questions 14 and 22 for additional 19-35 month old. Mark (X) first appropriate box. | 1 <input type="checkbox"/> Callback required } (Fill HIS-2A, then I11)<br>2 <input type="checkbox"/> Any immunizations }<br>3 <input type="checkbox"/> No immunizations (Return to I6 on page 6)  | <b>116</b>                 |            |                   |            |  |  |   |                            |  |
| <b>ITEM<br/>I11</b>  | Status of HIS-2A for additional 19-35 month old. Mark (X) one in each column.                | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; border-bottom: 1px dashed black;"><u>Provider</u></td> <td style="width: 5%; text-align: center;"><b>117</b></td> <td style="width: 45%; text-align: center; border-bottom: 1px dashed black;"><u>Permission</u></td> <td style="width: 5%; text-align: center;"><b>118</b></td> </tr> <tr> <td style="padding: 5px;">                             1 <input type="checkbox"/> Complete<br/>                             2 <input type="checkbox"/> Refused<br/>                             3 <input type="checkbox"/> Other (Explain in notes)                         </td> <td></td> <td style="padding: 5px;">                             0 <input type="checkbox"/> Not required<br/>                             1 <input type="checkbox"/> Complete<br/>                             2 <input type="checkbox"/> Refused<br/>                             3 <input type="checkbox"/> Other (Explain in notes)                         </td> <td style="vertical-align: middle; text-align: center;">                             } (Return to I6 on page 6)                         </td> </tr> </table> | <u>Provider</u>            | <b>117</b> | <u>Permission</u> | <b>118</b> | 1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other (Explain in notes) |  | 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other (Explain in notes) | } (Return to I6 on page 6) |  |
| <u>Provider</u>  | <b>117</b>   | <u>Permission</u>   | <b>118</b>                 |            |                   |            |  |  |   |                            |  |
| 1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other (Explain in notes) |  | 0 <input type="checkbox"/> Not required<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Refused<br>3 <input type="checkbox"/> Other (Explain in notes)   | } (Return to I6 on page 6) |            |                   |            |  |  |   |                            |  |

|       |                                  |            |
|-------|----------------------------------|------------|
| Notes | <b>2</b> Other 19-35 month child | <b>119</b> |
|-------|----------------------------------|------------|

| <b>Section II - DISABILITY</b>   |            | RT 65   |
|--|------------|---|
| <b>Part A - SENSORY, COMMUNICATION AND MOBILITY</b>  |            | PERSON 1<br>3-4   |
| <p><b>These next questions refer to everyone in the family, that is</b> <i>(read names of all nondeleted family members).</i></p>  |            |   |
| <p><b>1a. Does anyone in the family have SERIOUS difficulty seeing, even when wearing glasses or contact lenses?</b></p>   | <b>1a.</b> | <p>5</p> <p>1 <input type="checkbox"/> Yes (1b)<br/>2 <input type="checkbox"/> No } (2 on page 14)<br/>9 <input type="checkbox"/> DK }</p>  |
| <p><b>b. Who is this? (Anyone else?)</b><br/><i>Mark (X) "Difficulty seeing" box in person's column.</i><br/><i>Ask 1c-f for each person with box marked in 1b.</i></p>  | <b>b.</b>  | <p>6</p> <p>1 <input type="checkbox"/> Difficulty seeing</p>  |
| <p><b>c. What is the MAIN problem or condition which causes -- serious difficulty seeing?</b></p>  | <b>c.</b>  | <p>7</p> <p><i>(Enter condition on X1 and mark box)</i><br/>1 <input type="checkbox"/> In C2<br/>2 <input type="checkbox"/> Not in C2</p>   |
| <p><b>d. Is -- legally blind?</b></p>  | <b>d.</b>  | <p>8</p> <p>1 <input type="checkbox"/> Yes (1f)<br/>2 <input type="checkbox"/> No } (1e)<br/>9 <input type="checkbox"/> DK }</p>  |
| <p><b>e. [Do you expect/Is -- expected] to have SERIOUS difficulty seeing for at least the next 12 months?</b></p>   | <b>e.</b>  | <p>9</p> <p>1 <input type="checkbox"/> Yes (1f)<br/>2 <input type="checkbox"/> No } (1c for NP in 1b, or<br/>9 <input type="checkbox"/> DK } 2 on page 14)</p>  |
| <p><b>f. Does -- NOW use telescopic lenses, braille, readers, a guide dog, white cane, or any other equipment for people with visual impairments?</b><br/><i>If "No", mark (X) box 0.</i><br/><i>If "Yes", ask - "Which?" Mark (X) all that apply.</i></p> | <b>f.</b>  | <p>10</p> <p>0 <input type="checkbox"/> Does not use any<br/>1 <input type="checkbox"/> Telescopic lenses<br/>2 <input type="checkbox"/> Braille<br/>3 <input type="checkbox"/> Readers<br/>4 <input type="checkbox"/> Guide dog<br/>5 <input type="checkbox"/> White cane<br/>6 <input type="checkbox"/> Computer equipment<br/>7 <input type="checkbox"/> Other</p> <p style="text-align: right;"><i>(1c for NP in 1b, or 2 on page 14)</i></p> <p>11<br/>12<br/>13<br/>14<br/>15<br/>16<br/>17</p> |
| <p>Notes</p>   |            |   |

| <b>Section II – DISABILITY – Continued</b>   |   |   |
|--|---|---|
| <b>Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued</b>  |   | <b>PERSON 1</b>   |
| <p><b>2a. Does anyone in the family now use a hearing aid?</b></p>   | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (2d)</p>   | <p>18</p>   |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Hearing aid" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Hearing aid</p>  | <p>19</p>   |
| <p><b>c. Anyone else?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes (Reask 2b and c)      <input type="checkbox"/> No (2d)</p>   |   |   |
| <p><b>d. Does anyone in the family have any trouble hearing what is said in normal conversation (even when wearing a hearing aid)?</b></p>   | <p><b>d.</b></p> <p>1 <input type="checkbox"/> Yes (2e)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (4 on page 16)</p>  | <p>20</p>   |
| <p><b>e. Who is this? (Anyone else?)</b></p> <p>Mark (X) "Trouble hearing" box in person's column.</p> <p>Ask 2f-h and 3 for each person with box marked in 2e.</p>  | <p><b>e.</b></p> <p>1 <input type="checkbox"/> Trouble hearing</p>  | <p>21</p>   |
| <p><b>f. What is the MAIN problem or condition which causes -- to have trouble hearing?</b></p>  | <p><b>f.</b></p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2<br/>                 2 <input type="checkbox"/> Not in C2</p>  | <p>22</p>   |
| <p><b>g. Is -- able to hear loud noises?</b></p>   | <p><b>g.</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK</p>  | <p>23</p>   |
| <p><b>h. [Do you expect/Is -- expected] to have this trouble hearing for at least the next 12 months?</b></p>  | <p><b>h.</b></p> <p>1 <input type="checkbox"/> Yes (3)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (2f for NP in 2e, or 4 on page 16)</p>   | <p>24</p>   |
| <p><b>3. (Besides a hearing aid,) Does -- NOW use an amplifier for the telephone, a TDD, TTY or teletype, closed caption TV, assistive listening or signaling devices, an interpreter, or any other equipment for people with hearing impairments?</b></p> <p>Read if necessary: <b>Assistive listening devices include a loop, FM systems, and direct input devices that connect to a TV. Assistive signaling devices indicate that a door, telephone or fire bells are ringing.</b></p> <p>If "No", mark (X) box 0.<br/>                 If "Yes", ask "Which"? Mark (X) all that apply.</p> | <p><b>3.</b></p> <p>0 <input type="checkbox"/> Does not use any<br/>                 1 <input type="checkbox"/> Amplifier for telephone<br/>                 2 <input type="checkbox"/> TDD, TTY, or teletype<br/>                 3 <input type="checkbox"/> Closed caption TV<br/>                 4 <input type="checkbox"/> Assistive listening devices<br/>                 5 <input type="checkbox"/> Assistive signaling devices<br/>                 6 <input type="checkbox"/> Interpreter<br/>                 7 <input type="checkbox"/> Other</p> <p>(2f for NP in 2e, or 4 on page 16)</p> | <p>25<br/>                 26<br/>                 27<br/>                 28<br/>                 29<br/>                 30<br/>                 31<br/>                 32</p> |

| <b>Section II - DISABILITY - Continued</b>   |  |   |
|--|--|---|
| <b>Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued</b>  |  | <b>PERSON 1</b>   |
| <p><b>The next few questions refer only to family members who are 5 years old or older, that is (read names of family members 5 years old or older).</b></p>   |  | 33  |
| <p><b>4a. Do (read names of persons 5+) have SERIOUS difficulty communicating so that PEOPLE OUTSIDE THE FAMILY understand?</b></p> <p><i>Read if necessary: Do not include language problems.</i></p>                               | <p><b>4a.</b> 1 <input type="checkbox"/> Yes (4b)<br/>2 <input type="checkbox"/> No } (4f)<br/>9 <input type="checkbox"/> DK }</p>                 |   |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Difficulty communicating" box in person's column.</p>   | <p><b>b.</b> 1 <input type="checkbox"/> Difficulty communicating</p>   | 34  |
| <p><b>c. Anyone else?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes (Reask 4b and c)      <input type="checkbox"/> No</p> <p><i>Ask 4d-e for each person with "Difficulty communicating" marked in 4b.</i></p> |  | 35  |
| <p><b>d. Does -- have any difficulty communicating so that FAMILY MEMBERS understand?</b></p>  | <p><b>d.</b> 1 <input type="checkbox"/> Yes (4e)<br/>2 <input type="checkbox"/> No } (NP in 4b, or 4f)<br/>9 <input type="checkbox"/> DK }</p>     |   |
| <p><b>e. Does -- have difficulty communicating -- basic needs, such as hunger and thirst, to family members?</b></p>   | <p><b>e.</b> 1 <input type="checkbox"/> Yes } (4d for NP in 4b, or 4f)<br/>2 <input type="checkbox"/> No }<br/>9 <input type="checkbox"/> DK }</p> | 36  |
| <p><b>4f. Do (read names of persons 5+) have SERIOUS difficulty understanding other people when they talk or ask questions?</b></p> <p><i>Read if necessary: Do not include language problems.</i></p>                               |  | 37  |
| <p><b>g. Who is this?</b></p> <p>Mark (X) "Difficulty understanding" box in person's column.</p>   | <p><b>g.</b> 1 <input type="checkbox"/> Difficulty understanding</p>   | 38  |
| <p><b>h. Anyone else?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes (Reask 4g and h)      <input type="checkbox"/> No (A1)</p>   |  | 39  |
| <p><b>ITEM<br/>A1</b></p>  | <p><i>Refer to age or questions 4b and 4g for each person.</i></p>   | <p><b>A1</b> 2 <input type="checkbox"/> Under 5 (NP, or 4n on page 18)<br/>1 <input type="checkbox"/> "Difficulty communicating" in 4b and/or "Difficulty understanding" in 4g (4i on page 18)<br/>2 <input type="checkbox"/> All others (NP, or 4n on page 18)</p> |
| <p>Notes</p>   |  |   |

| <b>Section II – DISABILITY – Continued</b>   |            |  |
|--|------------|--|
| <b>Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued</b>  |            | <b>PERSON 1</b>  |
| <b>4i. How old was -- when -- first had difficulty [communicating with/(and) understanding] other people?</b>                            | <b>4i.</b> | 40-41<br>____ Years old (4i)<br>96 <input type="checkbox"/> At birth (4i)<br>99 <input type="checkbox"/> DK (4j)               |
| <b>j. Was it before -- was 18 years old?</b>   | <b>j.</b>  | 42<br>1 <input type="checkbox"/> Yes (4l)<br>2 <input type="checkbox"/> No (4k)<br>9 <input type="checkbox"/> DK (4l)          |
| <b>k. Was it before -- was 22 years old?</b>   | <b>k.</b>  | 43<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No } (4l)<br>9 <input type="checkbox"/> DK }                |
| <i>If obvious, mark without asking; otherwise ask:</i>   |            |  |
| <b>l. Is -- expected to have this difficulty with [communication/(and) understanding other people] for at least 12 months longer?</b>    | <b>l.</b>  | 44<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No } (4m)<br>9 <input type="checkbox"/> DK }                |
| <b>m. What condition causes -- difficulty [communicating with/(and) understanding] other people?</b>                                     | <b>m.</b>  | 45<br>(Enter condition in X1 and mark box)<br>1 <input type="checkbox"/> In C2<br>2 <input type="checkbox"/> Not in C2         |
| <i>Accept up to 2 conditions; then go to A1 on page 16 for next person, or 4n.</i>   |            | 46<br>(Enter condition in X1 and mark box)<br>1 <input type="checkbox"/> In C2<br>2 <input type="checkbox"/> Not in C2         |
| <b>4n. Do (read names of persons 5+) have SERIOUS difficulty learning how to do things that most people their age are able to learn?</b> | <b>4n.</b> | 47<br>1 <input type="checkbox"/> Yes (4o)<br>2 <input type="checkbox"/> No } (5 on page 20)<br>9 <input type="checkbox"/> DK } |
| <b>o. Who is this?</b>   | <b>o.</b>  | 48<br>1 <input type="checkbox"/> Difficulty learning   |
| <b>p. Anyone else?</b>   |            |  |
| <input type="checkbox"/> Yes (Reask 4o and p) <input type="checkbox"/> No (5 on page 20)   |            |  |
| Notes  |            |  |

| <b>Section II - DISABILITY - Continued</b>   |  |  |
|--|--|--|
| <b>Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued</b>  |  | <b>PERSON 1</b>                        |
| <i>HAND CARD DA1. Read parenthetical if telephone interview.</i>   |  | 49                                     |
| <b>5a. Does ANYONE in the family now use any of these aids to get around? (A cane, crutches, walker, medically prescribed shoes, a wheelchair, or a scooter?)</b>        | <b>5a.</b> 1 <input type="checkbox"/> Yes (5b)<br>2 <input type="checkbox"/> No } (6 on page 22)<br>9 <input type="checkbox"/> DK }  |  |
| <b>b. Who is this?</b><br><i>Mark (X) "Mobility aid" box in person's column.</i>   | <b>b.</b>  | 50                                     |
| <b>c. Anyone else?</b><br><input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No  |  |  |
| <i>Ask 5d and e for each person with "Mobility aid" in 5b.</i>   |  |  |
| <b>d. Which aids does -- use?</b><br><b>Any others?</b><br><i>Mark (X) all that apply.</i><br><i>If "wheelchair", ask: Does -- use an electric or manual wheelchair?</i> | <b>d.</b> 1 <input type="checkbox"/> Cane<br>2 <input type="checkbox"/> Crutches<br>3 <input type="checkbox"/> Walker<br>4 <input type="checkbox"/> Medically prescribed shoes<br>5 <input type="checkbox"/> Manual wheelchair<br>6 <input type="checkbox"/> Electric wheelchair<br>7 <input type="checkbox"/> Scooter | 51<br>52<br>53<br>54<br>55<br>56<br>57 |
| <i>Ask only about each aid marked in 5d. Then 5d for next person with 5b; otherwise 6 on page 22.</i>  |  | 58                                     |
| <b>e. Has -- used or is -- expected to use (aid in 5d) for 12 months or longer?</b>  | <b>e.</b>  |  |
| <b>(1) A cane</b>  | <b>(1)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 59                                     |
| <b>(2) Crutches</b>  | <b>(2)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 60                                     |
| <b>(3) A walker</b>  | <b>(3)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 61                                     |
| <b>(4) Medically prescribed shoes</b>  | <b>(4)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 62                                     |
| <b>(5) A manual wheelchair</b>   | <b>(5)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 63                                     |
| <b>(6) An electric wheelchair</b>  | <b>(6)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  | 64                                     |
| <b>(7) A scooter</b>   | <b>(7)</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK  |  |
| Notes  |  |  |

| <b>Section II - DISABILITY - Continued</b>   |   |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
|--|---|---|----|---|----|---|----|-------------------------------|----|------------------------------|----|-------------------------------|----|-------------------------------|----|--------------------------------|----|---|
| <b>Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued</b>  |   | <b>PERSON 1</b>                                 |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <p><b>6a. Does anyone in the family now use a brace of any kind?</b></p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Who is this?</b><br/> <i>Ask if necessary: On what part of the body is the brace worn? Is it worn on the back, neck, arm, hand, leg, foot or knee?</i><br/> <i>Mark (X) appropriate box(es) in person's column.</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Does anyone else now use a brace?</b><br/> <input type="checkbox"/> Yes (Reask 6b and c)      <input type="checkbox"/> No<br/> <i>Ask 6d for each person with an entry in 6b.</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. Has -- used or is -- expected to use [this brace/any of these braces] for 12 months or longer?</b></p> | <p><b>6a.</b> <input type="checkbox"/> Yes (6b)<br/> <input type="checkbox"/> No } (7)<br/> <input type="checkbox"/> DK } (7)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Back</td><td style="text-align: right; border: 1px solid black;">66</td></tr> <tr><td><input type="checkbox"/> Neck</td><td style="text-align: right; border: 1px solid black;">67</td></tr> <tr><td><input type="checkbox"/> Arm</td><td style="text-align: right; border: 1px solid black;">68</td></tr> <tr><td><input type="checkbox"/> Hand</td><td style="text-align: right; border: 1px solid black;">69</td></tr> <tr><td><input type="checkbox"/> Leg</td><td style="text-align: right; border: 1px solid black;">70</td></tr> <tr><td><input type="checkbox"/> Foot</td><td style="text-align: right; border: 1px solid black;">71</td></tr> <tr><td><input type="checkbox"/> Knee</td><td style="text-align: right; border: 1px solid black;">72</td></tr> <tr><td><input type="checkbox"/> Other</td><td style="text-align: right; border: 1px solid black;">73</td></tr> </table> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right;"><b>74</b></p> <p><b>d.</b> <input type="checkbox"/> Yes } (6d for NP with entry<br/> <input type="checkbox"/> No } in 6b, or 7)<br/> <input type="checkbox"/> DK }</p> | <input type="checkbox"/> Back                   | 66 | <input type="checkbox"/> Neck                   | 67 | <input type="checkbox"/> Arm  | 68 | <input type="checkbox"/> Hand | 69 | <input type="checkbox"/> Leg | 70 | <input type="checkbox"/> Foot | 71 | <input type="checkbox"/> Knee | 72 | <input type="checkbox"/> Other | 73 | <p style="border: 1px solid black; display: inline-block; padding: 2px;">65</p> |
| <input type="checkbox"/> Back  | 66  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Neck  | 67  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Arm   | 68  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Hand  | 69  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Leg   | 70  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Foot  | 71  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Knee  | 72  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Other   | 73  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <p><b>7a. (Does anyone in the family now use) an artificial leg, foot, arm or hand?</b></p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Who is this?</b><br/> <i>Ask if necessary: Which does -- use - an artificial leg, foot, arm or hand?</i><br/> <i>Mark (X) appropriate box(es) in person's column.</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Does anyone else now use an artificial limb?</b><br/> <input type="checkbox"/> Yes (Reask 7b and c)      <input type="checkbox"/> No (A2 on page 24)</p>   | <p><b>7a.</b> <input type="checkbox"/> Yes (7b)<br/> <input type="checkbox"/> No } (A2 on page 24)<br/> <input type="checkbox"/> DK }</p> <hr style="border-top: 1px dashed black;"/> <p><b>b.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Artificial leg or foot</td><td style="text-align: right; border: 1px solid black;">76</td></tr> <tr><td><input type="checkbox"/> Artificial arm or hand</td><td style="text-align: right; border: 1px solid black;">77</td></tr> </table>   | <input type="checkbox"/> Artificial leg or foot | 76 | <input type="checkbox"/> Artificial arm or hand | 77 | <p style="border: 1px solid black; display: inline-block; padding: 2px;">75</p> |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Artificial leg or foot  | 76  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <input type="checkbox"/> Artificial arm or hand  | 77  |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |
| <p>Notes</p>   |   |   |    |   |    |   |    |                               |    |                              |    |                               |    |                               |    |                                |    |   |



| <b>Section II – DISABILITY – Continued</b>   |   |                 |   |
|--|---|-----------------|---|
| <b>Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued</b>  |   | <b>PERSON 1</b> |   |
| <b>ITEM<br/>A2</b>   | <i>Refer to ages of ALL family members.</i> | <b>A2</b>       | 78<br>1 <input type="checkbox"/> All under 18<br><i>(Part B on page 28)</i><br>2 <input type="checkbox"/> Any 18+ (8)           |
| <b>8a. Do (names of persons 18+) now have any problem with dizziness that has lasted for at least three months?</b>  |   | <b>8a.</b>      | 79<br>1 <input type="checkbox"/> Yes (8b)<br>2 <input type="checkbox"/> No } (8d)<br>9 <input type="checkbox"/> DK }            |
| <b>b. Who is this?</b><br><i>Mark (X) "Dizziness" box in person's column.</i>  |   | <b>b.</b>       | 80<br>1 <input type="checkbox"/> Dizziness  |
| <b>c. Anyone else?</b><br><input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No (8d)   |   |                 |   |
| <b>d. Do (names of persons 18+) have any problem with balance that has lasted for at least three months?</b>   |   | <b>d.</b>       | 81<br>1 <input type="checkbox"/> Yes (8e)<br>2 <input type="checkbox"/> No } (9)<br>9 <input type="checkbox"/> DK }             |
| <b>e. Who is this?</b><br><i>Mark (X) "Problem with balance" box in person's column.</i>   |   | <b>e.</b>       | 82<br>1 <input type="checkbox"/> Problem with balance   |
| <b>f. Anyone else?</b><br><input type="checkbox"/> Yes (Reask 8e and f) <input type="checkbox"/> No  |   |                 |   |
| <b>g. Does -- need support or touch walls when walking due to balance problems?</b><br><i>Ask 8g for each person with "Problem with balance" marked in 8e.</i> |   | <b>g.</b>       | 83<br>1 <input type="checkbox"/> Yes }<br>2 <input type="checkbox"/> No } (NP in 8e, or 9)<br>9 <input type="checkbox"/> DK }   |
| <b>9a. Do (names of persons 18+) now have ringing, roaring, or buzzing in the ears that has lasted for at least three months?</b>                              |   | <b>9a.</b>      | 84<br>1 <input type="checkbox"/> Yes (9b)<br>2 <input type="checkbox"/> No } (10 on page 26)<br>9 <input type="checkbox"/> DK } |
| <b>b. Who is this?</b><br><i>Mark (X) "Noise in ears" box in person's column.</i>  |   | <b>b.</b>       | 85<br>1 <input type="checkbox"/> Noise in ears  |
| <b>c. Anyone else?</b><br><input type="checkbox"/> Yes (Reask 9b and c) <input type="checkbox"/> No (10 on page 26)  |   |                 |   |
| Notes  |   |                 |   |

**Section II – DISABILITY – Continued**

**Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued**

**PERSON 1**

|  |   |
|--|---|
| <p><b>10a. Do (names of persons 18+) now have any problems with their sense of smell, such as not being able to smell things or things not smelling the way they are supposed to?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>Mark (X) "Problem with smell" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 10b and c)      <input type="checkbox"/> No</p> <p>-----</p> <p>Ask 10d-f for each person with box marked in 10b.</p> <p><b>d. Which problem does -- have, not being able to smell things or things not smelling the way they are supposed to?</b></p> <p>-----</p> <p><b>e. Is -- loss of smell complete or partial?</b></p> <p>-----</p> <p><b>f. Has -- had problems with -- sense of smell for at least three months?</b></p>                                     | <p><b>10a.</b>      86</p> <p>1 <input type="checkbox"/> Yes (10b)<br/>2 <input type="checkbox"/> No } (11)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b>      87</p> <p>1 <input type="checkbox"/> Problem with smell</p> <p><b>d.</b>      88</p> <p>1 <input type="checkbox"/> Loss of smell (10e)<br/>2 <input type="checkbox"/> Things don't smell right } (10f)<br/>9 <input type="checkbox"/> DK }</p> <p><b>e.</b>      89</p> <p>1 <input type="checkbox"/> Complete<br/>2 <input type="checkbox"/> Partial<br/>9 <input type="checkbox"/> DK</p> <p><b>f.</b>      90</p> <p>1 <input type="checkbox"/> Yes } (10d for NP in 10b,<br/>2 <input type="checkbox"/> No } or 11)<br/>9 <input type="checkbox"/> DK }</p> |
| <p><b>11a. Do (names of persons 18+) have a problem with their sense of taste, such as not being able to taste salt or sugar or with tastes in the mouth that shouldn't be there, like bitter, salty, sour or sweet tastes?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>Mark (X) "Problem with taste" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 11b and c)      <input type="checkbox"/> No</p> <p>-----</p> <p>Ask 11d-e for each person with box marked in 11b.</p> <p><b>d. Which problem does -- have, not being able to taste salt or sugar, tastes in the mouth that shouldn't be there, or some other problem?</b></p> <p>-----</p> <p>Mark (X) all that apply.</p> <p><b>e. Has -- had [any of these/this] problem(s) with taste for at least three months?</b></p> | <p><b>11a.</b>      91</p> <p>1 <input type="checkbox"/> Yes (11b)<br/>2 <input type="checkbox"/> No } (Part B on page 28)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b>      92</p> <p>1 <input type="checkbox"/> Problem with taste</p> <p><b>d.</b>      93</p> <p>1 <input type="checkbox"/> Not tasting salt<br/>2 <input type="checkbox"/> Not tasting sugar      94<br/>3 <input type="checkbox"/> Tastes that shouldn't be there      95<br/>4 <input type="checkbox"/> Other problem      96</p> <p><b>e.</b>      97</p> <p>1 <input type="checkbox"/> Yes } (11d for NP in 11b,<br/>2 <input type="checkbox"/> No } or Part B on page 28)<br/>9 <input type="checkbox"/> DK }</p>                                   |

| <b>Section II – DISABILITY – Continued</b>  |                   | RT 66  |
|---|-------------------|--|
| <b>Part B – CONDITIONS</b>  |                   | PERSON 1<br>3-4  |
| <p><b>{I am going to read a list of medical conditions. Tell me if anyone in the family has any of these conditions, even if you have mentioned them before.}</b></p>   |                   |  |
| <p><b>1a. Does anyone in the family, that is (read names) have –</b></p> <p><b>(1) A learning disability?</b></p> <p>-----</p> <p><b>(2) Cerebral palsy</b> (cĕ Rĕ' brāĭ pawl'zee)?</p> <p>-----</p> <p><b>(3) Cystic fibrosis</b> (sis'tic fī brō'sis)?</p> <p>-----</p> <p><b>(4) Down syndrome?</b></p> <p>-----</p> <p><b>(5) Mental retardation?</b></p> <p>-----</p> <p><b>(6) Muscular dystrophy</b> (dis' trō fee)?</p> <p>-----</p> <p><b>(7) Spina bifida</b> (spīn' ah bif ī dah)?</p> <p>-----</p> <p><b>(8) Autism</b> (aw'tism)?</p> <p>-----</p> <p><b>(9) Hydrocephalus</b> (hī drō sef'ah lūs)?</p> <p>-----</p> | <p><b>1a.</b></p> | <p>5</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>6</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>7</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>8</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>9</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>10</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>11</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>12</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>13</p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No(2) 9 <input type="checkbox"/> DK(2)</p> |
| <p><b>b. Who is this?</b></p> <p><i>Mark (X) appropriate box in person's column.</i></p>  | <p><b>b.</b></p>  | <p>1 <input type="checkbox"/> Learning disability <b>14</b></p> <p>2 <input type="checkbox"/> Cerebral Palsy <b>15</b></p> <p>3 <input type="checkbox"/> Cystic Fibrosis <b>16</b></p> <p>4 <input type="checkbox"/> Down Syndrome <b>17</b></p> <p>5 <input type="checkbox"/> Mental Retardation <b>18</b></p> <p>6 <input type="checkbox"/> Muscular Dystrophy <b>19</b></p> <p>7 <input type="checkbox"/> Spina Bifida <b>20</b></p> <p>8 <input type="checkbox"/> Autism <b>21</b></p> <p>9 <input type="checkbox"/> Hydrocephalus <b>22</b></p>   |
| <p><b>c. Anyone else?</b></p> <p style="text-align: center;">If "Yes" (Reask 1b and c)      If "No" (1a for NC, or 2)</p>   |                   |  |
| <p><b>2a. Was anyone in the family EVER told by a doctor that they had polio, whether or not it resulted in physical disability?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b></p> <p><i>Mark (X) "Polio" box in person's column.</i></p> <p><i>Ask 2c for each person with "Polio" box marked in 2b.</i></p>   | <p><b>2a.</b></p> | <p>23</p> <p>1 <input type="checkbox"/> Yes (2b)</p> <p>2 <input type="checkbox"/> No } (Part C on page 30)</p> <p>9 <input type="checkbox"/> DK }</p> <p>24</p> <p>1 <input type="checkbox"/> Polio</p> <p>25</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>   |
| <p><b>c. Did -- EVER have paralysis of any kind caused by polio?</b></p>  | <p><b>c.</b></p>  |  |

| <b>Section II - DISABILITY - Continued</b>   |   | RT 67           |
|--|---|-----------------|
| <b>Part C - ADL / IADL</b>   |   | PERSON 1<br>3-4 |
| <p><i>HAND CARD DC1.</i><br/> <b>These next questions refer only to (read names of persons 5+).</b></p>  |   |                 |
| <p><b>1a. Because of a physical, mental, or emotional problem, do (read names of persons 5+) GET HELP FROM ANOTHER PERSON in —</b></p> <p><b>(1) Bathing or showering?</b></p> <p>-----</p> <p><b>(2) Dressing?</b></p> <p>-----</p> <p><b>(3) Eating?</b></p> <p>-----</p> <p><b>(4) Getting in and out of bed or chairs?</b></p> <p>-----</p> <p><b>(5) Using the toilet, including getting to the toilet?</b></p> <p>-----</p> <p><b>(6) Getting around inside the home?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/> <i>Mark (X) appropriate box in person's column AND in "Help/Remind" column in X2, then continue with 1a for next activity, or 2.</i></p>                                    | <p><b>1a.</b></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">5</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">6</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">7</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">8</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">9</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">10</span></p> <p>1 <input type="checkbox"/> Yes(1b) 2 <input type="checkbox"/> No(2) 9 <input type="checkbox"/> DK(2) <span style="float: right;">11</span></p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Bathing or showering <span style="float: right;">11</span></p> <p>2 <input type="checkbox"/> Dressing <span style="float: right;">12</span></p> <p>3 <input type="checkbox"/> Eating <span style="float: right;">13</span></p> <p>4 <input type="checkbox"/> Getting in/out bed or chairs <span style="float: right;">14</span></p> <p>5 <input type="checkbox"/> Using the toilet, including getting to the toilet <span style="float: right;">15</span></p> <p>6 <input type="checkbox"/> Getting around inside the home <span style="float: right;">16</span></p> <p><i>(Mark (X) appropriate box(es) in X2)</i></p> |                 |
| <p><i>Refer to Card DC1. Read all categories in 2c if telephone interview.</i></p>   |   |                 |
| <p><b>2a. Because of a physical, mental, or emotional problem, do (read names of persons 5+) need to be reminded to do [any of these/any of the following] activities, or need to have someone close by when they do them?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/> <i>Mark (X) "Remind/close" box in person's column.</i><br/> <i>Ask 2c for each person with "Remind/close" in 2b, then 3 on page 32.</i><br/> <i>Refer to Card DC1. Read each category if telephone interview.</i></p> <p><b>c. For which activities does -- need to be reminded or to have someone close by? (Any others?)</b><br/> <i>Mark (X) all that apply in person's column AND in "Help/Remind" column in X2.</i></p> | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b) <span style="float: right;">17</span></p> <p>2 <input type="checkbox"/> No } (3 on page 32)</p> <p>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Remind/close <span style="float: right;">18</span></p> <p>-----</p> <p><b>c.</b></p> <p>1 <input type="checkbox"/> Bathing or showering <span style="float: right;">19</span></p> <p>2 <input type="checkbox"/> Dressing <span style="float: right;">20</span></p> <p>3 <input type="checkbox"/> Eating <span style="float: right;">21</span></p> <p>4 <input type="checkbox"/> Getting in/out bed or chairs <span style="float: right;">22</span></p> <p>5 <input type="checkbox"/> Using the toilet, including getting to the toilet <span style="float: right;">23</span></p> <p>6 <input type="checkbox"/> Getting around inside the home <span style="float: right;">24</span></p> <p><i>(Mark (X) appropriate box(es) in X2)</i></p>   |                 |

| <b>Section II - DISABILITY - Continued</b>  |  |   |   |
|---|--|---|---|
| <b>Part C - ADL / IADL - Continued</b>  |  | <b>PERSON 1</b>                                     |   |
| <p>Refer to Card DC1. Read all categories in 3c if telephone interview.</p> <p><b>3a. Do (read names of persons 5+) use any SPECIAL EQUIPMENT to do any of [these/the following] activities?</b></p> <p><b>b. Who is this? (Anyone else?)</b></p> <p>Mark (X) "Equipment" box in person's column.</p> <p>Ask 3c for each person with "Equipment" in 3b, then go to C1.</p> <p>Refer to Card DC1. Read each category if telephone interview.</p> <p><b>C. For which activities does -- use special equipment? (Any others?)</b></p> <p>Mark (X) all that apply in person's column AND in "Spec. Equip." column in X2.</p>  |  | <p><b>3a.</b></p> <p><b>b.</b></p> <p><b>c.</b></p> | <p style="text-align: right;">25</p> <p>1 <input type="checkbox"/> Yes (3b)</p> <p>2 <input type="checkbox"/> No } (Item C1)</p> <p>9 <input type="checkbox"/> DK }</p> <hr/> <p style="text-align: right;">26</p> <p>1 <input type="checkbox"/> Equipment</p> <hr/> <p>1 <input type="checkbox"/> Bathing or showering</p> <p>2 <input type="checkbox"/> Dressing</p> <p>3 <input type="checkbox"/> Eating</p> <p>4 <input type="checkbox"/> Getting in/out bed or chairs</p> <p>5 <input type="checkbox"/> Using the toilet, including getting to the toilet</p> <p>6 <input type="checkbox"/> Getting around inside the home</p> <p>(Mark (X) appropriate box(es) in X2)</p>   |
| <b>ITEM C1</b>  | <p>Refer to age and Item X2. Mark (X) first appropriate box.</p> | <p><b>C1</b></p>                                    | <p style="text-align: right;">33</p> <p>0 <input type="checkbox"/> Under 5 (NP, or C2 on page 38)</p> <p>1 <input type="checkbox"/> One or more activities marked in X2 (4)</p> <p>2 <input type="checkbox"/> No activities in X2 (5 on page 36)</p>  |
| <p>Mark (X) box 0 or ask:</p> <p><b>4a. Does -- have any difficulty bathing?</b></p> <p>If doesn't do, Ask: <b>Is this because of a physical, mental, or emotional problem?</b></p> <p style="padding-left: 40px;">If "Yes", mark (X) box 3 "Doesn't do/health"</p> <p style="padding-left: 40px;">If "No", mark (X) box 2 "No"</p> <p><b>b. How much difficulty does -- have bathing -- some, a lot, or is -- unable to do it?</b></p> <p>Mark (X) box 0 or ask:</p> <p><b>c. Does -- have any difficulty dressing?</b></p> <p>If doesn't do, Ask: <b>Is this because of a physical, mental, or emotional problem?</b></p> <p style="padding-left: 40px;">If "Yes", mark (X) box 3 "Doesn't do/health"</p> <p style="padding-left: 40px;">If "No", mark (X) box 2 "No"</p> |  | <p><b>4a.</b></p> <p><b>b.</b></p> <p><b>c.</b></p> | <p style="text-align: right;">34</p> <p>0 <input type="checkbox"/> Bathing in X2 (4c)</p> <p>1 <input type="checkbox"/> Yes (Mark X2 then 4b)</p> <p>2 <input type="checkbox"/> No (4c)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X2, then 4c)</p> <p>9 <input type="checkbox"/> DK (4c)</p> <hr/> <p style="text-align: right;">35</p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p> <p>9 <input type="checkbox"/> DK</p> <hr/> <p style="text-align: right;">36</p> <p>0 <input type="checkbox"/> Dressing in X2 (4e on page 34)</p> <p>1 <input type="checkbox"/> Yes (Mark X2 then 4d on page 34)</p> <p>2 <input type="checkbox"/> No (4e on page 34)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X2, then 4e on page 34)</p> <p>9 <input type="checkbox"/> DK (4e on page 34)</p> |

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL-Continued**

|   |   | <b>PERSON 1</b> |
|---|---|-----------------|
| <p><b>4d. How much difficulty does -- have dressing -- some, a lot, or is -- unable to do it?</b></p> <p>-----</p> <p><i>Mark (X) box 0 or ask:</i></p>   | <p><b>4d.</b></p> <p>1 <input type="checkbox"/> Some<br/>                 2 <input type="checkbox"/> A lot<br/>                 3 <input type="checkbox"/> Unable<br/>                 9 <input type="checkbox"/> DK</p>  | <p>37</p>       |
| <p><b>e. Does -- have any difficulty eating?</b></p> <p><i>If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/> <i>If "No", mark (X) box 2 "No"</i></p> <p>-----</p>  | <p><b>e.</b></p> <p>0 <input type="checkbox"/> Eating in X2 (4g)<br/>                 1 <input type="checkbox"/> Yes (Mark X2 then 4f)<br/>                 2 <input type="checkbox"/> No (4g)<br/>                 3 <input type="checkbox"/> Doesn't do/health (Mark X2, then 4g)<br/>                 9 <input type="checkbox"/> DK (4g)</p>   | <p>38</p>       |
| <p><b>f. How much difficulty does -- have eating -- some, a lot, or is -- unable to do it?</b></p> <p>-----</p> <p><i>Mark (X) box 0 or ask:</i></p>  | <p><b>f.</b></p> <p>1 <input type="checkbox"/> Some<br/>                 2 <input type="checkbox"/> A lot<br/>                 3 <input type="checkbox"/> Unable<br/>                 9 <input type="checkbox"/> DK</p>   | <p>39</p>       |
| <p><b>g. Does -- have any difficulty getting in and out of bed or chairs?</b></p> <p><i>If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/> <i>If "No", mark (X) box 2 "No"</i></p> <p>-----</p>               | <p><b>g.</b></p> <p>0 <input type="checkbox"/> Bed/Chair in X2 (4i)<br/>                 1 <input type="checkbox"/> Yes (Mark X2 then 4h)<br/>                 2 <input type="checkbox"/> No (4i)<br/>                 3 <input type="checkbox"/> Doesn't do/health (Mark X2, then 4i)<br/>                 9 <input type="checkbox"/> DK (4i)</p>  | <p>40</p>       |
| <p><b>h. How much difficulty does -- have getting in and out of beds or chairs -- some, a lot, or is -- unable to do it?</b></p> <p>-----</p> <p><i>Mark (X) box 0 or ask:</i></p>  | <p><b>h.</b></p> <p>1 <input type="checkbox"/> Some<br/>                 2 <input type="checkbox"/> A lot<br/>                 3 <input type="checkbox"/> Unable<br/>                 9 <input type="checkbox"/> DK</p>   | <p>41</p>       |
| <p><b>i. Does -- have any difficulty using the toilet, including getting to the toilet?</b></p> <p><i>If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/> <i>If "No", mark (X) box 2 "No"</i></p> <p>-----</p> | <p><b>i.</b></p> <p>0 <input type="checkbox"/> Toilet in X2 (4k on page 36)<br/>                 1 <input type="checkbox"/> Yes (Mark X2 then 4j)<br/>                 2 <input type="checkbox"/> No (4k on page 36)<br/>                 3 <input type="checkbox"/> Doesn't do/health (Mark X2, then 4k on page 36)<br/>                 9 <input type="checkbox"/> DK (4k on page 36)</p> | <p>42</p>       |
| <p><b>j. How much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or is -- unable to do it?</b></p> <p>-----</p>  | <p><b>j.</b></p> <p>1 <input type="checkbox"/> Some<br/>                 2 <input type="checkbox"/> A lot<br/>                 3 <input type="checkbox"/> Unable<br/>                 9 <input type="checkbox"/> DK</p> <p style="text-align: right;">} (4k on page 36)</p>   | <p>43</p>       |

| <b>Section II – DISABILITY – Continued</b>   |   |                 |
|--|---|-----------------|
| <b>Part C – ADL / IADL – Continued</b>   |   | <b>PERSON 1</b> |
| <p>Mark (X) box 0 or ask:</p> <p><b>4k. Does -- have any difficulty getting around inside the home?</b></p> <p>If doesn't do, Ask: <b>Is this because of a physical, mental, or emotional problem?</b></p> <p style="padding-left: 40px;">If "Yes", mark (X) box 3 "Doesn't do/health"<br/>If "No", mark (X) box 2 "No"</p> <hr style="border-top: 1px dashed black;"/> <p><b>l. How much difficulty does -- have getting around inside the home — some, a lot, or is -- unable to do it?</b></p>  | <p><b>4k.</b></p> <p>0 <input type="checkbox"/> Getting around in X2 <span style="float: right;">44</span><br/>(C1 on page 32 for NP, or C2 on page 38)</p> <p>1 <input type="checkbox"/> Yes (Mark X2 then 4l)</p> <p>2 <input type="checkbox"/> No (C1 on page 32 for NP, or C2 on page 38)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X2, then C1 on page 32 for NP, or C2 on page 38)</p> <p>9 <input type="checkbox"/> DK (C1 on page 32 for NP, or C2 on page 38)</p> <hr style="border-top: 1px dashed black;"/> <p><b>l.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">45</span><br/>2 <input type="checkbox"/> A lot } (C1 on page 32 for<br/>3 <input type="checkbox"/> Unable } NP, or C2 on page<br/>9 <input type="checkbox"/> DK } 38)</p>  |                 |
| <p><i>HAND CARD DC1. Read categories if telephone interview.</i></p>   |   |                 |
| <p><b>5a. Because of a physical, mental, or emotional problem, does -- have any difficulty with any of [these/the following] activities?</b></p> <p>If "Yes", ask "<b>Which</b>?" and mark the appropriate box(es) in person's column AND in "Difficulty/Doesn't do" column in X2.</p> <p>If doesn't do, ask: <b>Is this because of a physical, mental, or emotional problem?</b></p> <p style="padding-left: 40px;">If "Yes", mark (X) box for that activity<br/>If "No", do not mark the box for that activity</p> <p>Mark (X) box 0 only if no other boxes are marked.</p> <hr style="border-top: 1px dashed black;"/> <p>Ask only if box 1 "Bathing" in 5a; otherwise, skip to 5c.</p> <p><b>b. How much difficulty does -- have bathing or showering — some, a lot, or is -- unable to do it?</b></p> <hr style="border-top: 1px dashed black;"/> <p>Ask only if box 2 "Dressing" in 5a; otherwise, skip to 5d.</p> <p><b>c. How much difficulty does -- have dressing — some, a lot, or is -- unable to do it?</b></p> <hr style="border-top: 1px dashed black;"/> <p>Ask only if box 3 "Eating" in 5a; otherwise, skip to 5e.</p> <p><b>d. How much difficulty does -- have eating — some, a lot, or is -- unable to do it?</b></p> <hr style="border-top: 1px dashed black;"/> <p>Ask only if box 4 "Getting in/out bed or chairs" in 5a; otherwise, skip to 5f on page 38.</p> <p><b>e. How much difficulty does -- have getting in and out of bed or chairs — some, a lot, or is -- unable to do it?</b></p> | <p><b>5a.</b></p> <p>0 <input type="checkbox"/> No difficulty (C1 on page 32 for NP, or C2 on page 38) <span style="float: right;">46</span></p> <p>1 <input type="checkbox"/> Bathing or showering <span style="float: right;">47</span></p> <p>2 <input type="checkbox"/> Dressing <span style="float: right;">48</span></p> <p>3 <input type="checkbox"/> Eating <span style="float: right;">49</span></p> <p>4 <input type="checkbox"/> Getting in/out bed or chairs <span style="float: right;">50</span></p> <p>5 <input type="checkbox"/> Using the toilet, including getting to the toilet <span style="float: right;">51</span></p> <p>6 <input type="checkbox"/> Getting around inside the home <span style="float: right;">52</span></p> <p>Mark (X) appropriate box(es) in X2</p> <hr style="border-top: 1px dashed black;"/> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">53</span><br/>2 <input type="checkbox"/> A lot }<br/>3 <input type="checkbox"/> Unable }<br/>9 <input type="checkbox"/> DK }</p> <hr style="border-top: 1px dashed black;"/> <p><b>c.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">54</span><br/>2 <input type="checkbox"/> A lot }<br/>3 <input type="checkbox"/> Unable }<br/>9 <input type="checkbox"/> DK }</p> <hr style="border-top: 1px dashed black;"/> <p><b>d.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">55</span><br/>2 <input type="checkbox"/> A lot }<br/>3 <input type="checkbox"/> Unable }<br/>9 <input type="checkbox"/> DK }</p> <hr style="border-top: 1px dashed black;"/> <p><b>e.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">56</span><br/>2 <input type="checkbox"/> A lot } (5f on page 38)<br/>3 <input type="checkbox"/> Unable }<br/>9 <input type="checkbox"/> DK }</p> |                 |

| <b>Section II – DISABILITY – Continued</b>                  |   |                 |  |
|---|---|-----------------|--|
| <b>Part C – ADL / IADL – Continued</b>                      |   | <b>PERSON 1</b> |  |
|   | <i>Ask only if box 5 "Using the toilet" in 5a; otherwise, skip to 5g.</i>   |                 | <b>57</b>  |
| <b>5f.</b>  | <b>How much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or is -- unable to do it?</b> | <b>5f.</b>      | <input type="checkbox"/> 1 Some<br><input type="checkbox"/> 2 A lot<br><input type="checkbox"/> 3 Unable<br><input type="checkbox"/> 9 DK  |
|   | <i>Ask only if box 6 "Getting around inside" in 5a; otherwise, go to C1 on page 32 for NP, or C2.</i>                               |                 | <b>58</b>  |
|   | <b>g.</b> How much difficulty does -- have getting around inside the home -- some, a lot, or is -- unable to do it?                 | <b>g.</b>       | <input type="checkbox"/> 1 Some<br><input type="checkbox"/> 2 A lot<br><input type="checkbox"/> 3 Unable<br><input type="checkbox"/> 9 DK <div style="display: inline-block; vertical-align: middle; margin-left: 10px;">           } (C1 on page 32<br/>for NP, or C2)         </div> |
| <b>ITEM<br/>C2</b>  | <i>Refer to age and item X2. Mark (X) first appropriate box.</i>  | <b>C2</b>       | <b>59</b>  |
| <b>If no more persons in family, skip to 10 on page 56.</b> |   |                 |  |
| Notes   |   |                 |  |



**Section II - DISABILITY - Continued**

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**Part C - ADL / IADL - Continued**

**ADL TABLE 1**

|   |  |  |  |     |
|---|--|--|--|-----|
| <b>ITEM C3</b>  | Enter person's number and name.                              | <b>C3</b>  | Person number _____<br>Name _____  | 3-4 |
| <b>ITEM C4</b>  | Refer to X2 for this person. Mark (X) first appropriate box. | <b>C4</b>  | 1 <input type="checkbox"/> "Help/Remind" (6)<br>2 <input type="checkbox"/> "Special equip." (7)<br>3 <input type="checkbox"/> "Difficulty/doesn't do" (8 on page 42) | 5   |
| <b>6a. You said that -- gets help, needs to be reminded, or needs someone close by when</b> (activities with "help/remind" in X2).<br><b>Who gives this help?</b><br><b>Anyone else?</b><br>Mark (X) all that apply.<br><br>If ONLY help is from spouse/child(ren)/parent, mark (X) box 0; otherwise, ask:<br><br><b>b. Is any of this help paid for?</b><br><br><br><b>c. Which helpers are paid?</b><br><b>Anyone else?</b><br>Mark (X) all the apply.  |  | <b>6a.</b> Household members <span style="float:right">Nonhousehold members</span><br>1 <input type="checkbox"/> Relative(s) <span style="float:right">6</span> <span style="float:right">3 <input type="checkbox"/> Relative(s) <span style="float:right">8</span></span><br>2 <input type="checkbox"/> Nonrelative(s) <span style="float:right">7</span> <span style="float:right">4 <input type="checkbox"/> Nonrelative(s) <span style="float:right">9</span></span><br><br>0 <input type="checkbox"/> Spouse/child(ren)/parent only (7) <span style="float:right">10</span><br><br><b>b.</b> 1 <input type="checkbox"/> Yes (6c)<br>2 <input type="checkbox"/> No } (7)<br>9 <input type="checkbox"/> DK }<br><br><b>c.</b> Household members <span style="float:right">Nonhousehold members</span><br>1 <input type="checkbox"/> Relative(s) <span style="float:right">11</span> <span style="float:right">3 <input type="checkbox"/> Relative(s) <span style="float:right">13</span></span><br>2 <input type="checkbox"/> Nonrelative(s) <span style="float:right">12</span> <span style="float:right">4 <input type="checkbox"/> Nonrelative(s) <span style="float:right">14</span></span> |  |     |
| Ask 7a and b only if "Help/remind" and/or "Special equip." for <b>Bathing</b> ; otherwise, skip to 7c. <span style="float:right">15</span><br><br><b>7a. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have bathing -- some, a lot, or would -- be completely unable to do this?</b><br><br>1 <input type="checkbox"/> Some <span style="float:right">3 <input type="checkbox"/> Completely unable</span><br>2 <input type="checkbox"/> A lot <span style="float:right">9 <input type="checkbox"/> DK</span><br><br><b>b. WITH [help from another person/(and) special equipment], how much difficulty does -- have bathing -- some, a lot, or is -- completely unable to do this?</b> <span style="float:right">16</span><br><br>0 <input type="checkbox"/> No difficulty <span style="float:right">2 <input type="checkbox"/> A lot <span style="float:right">9 <input type="checkbox"/> DK</span></span><br>1 <input type="checkbox"/> Some <span style="float:right">3 <input type="checkbox"/> Completely unable</span> |  | Ask 7c and d only if "Help/remind" and/or "Special equip." for <b>Dressing</b> ; otherwise, skip to 7e. <span style="float:right">17</span><br><br><b>7c. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have dressing -- some, a lot, or would -- be completely unable to do this?</b><br><br>1 <input type="checkbox"/> Some <span style="float:right">3 <input type="checkbox"/> Completely unable</span><br>2 <input type="checkbox"/> A lot <span style="float:right">9 <input type="checkbox"/> DK</span><br><br><b>d. WITH [help from another person/(and) special equipment] how much difficulty does -- have dressing -- some, a lot, or is -- completely unable to do this?</b> <span style="float:right">18</span><br><br>0 <input type="checkbox"/> No difficulty <span style="float:right">2 <input type="checkbox"/> A lot <span style="float:right">9 <input type="checkbox"/> DK</span></span><br>1 <input type="checkbox"/> Some <span style="float:right">3 <input type="checkbox"/> Completely unable</span>  |  |     |
| Notes   |  |  |  |     |

**Section II – DISABILITY – Continued**

**Part C – ADL / IADL – Continued**

**ADL TABLE 1 – Continued**

Ask 7e and f only if "Help/remind" and/or "Special equip." for **Eating**; otherwise, skip to 7g. 19

**7e. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have eating -- some, a lot, or would -- be completely unable to do this?**

- 1  Some                      3  Completely unable  
 2  A lot                      9  DK

**f. WITH [help from another person/(and) special equipment] how much difficulty does -- have eating -- some, a lot, or is -- completely unable to do this?** 20

- 0  No difficulty    2  A lot                      9  DK  
 1  Some                      3  Completely unable

Ask 7g and h only if "Help/remind" and/or "Special equip." for **Bed or chair**; otherwise, skip to 7i. 21

**g. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have getting in and out of bed or chairs -- some, a lot, or would -- be completely unable to do this?**

- 1  Some                      3  Completely unable  
 2  A lot                      9  DK

**h. WITH [help from another person/(and) special equipment], how much difficulty does -- have getting in and out of bed or chairs -- some, a lot, or is -- completely unable to do this?** 22

- 0  No difficulty    2  A lot                      9  DK  
 1  Some                      3  Completely unable

Ask 7i and j only if "Help/remind" and/or "Special equip." for **Toilet**; otherwise, skip to 7k. 23

**7i. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have using the toilet, including getting to the toilet -- some, a lot, or would -- be completely unable to do this?**

- 1  Some                      3  Completely unable  
 2  A lot                      9  DK

**j. WITH [help from another person/(and) special equipment] how much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or would -- be completely unable to do this?** 24

- 0  No difficulty    2  A lot                      9  DK  
 1  Some                      3  Completely unable

Ask 7k and l only if "Help/remind" and/or "Special equip." for **Getting around**; otherwise, skip to 8 on page 42. 25

**k. If -- did not [get help from another person/(and) use special equipment], how much difficulty, would -- have getting around inside the home -- some, a lot, or would -- be completely unable to do this?**

- 1  Some                      3  Completely unable  
 2  A lot                      9  DK

**l. WITH [help from another person/(and) special equipment] how much difficulty does -- have getting around inside the home -- some, a lot, or is -- completely unable to do this?** 26

- 0  No difficulty    2  A lot                      9  DK  
 1  Some                      3  Completely unable

(Go to 8 on page 42)

Notes

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL - Continued**

**ADL TABLE 1 - Continued**

|  |  |
|--|--|
| <p style="font-size: small;">Ask only if "<b>Bathing</b>" marked in X2; otherwise, 8a for next activity.</p> <p><b>8a. How old was -- when -- first had a problem with bathing or showering?</b></p> <p style="margin-left: 20px;">_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)</p> <p>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b></p> <p>1 <input type="checkbox"/> Yes (8d)</p> <p>2 <input type="checkbox"/> No (8c)</p> <p>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask:</p> <p><b>d. Is -- expected to have this problem with bathing or showering for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes } (8a for next activity)</p> <p>2 <input type="checkbox"/> No }</p> <p>9 <input type="checkbox"/> DK }</p> | <p style="font-size: small;">Ask only if "<b>Dressing</b>" marked in X2; otherwise, 8a for next activity.</p> <p><b>8a. How old was -- when -- first had a problem with dressing?</b></p> <p style="margin-left: 20px;">_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)</p> <p>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b></p> <p>1 <input type="checkbox"/> Yes (8d)</p> <p>2 <input type="checkbox"/> No (8c)</p> <p>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask:</p> <p><b>d. Is -- expected to have this problem with dressing for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes } (8a for next activity)</p> <p>2 <input type="checkbox"/> No }</p> <p>9 <input type="checkbox"/> DK }</p>  |
| <p style="font-size: small;">Ask only if "<b>Eating</b>" marked in X2; otherwise, 8a for next activity.</p> <p><b>8a. How old was -- when -- first had a problem with eating?</b></p> <p style="margin-left: 20px;">_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)</p> <p>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b></p> <p>1 <input type="checkbox"/> Yes (8d)</p> <p>2 <input type="checkbox"/> No (8c)</p> <p>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask:</p> <p><b>d. Is -- expected to have this problem with eating for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes } (8a for next activity)</p> <p>2 <input type="checkbox"/> No }</p> <p>9 <input type="checkbox"/> DK }</p>                              | <p style="font-size: small;">Ask only if "<b>Bed or chairs</b>" marked in X2; otherwise, 8a for next activity.</p> <p><b>8a. How old was -- when -- first had a problem with getting in and out of bed or chairs?</b></p> <p style="margin-left: 20px;">_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)</p> <p>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b></p> <p>1 <input type="checkbox"/> Yes (8d)</p> <p>2 <input type="checkbox"/> No (8c)</p> <p>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask:</p> <p><b>d. Is -- expected to have this problem with getting in and out of bed or chairs for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes } (8a for next activity)</p> <p>2 <input type="checkbox"/> No }</p> <p>9 <input type="checkbox"/> DK }</p> |

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL - Continued**

**ADL TABLE 1 - Continued**

|   |   |
|---|---|
| <p style="font-size: small;">Ask only if "<b>Toilet</b>" marked in X2; otherwise, 8a for next activity. <span style="float: right;">47-48</span></p> <p><b>8a. How old was -- when -- first had a problem with using the toilet?</b></p> <p>_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)<br/>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">49</span></p> <p>1 <input type="checkbox"/> Yes (8d)<br/>2 <input type="checkbox"/> No (8c)<br/>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">50</span></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">51</span></p> <p><b>d. Is -- expected to have this problem with using the toilet for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK } (8a for next activity)</p> | <p style="font-size: small;">Ask only if "<b>Getting around</b>" marked in X2; otherwise, 9 below. <span style="float: right;">52-53</span></p> <p><b>8a. How old was -- when -- first had a problem with getting around inside the home?</b></p> <p>_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d)<br/>99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">54</span></p> <p>1 <input type="checkbox"/> Yes (8d)<br/>2 <input type="checkbox"/> No (8c)<br/>9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">55</span></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">56</span></p> <p><b>d. Is -- expected to have this problem with getting around inside the home for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK } (9)</p> |
| <p><b>9. What is the MAIN problem or condition which causes -- trouble in (activities marked in X2)?</b></p>  | <p style="font-size: small;">(Enter condition in X1 and mark box) <span style="float: right;">57</span></p> <p>1 <input type="checkbox"/> In C2<br/>2 <input type="checkbox"/> Not in C2 } (C2 on page 38 for NP; or 10 on page 56)</p>   |

Notes

| <b>Section II - DISABILITY - Continued</b>  |   | RT 69  |
|---|---|--|
| <b>Part C - ADL / IADL</b>  |   | PERSON 1<br>3-4  |
| <p><i>Skip to Part D, page 80 if no family members 18+ years old.</i><br/> <b>HAND CARD DC2.</b><br/> <b>{Now I will ask about some other activities. These next few questions refer only to (read names of persons 18+).}</b></p>  |   |  |
| <p><b>10a. Because of a physical, mental, or emotional problem, do (read names of persons 18+) GET HELP OR SUPERVISION FROM ANOTHER PERSON with —</b></p> <p><b>(1) Preparing their own meals?</b><br/>-----</p> <p><b>(2) Shopping for personal items, such as toilet items or medicine?</b><br/>-----</p> <p><b>(3) Managing money, such as keeping track of expenses or paying bills?</b><br/>-----</p> <p><b>(4) Using the telephone?</b><br/>-----</p> <p><b>(5) Doing heavy work around the house like scrubbing floors, washing windows, and doing heavy yard work?</b><br/>-----</p> <p><b>(6) Doing light work around the house like doing dishes, straightening up, light cleaning, or taking out the trash?</b><br/>-----</p> <p><b>b. Who is this?</b><br/><b>(Anyone else?)</b></p> <p><i>Mark (X) appropriate box in person's column AND in "Help/supv." column in X3, then continue with 10a, or go to C5.</i></p> | <p><b>10a.</b></p> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">5</span></p> <hr/> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">6</span></p> <hr/> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">7</span></p> <hr/> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">8</span></p> <hr/> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <span style="float: right;">9</span></p> <hr/> <p>1 <input type="checkbox"/> Yes(10b) 2 <input type="checkbox"/> No(C5) 9 <input type="checkbox"/> DK(C5) <span style="float: right;">10</span></p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Preparing meals <span style="float: right;">11</span></p> <p>2 <input type="checkbox"/> Shopping <span style="float: right;">12</span></p> <p>3 <input type="checkbox"/> Managing money <span style="float: right;">13</span></p> <p>4 <input type="checkbox"/> Using telephone <span style="float: right;">14</span></p> <p>5 <input type="checkbox"/> Heavy housework <span style="float: right;">15</span></p> <p>6 <input type="checkbox"/> Light housework <span style="float: right;">16</span></p> <p><i>(Mark (X) appropriate box(es) in X3)</i></p> |  |
| <b>ITEM C5</b>  | <p><i>Refer to age and item X3 for each person. Mark (X) first appropriate box.</i></p>   | <p><b>C5</b></p> <p>0 <input type="checkbox"/> Under 18 (NP, or C6 on page 62) <span style="float: right;">17</span></p> <p>1 <input type="checkbox"/> One or more activities marked in X3 (11)</p> <p>2 <input type="checkbox"/> No activities in X3 (12 on page 60)</p>  |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>11a. Does -- have any difficulty preparing -- own meals?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i></p> <p style="padding-left: 40px;"><i>If "No", mark (X) box 2 "No"</i></p> <hr/> <p><b>b. How much difficulty does -- have preparing -- own meals — some, a lot, or is -- unable to do it?</b></p>  |   | <p><b>11a.</b></p> <p>0 <input type="checkbox"/> Preparing meals in X3 (11c on page 58) <span style="float: right;">18</span></p> <p>1 <input type="checkbox"/> Yes (Mark X3, then 11b)</p> <p>2 <input type="checkbox"/> No (11c on page 58)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X3, then 11c on page 58)</p> <p>9 <input type="checkbox"/> DK(11c on page 58)</p> <hr/> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Some } <span style="float: right;">19</span></p> <p>2 <input type="checkbox"/> A lot } (11c on page 58)</p> <p>3 <input type="checkbox"/> Unable }</p> <p>9 <input type="checkbox"/> DK }</p> |

| <b>Section II – DISABILITY – Continued</b>  |  |   |
|---|--|---|
| <b>Part C – ADL / IADL – Continued</b>  |  | <b>PERSON 1</b>   |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>11c. Does -- have any difficulty shopping for personal items?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/><i>If "No", mark (X) box 2 "No"</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. How much difficulty does -- have shopping for personal items — some, a lot, or is -- unable to do it?</b></p>           | <p><b>11c.</b></p> <p>0 <input type="checkbox"/> Shopping in X3 (11e)</p> <p>1 <input type="checkbox"/> Yes (Mark X3, then 11d)</p> <p>2 <input type="checkbox"/> No (11e)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X3, then 11e)</p> <p>9 <input type="checkbox"/> DK(11e)</p> <hr style="border-top: 1px dashed black;"/> <p><b>d.</b></p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p> <p>9 <input type="checkbox"/> DK</p>   | <p style="text-align: right;">20</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right;">21</p> |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>e. Does -- have any difficulty managing money?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/><i>If "No", mark (X) box 2 "No"</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>f. How much difficulty does -- have managing money — some, a lot, or is -- unable to do it?</b></p>                                       | <p><b>e.</b></p> <p>0 <input type="checkbox"/> Managing money in X3 (11g)</p> <p>1 <input type="checkbox"/> Yes (Mark X3, then 11f)</p> <p>2 <input type="checkbox"/> No (11g)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X3, then 11g)</p> <p>9 <input type="checkbox"/> DK(11g)</p> <hr style="border-top: 1px dashed black;"/> <p><b>f.</b></p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p> <p>9 <input type="checkbox"/> DK</p>   | <p style="text-align: right;">22</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right;">23</p> |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>g. Does -- have any difficulty using the telephone?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/><i>If "No", mark (X) box 2 "No"</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>h. How much difficulty does -- have using the telephone — some, a lot, or is -- unable to do it?</b></p>                             | <p><b>g.</b></p> <p>0 <input type="checkbox"/> Telephone in X3 (11i)</p> <p>1 <input type="checkbox"/> Yes (Mark X3, then 11h)</p> <p>2 <input type="checkbox"/> No (11i)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X3, then 11i)</p> <p>9 <input type="checkbox"/> DK(11i)</p> <hr style="border-top: 1px dashed black;"/> <p><b>h.</b></p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p> <p>9 <input type="checkbox"/> DK</p>  | <p style="text-align: right;">24</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right;">25</p> |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>i. Does -- have any difficulty doing heavy work around the house?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="padding-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i><br/><i>If "No", mark (X) box 2 "No"</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>j. How much difficulty does -- have doing heavy work around the house — some, a lot, or is -- unable to do it?</b></p> | <p><b>i.</b></p> <p>0 <input type="checkbox"/> Heavy work in X3 (11k on page 60)</p> <p>1 <input type="checkbox"/> Yes (Mark X3, then 11j)</p> <p>2 <input type="checkbox"/> No (11k on page 60)</p> <p>3 <input type="checkbox"/> Doesn't do/health (Mark X3, then 11k on page 60)</p> <p>9 <input type="checkbox"/> DK (11k on page 60)</p> <hr style="border-top: 1px dashed black;"/> <p><b>j.</b></p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p> <p>9 <input type="checkbox"/> DK</p> <p style="text-align: right;">(11k on page 60)</p> | <p style="text-align: right;">26</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right;">27</p> |

| <b>Section II - DISABILITY - Continued</b>   |   |                 |
|--|---|-----------------|
| <b>Part C - ADL / IADL - Continued</b>   |   | <b>PERSON 1</b> |
| <p><i>Mark (X) box 0 or ask:</i></p> <p><b>11k. Does -- have any difficulty doing light work around the house?</b></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="margin-left: 40px;"><i>If "Yes", mark (X) box 3 "Doesn't do/health"</i></p> <p style="margin-left: 40px;"><i>If "No", mark (X) box 2 "No"</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>l. How much difficulty does -- have doing light work around the house -- some, a lot, or is -- unable to do it?</b></p>  | <p style="text-align: right;"><b>28</b></p> <p><b>11k.</b></p> <p><input type="checkbox"/> Light work in X3<br/><i>(C5 on page 56 for NP, or C6 on page 62)</i></p> <p><input type="checkbox"/> Yes <i>(Mark X3, then 11l)</i></p> <p><input type="checkbox"/> No <i>(C5 on page 56 for NP, or C6 on page 62)</i></p> <p><input type="checkbox"/> Doesn't do/health <i>(Mark X3, then C5 on page 56 for NP, or C6 on page 62)</i></p> <p><input type="checkbox"/> DK <i>(C5 on page 56 for NP, or C6 on page 62)</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>l.</b></p> <p><input type="checkbox"/> Some } <i>(C5 on page 56 for NP, or C6 on page 62)</i></p> <p><input type="checkbox"/> A lot }</p> <p><input type="checkbox"/> Unable }</p> <p><input type="checkbox"/> DK }</p> <p style="text-align: right;"><b>29</b></p>  |                 |
| <p><i>Hand Card DC2.</i></p> <p><b>12a. Because of a physical, mental, or emotional problem does -- have any difficulty with any of [these/the following] activities? Read categories if telephone interview.</b></p> <p><i>If "Yes", ask "Which"? and mark the appropriate box(es), in person's column AND in "Difficulty/doesn't do" column in X3.</i></p> <p><i>If doesn't do, ask: Is this because of a physical, mental, or emotional problem?</i></p> <p style="margin-left: 40px;"><i>If "Yes", mark the box for that activity</i></p> <p style="margin-left: 40px;"><i>If "No", do not make any entries</i></p> <p><i>Mark (X) box 0 only if no other box(es) are marked.</i></p> <p><i>Ask only if box 1 "Preparing meals" in 12a; otherwise, skip to 12c.</i></p> <p><b>b. How much difficulty does -- have preparing -- own meals -- some, a lot, or is -- unable to do it?</b></p> <p><i>Ask only if box 2 "Shopping" in 12a; otherwise, skip to 12d.</i></p> <p><b>c. How much difficulty does -- have shopping for personal items -- some, a lot, or is -- unable to do it?</b></p> <p><i>Ask only if box 3 "Managing money" in 12a; otherwise, skip to 12e.</i></p> <p><b>d. How much difficulty does -- have managing money -- some, a lot, or is -- unable to do it?</b></p> <p><i>Ask only if box 4 "Using the telephone" in 12a; otherwise, skip to 12f on page 62.</i></p> <p><b>e. How much difficulty does -- have using the telephone -- some, a lot, or is -- unable to do it?</b></p> | <p style="text-align: right;"><b>30</b></p> <p><b>12a.</b></p> <p><input type="checkbox"/> No difficulty <i>(C5 on page 56 for NP, or C6 on page 62)</i></p> <p><input type="checkbox"/> Preparing meals <b>31</b></p> <p><input type="checkbox"/> Shopping <b>32</b></p> <p><input type="checkbox"/> Managing money <b>33</b></p> <p><input type="checkbox"/> Using the telephone <b>34</b></p> <p><input type="checkbox"/> Heavy housework <b>35</b></p> <p><input type="checkbox"/> Light housework <b>36</b></p> <p><i>(Mark (X) appropriate box(es) in X3)</i></p> <hr style="border-top: 1px dashed black;"/> <p><b>b.</b></p> <p><input type="checkbox"/> Some <b>37</b></p> <p><input type="checkbox"/> A lot</p> <p><input type="checkbox"/> Unable</p> <p><input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><b>c.</b></p> <p><input type="checkbox"/> Some <b>38</b></p> <p><input type="checkbox"/> A lot</p> <p><input type="checkbox"/> Unable</p> <p><input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><b>d.</b></p> <p><input type="checkbox"/> Some <b>39</b></p> <p><input type="checkbox"/> A lot</p> <p><input type="checkbox"/> Unable</p> <p><input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><b>e.</b></p> <p><input type="checkbox"/> Some } <b>40</b></p> <p><input type="checkbox"/> A lot } <i>(12f on page 62)</i></p> <p><input type="checkbox"/> Unable }</p> <p><input type="checkbox"/> DK }</p> |                 |





**Section II - DISABILITY - Continued**

RT 70

**Part C - ADL / IADL - Continued**

**IADL TABLE 1**

|   |   |   |  |     |   |   |    |    |
|---|---|---|--|-----|---|---|----|----|
| <b>ITEM C7</b>  | Enter person's number and name.                                 | <b>C7</b>   | Person number _____<br>Name _____  | 3-4 |   |   |    |    |
| <b>ITEM C8</b>  | Refer to X3 for this person.<br>Mark (X) first appropriate box. | <b>C8</b>   | 1 <input type="checkbox"/> "Help/supv." (13)<br>2 <input type="checkbox"/> "Difficulty/doesn't do" (15 on page 66)   | 5   |   |   |    |    |
| <b>13a. You said that -- gets help or supervision with (activities with "help/supv." in X3).</b><br><b>Who gives this help?</b><br><b>Anyone else?</b><br>Mark (X) all that apply.<br><br>If ONLY help is from spouse/child(ren)/parent, mark (X) box 0; otherwise, ask:  |   | <b>13a.</b>   |  | 10  |   |   |    |    |
|   |   | Household members<br>1 <input type="checkbox"/> Relative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>6</td></tr></table><br>2 <input type="checkbox"/> Nonrelative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>7</td></tr></table>                    | 6  | 7   | Nonhousehold members<br>3 <input type="checkbox"/> Relative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>8</td></tr></table><br>4 <input type="checkbox"/> Nonrelative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>9</td></tr></table> | 8   | 9  |    |
| 6   |   |   |  |     |   |   |    |    |
| 7   |   |   |  |     |   |   |    |    |
| 8   |   |   |  |     |   |   |    |    |
| 9   |   |   |  |     |   |   |    |    |
| <b>b. Is any of this help paid for?</b><br><br><b>c. Which helpers are paid?</b><br>Anyone else?<br>Mark (X) all the apply.   |   | <b>b.</b>   | 0 <input type="checkbox"/> Spouse/child(ren)/parent only (14)<br><br>1 <input type="checkbox"/> Yes (13c)<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> DK } (14)   | 10  |   |   |    |    |
|   |   | <b>c.</b>   | Household members<br>1 <input type="checkbox"/> Relative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>11</td></tr></table><br>2 <input type="checkbox"/> Nonrelative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>12</td></tr></table> | 11  | 12  | Nonhousehold members<br>3 <input type="checkbox"/> Relative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>13</td></tr></table><br>4 <input type="checkbox"/> Nonrelative(s) <table border="1" style="display:inline-table; width:40px; height:15px; text-align:center;"><tr><td>14</td></tr></table> | 13 | 14 |
| 11  |   |   |  |     |   |   |    |    |
| 12  |   |   |  |     |   |   |    |    |
| 13  |   |   |  |     |   |   |    |    |
| 14  |   |   |  |     |   |   |    |    |
| Ask 14a and b only if "Help/supv." for <b>Preparing meals</b> ; otherwise, skip to 14c.   |   | <b>15</b>   |  |     |   |   |    |    |
| <b>14a. If -- did not get help or supervision from another person, how much difficulty would -- have preparing -- meals on -- own -- some, a lot, or would -- be completely unable to do this?</b><br><br>1 <input type="checkbox"/> Some      3 <input type="checkbox"/> Completely unable<br>2 <input type="checkbox"/> A lot      9 <input type="checkbox"/> DK    |   | <b>14c.</b>   |  | 17  |   |   |    |    |
|   |   | Ask 14c and d only if "Help or supv." for <b>Shopping</b> ; otherwise, skip to 14e.   |  |     |   |   |    |    |
| <b>b. WITH help or supervision, how much difficulty does -- have preparing -- meals -- some, a lot, or is -- completely unable to do this?</b><br><br>0 <input type="checkbox"/> No difficulty      2 <input type="checkbox"/> A lot      9 <input type="checkbox"/> DK<br>1 <input type="checkbox"/> Some      3 <input type="checkbox"/> Completely unable          |   | <b>d.</b>   |  | 18  |   |   |    |    |
|   |   | <b>14c. If -- did not get help or supervision from another person, how much difficulty would -- have shopping for personal items on -- own -- some, a lot, or would -- be completely unable to do this?</b><br><br>1 <input type="checkbox"/> Some      3 <input type="checkbox"/> Completely unable<br>2 <input type="checkbox"/> A lot      9 <input type="checkbox"/> DK |  |     |   |   |    |    |
| <b>d. WITH help or supervision, how much difficulty does -- have shopping for personal items -- some, a lot, or is -- completely unable to do this?</b><br><br>0 <input type="checkbox"/> No difficulty      2 <input type="checkbox"/> A lot      9 <input type="checkbox"/> DK<br>1 <input type="checkbox"/> Some      3 <input type="checkbox"/> Completely unable |   |   |  | 18  |   |   |    |    |
|   |   |   |  |     |   |   |    |    |
| Notes   |   |   |  |     |   |   |    |    |

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL - Continued**

**IADL TABLE 1 - Continued**

|  |  |
|--|--|
| <p style="text-align: right; margin-bottom: 0;">19</p> <p><i>Ask 14e and f only if "Help/supv." for <b>Managing money</b>; otherwise, skip to 14g.</i></p> <p><b>14e. If -- did not get help or supervision from another person, how much difficulty would -- managing money on -- own -- some, a lot, or is -- be completely unable to do this?</b></p> <p>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable<br/>2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">20</p> <p><b>f. WITH help or supervision, how much difficulty does -- have managing money -- some, a lot, or is -- completely unable to do this?</b></p> <p>0 <input type="checkbox"/> No difficulty    2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK<br/>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">21</p> <p><i>Ask 14g and h only if "Help/supv. for <b>Telephone</b>"; otherwise, skip to 14i.</i></p> <p><b>g. If -- did not get help or supervision from another person, how much difficulty would -- have using the telephone -- some, a lot, or would -- be completely unable to do this?</b></p> <p>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable<br/>2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">22</p> <p><b>h. WITH help or supervision, how much difficulty does -- have using the telephone -- some, a lot, or is -- completely unable to do this?</b></p> <p>0 <input type="checkbox"/> No difficulty    2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK<br/>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable</p> | <p style="text-align: right; margin-bottom: 0;">23</p> <p><i>Ask 14i and j only if "Help/supv." for <b>Heavy housework</b>; otherwise, skip to 14k.</i></p> <p><b>14i. If -- did not get help or supervision from another person, how much difficulty would -- have doing heavy work around the house -- some, a lot, or would -- be completely unable to do this?</b></p> <p>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable<br/>2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">24</p> <p><b>j. WITH help or supervision, how much difficulty does -- have doing heavy work around the house -- some, a lot, or is -- completely unable to do this?</b></p> <p>0 <input type="checkbox"/> No difficulty    2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK<br/>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">25</p> <p><i>Ask 14k and l only if "Help/supv." for <b>Light housework</b>; otherwise, skip to 15 on page 66.</i></p> <p><b>k. If -- did not get help or supervision from another person, how much difficulty would -- have doing light work around the house -- some, a lot, or would -- be completely unable to do this?</b></p> <p>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable<br/>2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: right; margin-bottom: 0;">26</p> <p><b>l. WITH help or supervision, how much difficulty does -- have doing light work around the house -- some, a lot, or is -- completely unable to do this?</b></p> <p>0 <input type="checkbox"/> No difficulty    2 <input type="checkbox"/> A lot            9 <input type="checkbox"/> DK<br/>1 <input type="checkbox"/> Some            3 <input type="checkbox"/> Completely unable</p> <p style="text-align: right; margin-top: 10px;"><i>(Go to 15 on page 66)</i></p> |
|--|--|

Notes

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL - Continued**

**IADL TABLE 1 - Continued**

|   |  |
|---|--|
| <p style="text-align: right; margin-bottom: 0;">27-28</p> <p><i>Ask only if "Preparing meals" marked in X3; otherwise, 15a for next activity.</i></p> <p><b>15a. How old was -- when -- first had a problem with preparing -- own meals?</b></p> <p>_____ Years old (15d)<br/> <input type="checkbox"/> At birth (15d)<br/> <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">29</span></p> <p><input type="checkbox"/> Yes (15d)<br/> <input type="checkbox"/> No (15c)<br/> <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">30</span></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">31</span></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. Is -- expected to have this problem with preparing -- own meals for at least 12 months longer?</b></p> <p><input type="checkbox"/> Yes } (15a for next activity)<br/> <input type="checkbox"/> No }<br/> <input type="checkbox"/> DK }</p> | <p style="text-align: right; margin-bottom: 0;">37-38</p> <p><i>Ask only if "Shopping" marked in X3; otherwise, 15a for next activity.</i></p> <p><b>15a. How old was -- when -- first had a problem with shopping for personal items?</b></p> <p>_____ Years old (15d)<br/> <input type="checkbox"/> At birth (15d)<br/> <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">39</span></p> <p><input type="checkbox"/> Yes (15d)<br/> <input type="checkbox"/> No (15c)<br/> <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">40</span></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">41</span></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. Is -- expected to have this problem with shopping for personal items for at least 12 months longer?</b></p> <p><input type="checkbox"/> Yes } (15a for next activity)<br/> <input type="checkbox"/> No }<br/> <input type="checkbox"/> DK }</p> |
| <p style="text-align: right; margin-bottom: 0;">32-33</p> <p><i>Ask only if "Managing money" marked in X3; otherwise, 15a for next activity.</i></p> <p><b>15a. How old was -- when -- first had a problem with managing money?</b></p> <p>_____ Years old (15d)<br/> <input type="checkbox"/> At birth (15d)<br/> <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">34</span></p> <p><input type="checkbox"/> Yes (15d)<br/> <input type="checkbox"/> No (15c)<br/> <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">35</span></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">36</span></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. Is -- expected to have this problem managing money for at least 12 months longer?</b></p> <p><input type="checkbox"/> Yes } (15a for next activity)<br/> <input type="checkbox"/> No }<br/> <input type="checkbox"/> DK }</p>                       | <p style="text-align: right; margin-bottom: 0;">42-43</p> <p><i>Ask only if "Telephone" marked in X3; otherwise, 15a, for next activity.</i></p> <p><b>15a. How old was -- when -- first had a problem with using the telephone?</b></p> <p>_____ Years old (15d)<br/> <input type="checkbox"/> At birth (15d)<br/> <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right;">44</span></p> <p><input type="checkbox"/> Yes (15d)<br/> <input type="checkbox"/> No (15c)<br/> <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right;">45</span></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> <span style="float: right;">46</span></p> <hr style="border-top: 1px dashed black;"/> <p><b>d. Is -- expected to have this problem using the telephone for at least 12 months longer?</b></p> <p><input type="checkbox"/> Yes } (15a for next activity)<br/> <input type="checkbox"/> No }<br/> <input type="checkbox"/> DK }</p>                    |

**Section II - DISABILITY - Continued**

**Part C - ADL / IADL - Continued**

**IADL TABLE 1 - Continued**

|  |   |
|--|---|
| <p style="text-align: right; font-size: small;">47-48</p> <p style="font-size: x-small;">Ask only if "<b>Heavy work</b>" marked in X3; otherwise, 15a for next activity.</p> <p><b>15a. How old was -- when -- first had a problem with doing heavy work around the house?</b></p> <p>_____ Years old (15d)</p> <p>96 <input type="checkbox"/> At birth (15d)<br/>99 <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right; border: 1px solid black; padding: 2px;">49</span></p> <p>1 <input type="checkbox"/> Yes (15d)<br/>2 <input type="checkbox"/> No (15c)<br/>9 <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right; border: 1px solid black; padding: 2px;">50</span></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask: <span style="float: right; border: 1px solid black; padding: 2px;">51</span></p> <p><b>d. Is -- expected to have this problem doing heavy work around the house for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK } (15a for next activity)</p> | <p style="text-align: right; font-size: small;">52-53</p> <p style="font-size: x-small;">Ask only if "<b>Light work</b>" marked in X3; otherwise, 16, below.</p> <p><b>15a. How old was -- when -- first had a problem with doing light work around the house?</b></p> <p>_____ Years old (15d)</p> <p>96 <input type="checkbox"/> At birth (15d)<br/>99 <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p><b>b. Was it before -- was 18 years old?</b> <span style="float: right; border: 1px solid black; padding: 2px;">54</span></p> <p>1 <input type="checkbox"/> Yes (15d)<br/>2 <input type="checkbox"/> No (15c)<br/>9 <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p><b>c. Was it before -- was 22 years old?</b> <span style="float: right; border: 1px solid black; padding: 2px;">55</span></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p style="font-size: x-small;">If obvious, mark without asking; otherwise ask: <span style="float: right; border: 1px solid black; padding: 2px;">56</span></p> <p><b>d. Is -- expected to have this problem doing light work around the house for at least 12 months longer?</b></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK } (16)</p> |
| <p><b>16. What is the MAIN problem or condition which causes -- trouble in (activities marked in X3)?</b></p>  | <p style="font-size: x-small;">(Enter condition in X1 and mark box) <span style="float: right; border: 1px solid black; padding: 2px;">57</span></p> <p>1 <input type="checkbox"/> In C2<br/>2 <input type="checkbox"/> Not in C2 } (C6 on page 62 for NP, or Part D on page 80)</p>  |

Notes

| <b>Section II - DISABILITY - Continued</b>  |   | RT 71    |
|---|---|----------|
| <b>Part D - FUNCTIONAL LIMITATION</b>   |   | PERSON 1 |
| <b>ITEM D1</b>  | <i>Refer to ages of all family members.</i> | 3-4<br>5 |
| <p><b>These next few questions also refer to family members who are 18 years old or older, that is (read names of nondeleted persons 18+).</b></p> <p><b>1a. Do (names of persons 18+) have ANY difficulty lifting something as heavy as 10 pounds, such as a full bag of groceries?</b></p>  |   | 6        |
| <p><b>1a.</b> 1 <input type="checkbox"/> Yes (1b)<br/>2 <input type="checkbox"/> No } (2 on page 82)<br/>9 <input type="checkbox"/> DK</p>  |   |          |
| <p><b>b. Who is this?</b><br/><i>Mark (X) "Difficulty lifting" box in person's column.</i></p>  |   | 7        |
| <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No</p> <p><i>Ask 1d-g for each person with "Difficulty lifting" marked in 1b.</i></p>  |   |          |
| <p><b>d. How much difficulty does -- have lifting 10 pounds, some, a lot, or is -- completely unable to do this?</b></p>  |   | 8        |
| <p><b>d.</b> 1 <input type="checkbox"/> Some difficulty<br/>2 <input type="checkbox"/> A lot of difficulty<br/>3 <input type="checkbox"/> Completely unable<br/>9 <input type="checkbox"/> DK</p>   |   |          |
| <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p>_____ Years old</p> <p style="text-align: center;">OR</p> <p>96 <input type="checkbox"/> Always had difficulty<br/>97 <input type="checkbox"/> Never able<br/>99 <input type="checkbox"/> DK</p> <p><i>Ask only if "Completely unable" in 1d; otherwise, skip to 1g.</i></p> |   | 9-10     |
| <p><b>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</b></p>  |   | 11       |
| <p><b>f.</b> 1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p>   |   |          |
| <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p>  |   | 12       |
| <p><b>g.</b> 1 <input type="checkbox"/> Yes } (1d for NP in 1b,<br/>2 <input type="checkbox"/> No } or 2 on page 82)<br/>9 <input type="checkbox"/> DK</p>  |   |          |
| Notes   |   |          |

| <b>Section II - DISABILITY - Continued</b>   |   |                 |
|--|---|-----------------|
| <b>Part D - FUNCTIONAL LIMITATION - Continued</b>  |   | <b>PERSON 1</b> |
| <p><b>2a. Do (names of persons 18+) have any difficulty walking up 10 steps without resting?</b></p>   | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (3 on page 84)</p>   | <p>13</p>       |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Difficulty walking up steps" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Difficulty walking up steps</p>  | <p>14</p>       |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 2b and c)      <input type="checkbox"/> No</p> <p>Ask 2d-g for each person with "Difficulty walking up steps" marked in 2b.</p> |   |                 |
| <p><b>d. How much difficulty does -- have walking up 10 steps without rest, some, a lot, or is -- completely unable to do this?</b></p>  | <p><b>d.</b></p> <p>1 <input type="checkbox"/> Some difficulty<br/>                 2 <input type="checkbox"/> A lot of difficulty<br/>                 3 <input type="checkbox"/> Completely unable<br/>                 9 <input type="checkbox"/> DK</p> | <p>15</p>       |
| <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p>Ask only if "Completely unable" in 2d; otherwise, skip to 2g.</p>   | <p><b>e.</b></p> <p>_____ Years old<br/>                 OR<br/>                 96 <input type="checkbox"/> Always had difficulty<br/>                 97 <input type="checkbox"/> Never able<br/>                 99 <input type="checkbox"/> DK</p>      | <p>16-17</p>    |
| <p><b>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</b></p>   | <p><b>f.</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK</p>  | <p>18</p>       |
| <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p>   | <p><b>g.</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (2d for NP in 2b, or 3 on page 84)</p>   | <p>19</p>       |
| <p>Notes</p>   |   |                 |

| <b>Section II - DISABILITY - Continued</b>  |   |
|---|---|
| <b>Part D - FUNCTIONAL LIMITATION - Continued</b>   |   |
|   | <b>PERSON 1</b>   |
| <p><b>3a. Do (names of persons 18+) have any difficulty walking a quarter of a mile - about 3 city blocks?</b></p>  | <p><b>3a.</b> <span style="float: right;">20</span></p> <p>1 <input type="checkbox"/> Yes (3b)<br/>                 2 <input type="checkbox"/> No } (4 on page 86)<br/>                 9 <input type="checkbox"/> DK</p>   |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Difficulty walking" box in person's column.</p>  | <p><b>b.</b> <span style="float: right;">21</span></p> <p>1 <input type="checkbox"/> Difficulty walking</p>   |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 3b and c)      <input type="checkbox"/> No</p> <p>Ask 3d-g for each person with "Difficulty walking" marked in 3b.</p> | <p><b>c.</b> <span style="float: right;">22</span></p>  |
| <p><b>d. How much difficulty does -- have walking a quarter of a mile, some, a lot, or is -- completely unable to do this?</b></p>  | <p><b>d.</b> <span style="float: right;">22</span></p> <p>1 <input type="checkbox"/> Some difficulty<br/>                 2 <input type="checkbox"/> A lot of difficulty<br/>                 3 <input type="checkbox"/> Completely unable<br/>                 9 <input type="checkbox"/> DK</p> |
| <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p>Ask only if "Completely unable" in 3d; otherwise, skip to 3g.</p>  | <p><b>e.</b> <span style="float: right;">23-24</span></p> <p>_____ Years old<br/>                 OR<br/>                 96 <input type="checkbox"/> Always had difficulty<br/>                 97 <input type="checkbox"/> Never able<br/>                 99 <input type="checkbox"/> DK</p>   |
| <p><b>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</b></p>  | <p><b>f.</b> <span style="float: right;">25</span></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK</p>  |
| <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p>  | <p><b>g.</b> <span style="float: right;">26</span></p> <p>1 <input type="checkbox"/> Yes } (3d for NP in 3b,<br/>                 2 <input type="checkbox"/> No } or 4 on page 86)<br/>                 9 <input type="checkbox"/> DK</p>   |
| <p>Notes</p>  |   |

| <b>Section II - DISABILITY - Continued</b>  |   |  |
|---|---|--|
| <b>Part D - FUNCTIONAL LIMITATION - Continued</b>   |   | <b>PERSON 1</b>  |
| <p><b>4a. Do (names of persons 18+) have any difficulty standing for about 20 minutes?</b></p>  | <p><b>4a.</b></p> <p>1 <input type="checkbox"/> Yes (4b)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (5 on page 88)</p>   | <p style="border: 1px solid black; display: inline-block; padding: 2px;">27</p>    |
| <p><b>b. Who is this?</b><br/>                 Mark (X) "Difficulty standing" box in person's column.</p>   | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Difficulty standing</p>  | <p style="border: 1px solid black; display: inline-block; padding: 2px;">28</p>    |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 4b and c)      <input type="checkbox"/> No</p> <p><i>Ask 4d-g for each person with "Difficulty standing" marked in 4b.</i></p> |   | <p style="border: 1px solid black; display: inline-block; padding: 2px;">29</p>    |
| <p><b>d. How much difficulty does -- have standing for about 20 minutes, some, a lot, or is -- completely unable to do this?</b></p>  | <p><b>d.</b></p> <p>1 <input type="checkbox"/> Some difficulty<br/>                 2 <input type="checkbox"/> A lot of difficulty<br/>                 3 <input type="checkbox"/> Completely unable<br/>                 9 <input type="checkbox"/> DK</p> | <p style="border: 1px solid black; display: inline-block; padding: 2px;">30-31</p> |
| <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p><i>Ask only if "Completely unable" in 4d; otherwise, skip to 4g.</i></p>   | <p><b>e.</b></p> <p>_____ Years old<br/>                 OR<br/>                 96 <input type="checkbox"/> Always had difficulty<br/>                 97 <input type="checkbox"/> Never able<br/>                 99 <input type="checkbox"/> DK</p>      | <p style="border: 1px solid black; display: inline-block; padding: 2px;">32</p>    |
| <p><b>f. [Do you expect/Is -- expected] to remain unable to do this for at least 12 months longer?</b></p>  | <p><b>f.</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK</p>  | <p style="border: 1px solid black; display: inline-block; padding: 2px;">33</p>    |
| <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p>  | <p><b>g.</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (4d for NP in 4b, or 5 on page 88)</p>   | <p style="border: 1px solid black; display: inline-block; padding: 2px;">33</p>    |
| <p>Notes</p>  |   |  |



| <b>Section II – DISABILITY – Continued</b>  |   | <b>PERSON 1</b> |
|---|---|-----------------|
| <b>Part D – FUNCTIONAL LIMITATION – Continued</b>   |   |                 |
| <p><b>5a. Do</b> <i>(names of persons 18+)</i> <b>have any difficulty bending down from a standing position to pick up an object from the floor, for example, a shoe?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/><i>Mark (X) "Difficulty bending" box in person's column.</i></p> <p>-----</p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes <i>(Reask 5b and c)</i>      <input type="checkbox"/> No</p> <p><i>Ask 5d-g for each person with "Difficulty bending" marked in 5b.</i></p> <p>-----</p> <p><b>d. How much difficulty does -- have bending down from a standing position, some, a lot, or is - completely unable to do this?</b></p> <p>-----</p> <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p>-----</p> <p><i>Ask only if "Completely unable" in 5d; otherwise, skip to 5g.</i></p> <p>-----</p> <p><b>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</b></p> <p>-----</p> <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p> | <p><b>5a.</b> <span style="float: right;">34</span><br/>                     1 <input type="checkbox"/> Yes <i>(5b)</i><br/>                     2 <input type="checkbox"/> No } <i>(6 on page 90)</i><br/>                     9 <input type="checkbox"/> DK</p> <p><b>b.</b> <span style="float: right;">35</span><br/>                     1 <input type="checkbox"/> Difficulty bending</p> <p style="background-color: #cccccc; text-align: center;"> </p> <p><b>d.</b> <span style="float: right;">36</span><br/>                     1 <input type="checkbox"/> Some difficulty<br/>                     2 <input type="checkbox"/> A lot of difficulty<br/>                     3 <input type="checkbox"/> Completely unable<br/>                     9 <input type="checkbox"/> DK</p> <p><b>e.</b> <span style="float: right;">37-38</span><br/>                     _____ Years old<br/>                     OR<br/>                     96 <input type="checkbox"/> Always had difficulty<br/>                     97 <input type="checkbox"/> Never able<br/>                     99 <input type="checkbox"/> DK</p> <p><b>f.</b> <span style="float: right;">39</span><br/>                     1 <input type="checkbox"/> Yes<br/>                     2 <input type="checkbox"/> No<br/>                     9 <input type="checkbox"/> DK</p> <p><b>g.</b> <span style="float: right;">40</span><br/>                     1 <input type="checkbox"/> Yes } <i>(5d for NP in 5b, or 6 on page 90)</i><br/>                     2 <input type="checkbox"/> No }<br/>                     9 <input type="checkbox"/> DK }</p> |                 |
| Notes   |   |                 |

| <b>Section II – DISABILITY – Continued</b>   |  |                 |
|--|--|-----------------|
| <b>Part D – FUNCTIONAL LIMITATION – Continued</b>  |  | <b>PERSON 1</b> |
| <p><b>6a. Do (names of persons 18+) have any difficulty reaching up over the head or reaching out as if to shake someone's hand?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>Mark (X) "Difficulty reaching" box in person's column.</p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 6b and c)      <input type="checkbox"/> No</p> <p>-----<br/>Ask 6d-g for each person with "Difficulty reaching" marked in 6b.</p> <p><b>d. How much difficulty does -- have reaching up over the head or reaching out, some, a lot, or is -- completely unable to do this?</b></p> <p>-----</p> <p><b>e. At what age did -- first have difficulty doing this?</b></p> <p>-----</p> <p>Ask only if "Completely unable" in 6d; otherwise, skip to 6g.</p> <p><b>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</b></p> <p>-----</p> <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p> | <p><b>6a.</b> <span style="float: right;">41</span></p> <p>1 <input type="checkbox"/> Yes (6b)<br/>2 <input type="checkbox"/> No } (7 on page 92)<br/>9 <input type="checkbox"/> DK</p> <hr/> <p><b>b.</b> <span style="float: right;">42</span></p> <p>1 <input type="checkbox"/> Difficulty reaching</p> <hr/> <p><b>d.</b> <span style="float: right;">43</span></p> <p>1 <input type="checkbox"/> Some difficulty<br/>2 <input type="checkbox"/> A lot of difficulty<br/>3 <input type="checkbox"/> Completely unable<br/>9 <input type="checkbox"/> DK</p> <hr/> <p><b>e.</b> <span style="float: right;">44-45</span></p> <p>_____ Years old<br/>OR<br/>96 <input type="checkbox"/> Always had difficulty<br/>97 <input type="checkbox"/> Never able<br/>99 <input type="checkbox"/> DK</p> <hr/> <p><b>f.</b> <span style="float: right;">46</span></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p> <hr/> <p><b>g.</b> <span style="float: right;">47</span></p> <p>1 <input type="checkbox"/> Yes } (6d for NP in 6b,<br/>2 <input type="checkbox"/> No } or 7 on page 92)<br/>9 <input type="checkbox"/> DK</p> |                 |

Notes

| <b>Section II - DISABILITY - Continued</b>  |   |
|---|---|
| <b>Part D - FUNCTIONAL LIMITATION - Continued</b>   |   |
| <b>PERSON 1</b>   |   |
| <p><b>7a. Do (names of persons 18+) have any difficulty using fingers to grasp or handle something such as picking up a glass from a table?</b></p>   | <p><b>7a.</b> <span style="float: right;">48</span><br/>                     1 <input type="checkbox"/> Yes (7b)<br/>                     2 <input type="checkbox"/> No } (8 on page 94)<br/>                     9 <input type="checkbox"/> DK</p>   |
| <p><b>b. Who is this?</b><br/>                     Mark (X) "Difficulty using fingers" box in person's column.</p>  | <p><b>b.</b> <span style="float: right;">49</span><br/>                     1 <input type="checkbox"/> Difficulty using fingers</p>   |
| <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No<br/>                     Ask 7d-g for each person with "Difficulty using fingers" marked in 7b.</p> |   |
| <p><b>d. How much difficulty does -- have using the fingers to grasp or handle something, some, a lot, or is -- completely unable to do this?</b></p>   | <p><b>d.</b> <span style="float: right;">50</span><br/>                     1 <input type="checkbox"/> Some difficulty<br/>                     2 <input type="checkbox"/> A lot of difficulty<br/>                     3 <input type="checkbox"/> Completely unable<br/>                     9 <input type="checkbox"/> DK</p>   |
| <p><b>e. At what age did -- first have difficulty doing this?</b><br/>                     Ask only if "Completely unable" in 7d; otherwise, skip to 7g.</p>  | <p><b>e.</b> <span style="float: right;">51-52</span><br/>                     _____ Years old<br/>                     OR<br/>                     96 <input type="checkbox"/> Always had difficulty<br/>                     97 <input type="checkbox"/> Never able<br/>                     99 <input type="checkbox"/> DK</p> |
| <p><b>f. [Do you expect/Is -- expected] to remain unable to do this for at least 12 months longer?</b></p>  | <p><b>f.</b> <span style="float: right;">53</span><br/>                     1 <input type="checkbox"/> Yes<br/>                     2 <input type="checkbox"/> No<br/>                     9 <input type="checkbox"/> DK</p>  |
| <p><b>g. Did this difficulty result from a motor vehicle accident?</b></p>  | <p><b>g.</b> <span style="float: right;">54</span><br/>                     1 <input type="checkbox"/> Yes } (7d for NP in 7b,<br/>                     2 <input type="checkbox"/> No } or 8 on page 94)<br/>                     9 <input type="checkbox"/> DK</p>   |
| <p>Notes</p>  |   |

| <b>Section II – DISABILITY – Continued</b>  |  |  |
|---|--|--|
| <b>Part D – FUNCTIONAL LIMITATION – Continued</b>   |  | <b>PERSON 1</b>  |
| <b>8a.</b> Do <i>(names of persons 18+)</i> have any difficulty holding a pen or pencil?  |  | <b>8a.</b> <span style="float: right;">55</span><br>1 <input type="checkbox"/> Yes (8b)<br>2 <input type="checkbox"/> No } (D2)<br>9 <input type="checkbox"/> DK }   |
| <b>b.</b> Who is this?<br><br><i>Mark (X) "Difficulty holding a pen or pencil" box in person's column.</i>  |  | <b>b.</b> <span style="float: right;">56</span><br>1 <input type="checkbox"/> Difficulty holding a pen or pencil   |
| <b>c.</b> Anyone else? <input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No<br><br><i>Ask 8d-g for each person with "Difficulty holding a pen or pencil" marked in 8b.</i> |  |  |
| <b>d.</b> How much difficulty -- have holding a pen or pencil, some, a lot, or is -- completely unable to do this?  |  | <b>d.</b> <span style="float: right;">57</span><br>1 <input type="checkbox"/> Some difficulty<br>2 <input type="checkbox"/> A lot of difficulty<br>3 <input type="checkbox"/> Completely unable<br>9 <input type="checkbox"/> DK |
| <b>e.</b> At what age did -- first have difficulty doing this?<br><br><i>Ask only if "Completely unable" in 8d; otherwise, skip to 8g.</i>  |  | <b>e.</b> <span style="float: right;">58-59</span><br>____ Years old<br>OR<br>96 <input type="checkbox"/> Always had difficulty<br>97 <input type="checkbox"/> Never able<br>99 <input type="checkbox"/> DK                      |
| <b>f.</b> Is -- expected to remain unable to do this for at least 12 months longer?   |  | <b>f.</b> <span style="float: right;">60</span><br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> DK  |
| <b>g.</b> Did this difficulty result from a motor vehicle accident?   |  | <b>g.</b> <span style="float: right;">61</span><br>1 <input type="checkbox"/> Yes } (8d for NP in 8b,<br>2 <input type="checkbox"/> No } or D2)<br>9 <input type="checkbox"/> DK }   |
| <b>ITEM D2</b>  | <i>Refer to questions 1b, 2b, 3b, 4b, 5b, 6b, 7b, and 8b on pages 80-95 in this HIS-2.</i> | <b>D2</b> <span style="float: right;">62</span><br>1 <input type="checkbox"/> Any limitations marked (9)<br>2 <input type="checkbox"/> No limitations marked (NP)  |
| <b>9.</b> What is the MAIN problem or condition which causes -- trouble in <i>(limitations marked in Part D, Q1-8)?</i>   |  | <b>9.</b> <span style="float: right;">63</span><br><i>(Enter condition in X1 and mark box)</i><br>1 <input type="checkbox"/> In C2 } (D2 for NP, or<br>2 <input type="checkbox"/> Not in C2 } D3 on page 96)                     |

| <b>Section II - DISABILITY - Continued</b>   |   | <b>PERSON 1</b> |  |
|--|---|-----------------|--|
| <b>Part D - FUNCTIONAL LIMITATION - Continued</b>  |   |                 |  |
| <b>ITEM<br/>D3</b>   | <p style="text-align: center;"><i>Refer to age or HIS-1, Part B, Questions 2a/b and 5a/b (pages 6-7).</i></p> | <b>D3</b>       | <div style="text-align: right; border: 1px solid black; padding: 2px;">64</div> <p>2 <input type="checkbox"/> Under 18 (NP, or Part E on page 98)</p> <p>1 <input type="checkbox"/> Yes in 2a/b or 5a/b (10)</p> <p>2 <input type="checkbox"/> Other (NP, or Part E on page 98)</p>  |
| <p><b>10. Earlier, I was told that -- was unable to work or was limited in the kind or amount of work -- could do because of an impairment or health problem. About how long has -- been unable to work or limited in the kind or amount of work -- can do?</b></p> <p><i>If less than one month, enter 1 month.</i></p> |   | <b>10.</b>      | <div style="text-align: right; border: 1px solid black; padding: 2px;">65-67</div> <p>Number { 1 <input type="checkbox"/> Months<br/>                  2 <input type="checkbox"/> Years</p> <p style="text-align: center;">OR</p> <p>3 <input type="checkbox"/> Never able</p> <p style="text-align: center;"><i>(D3 for NP, or Part E on page 98)</i></p> |
| <p>Notes</p>   |   |                 |  |

| <b>Section II - DISABILITY - Continued</b>  |  | RT 72                  |
|---|--|------------------------|
| <b>Part E - MENTAL HEALTH</b>   |  | <b>PERSON 1</b><br>3-4 |
| <p><b>These next questions are about mental and emotional health. They refer again only to (names of nondeleted persons age 18+).</b></p> |  |                        |
| <p><b>1a. Are (read names of persons 18+) FREQUENTLY depressed or anxious?</b></p>  | <p><b>1a.</b></p> <p>1 <input type="checkbox"/> Yes (1b)<br/>                 2 <input type="checkbox"/> No } (2)<br/>                 9 <input type="checkbox"/> DK }</p>             | 5                      |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Depressed or anxious" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Depressed or anxious</p>  | 6                      |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 1b and c)      <input type="checkbox"/> No (2)</p>                     |  |                        |
| <p><b>2a. Do (any of/either of) you have a lot of trouble making or keeping friendships?</b></p>  | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b)<br/>                 2 <input type="checkbox"/> No } (3)<br/>                 9 <input type="checkbox"/> DK }</p>             | 7                      |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Trouble with friendships" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Trouble with friendships</p>  | 8                      |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 2b and c)      <input type="checkbox"/> No (3)</p>                     |  |                        |
| <p><b>3a. Do (any of/either of) you have a lot of trouble getting along with other people in social or recreational settings?</b></p>     | <p><b>3a.</b></p> <p>1 <input type="checkbox"/> Yes (3b)<br/>                 2 <input type="checkbox"/> No } (4)<br/>                 9 <input type="checkbox"/> DK }</p>             | 9                      |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Trouble in social settings" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Trouble in social settings</p>  | 10                     |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 3b and c)      <input type="checkbox"/> No (4)</p>                     |  |                        |
| <p><b>4a. Do (any of/either of) you have a lot of trouble concentrating long enough to complete everyday tasks?</b></p>                   | <p><b>4a.</b></p> <p>1 <input type="checkbox"/> Yes (4b)<br/>                 2 <input type="checkbox"/> No } (5 on page 100)<br/>                 9 <input type="checkbox"/> DK }</p> | 11                     |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Trouble concentrating" box in person's column.</p>   | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Trouble concentrating</p>   | 12                     |
| <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 4b and c)      <input type="checkbox"/> No (5 on page 100)</p>         |  |                        |

| <b>Section II - DISABILITY - Continued</b>   |   |                     |
|--|---|---------------------|
| <b>Part E - MENTAL HEALTH - Continued</b>  |   | <b>PERSON 1</b>     |
| <p><b>5a. Do ([any of/either of]) you have <b>SERIOUS</b> difficulty coping with day-to-day stresses?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>                     Mark (X) "Trouble coping with stress" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b><br/> <input type="checkbox"/> Yes (Reask 5b and c)      <input type="checkbox"/> No (6)</p>   | <p><b>5a.</b></p> <p>1 <input type="checkbox"/> Yes (5b)<br/>                     2 <input type="checkbox"/> No } (6)<br/>                     9 <input type="checkbox"/> DK }</p> <p>-----</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Trouble coping with stress</p> | <p>13</p> <p>14</p> |
| <p><b>6a. Are ([any of/either of]) you <b>FREQUENTLY</b> confused, disoriented or forgetful?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>                     Mark (X) "Confused" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b><br/> <input type="checkbox"/> Yes (Reask 6b and c)      <input type="checkbox"/> No (7)</p>  | <p><b>6a.</b></p> <p>1 <input type="checkbox"/> Yes (6b)<br/>                     2 <input type="checkbox"/> No } (7)<br/>                     9 <input type="checkbox"/> DK }</p> <p>-----</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Confused</p>                   | <p>15</p> <p>16</p> |
| <p><b>7a. Do ([any of/either of]) you have phobias or <b>UNREASONABLY</b> strong fears, that is, a fear of something or some situation where most people would not be afraid?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>                     Mark (X) "Phobia" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b><br/> <input type="checkbox"/> Yes (Reask 7b and c)      <input type="checkbox"/> No (Check Item E1)</p> | <p><b>7a.</b></p> <p>1 <input type="checkbox"/> Yes (7b)<br/>                     2 <input type="checkbox"/> No } (Check Item E1)<br/>                     9 <input type="checkbox"/> DK }</p> <p>-----</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Phobia</p>         | <p>17</p> <p>18</p> |
| <p><b>ITEM E1</b></p> <p>Refer to age or questions 1b, 2b, 3b, 4b, 5b, 6b, and 7b on pages 98-101 for each person.</p>   | <p><b>E1</b></p> <p>2 <input type="checkbox"/> Under 18 (NP, or 9 on page 102)<br/>                     1 <input type="checkbox"/> Any box marked (8)<br/>                     2 <input type="checkbox"/> No box marked (NP, or 9 on page 102)</p>                            | <p>19</p>           |
| <p><b>8. During the past 12 months, did any of these problems <b>SERIOUSLY</b> interfere with -- ability to work or attend school or to manage -- day-to-day activities?</b></p>   | <p><b>8.</b></p> <p>1 <input type="checkbox"/> Yes } (E1 for NP, or 9 on page 102)<br/>                     2 <input type="checkbox"/> No }<br/>                     9 <input type="checkbox"/> DK }</p>  | <p>20</p>           |

| <b>Section II – DISABILITY – Continued</b>  |   |                 |  |
|---|---|-----------------|--|
| <b>Part E – MENTAL HEALTH – Continued</b>   |   | <b>PERSON 1</b> |  |
| <b>These next questions are about specific mental and emotional disorders. Again, I will only ask about (names of persons 18 years of age and older).</b> |   |                 |  |
| <b>9a. During the past 12 months, did (names of persons 18+) have –</b>   | <b>9a.</b>  | <b>21</b>       |  |
| (1) <b>Schizophrenia</b> (skit-suh-free'-nee-uh)?   | (1) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>22</b>       |  |
| (2) <b>Paranoid or delusional disorder, other than schizophrenia?</b>   | (2) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>23</b>       |  |
| (3) <b>Manic episodes or manic depression, also called bipolar disorder?</b>  | (3) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>24</b>       |  |
| (4) <b>Major depression? Major depression is a depressed mood and loss of interest in almost all activities FOR AT LEAST 2 WEEKS.</b>                     | (4) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>25</b>       |  |
| (5) <b>Anti-social personality, obsessive-compulsive personality, or any other SEVERE personality disorder?</b>   | (5) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>26</b>       |  |
| (6) <b>Alzheimer's (alltz'hi-merz) disease or another type of senile disorder?</b>  | (6) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>27</b>       |  |
| (7) <b>Alcohol abuse disorder?</b>  | (7) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK           | <b>28</b>       |  |
| (8) <b>Drug abuse disorder?</b>   | (8) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No (10) 9 <input type="checkbox"/> DK (10) |                 |  |
| <b>b. Who is this?</b><br><i>Mark (X) appropriate box in person's column and enter condition in X1.</i>   | <b>b.</b>   | <b>29</b>       |  |
|   | 1 <input type="checkbox"/> Schizophrenia  | <b>30</b>       |  |
|   | 2 <input type="checkbox"/> Paranoid disorder  | <b>31</b>       |  |
|   | 3 <input type="checkbox"/> Bipolar disorder   | <b>32</b>       |  |
|   | 4 <input type="checkbox"/> Major depression   | <b>33</b>       |  |
|   | 5 <input type="checkbox"/> Personality disorder   | <b>34</b>       |  |
|   | 6 <input type="checkbox"/> Senility   | <b>35</b>       |  |
|   | 7 <input type="checkbox"/> Alcohol abuse  | <b>36</b>       |  |
|   | 8 <input type="checkbox"/> Drug abuse disorder  |                 |  |
|   | <i>(Enter condition in X1, then 9c)</i>   |                 |  |
| <b>c. Anyone else?</b>  | If "Yes" (Reask 9b and c)      If "No" (9a for next disorder, or 10 on page 104)                              |                 |  |
| Notes   |   |                 |  |



| <b>Section II – DISABILITY – Continued</b>   |  |                               |                 |
|--|--|-------------------------------|-----------------|
| <b>Part E – MENTAL HEALTH – Continued</b>  |  |                               | <b>PERSON 1</b> |
| <p><b>10a. DURING THE PAST 12 MONTHS, did (any of/either of) you have any OTHER mental or emotional disorders? Include only those disorders which SERIOUSLY interfered with [their/your] ability to work or attend school or to manage [their/your] day-to-day activities.</b></p> <p><b>b. Who is this?</b><br/><i>Mark (X) "Other disorder" box in person's column.</i></p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 10b and c)      <input type="checkbox"/> No</p> <p><i>Ask for each person with "Other disorder" marked in 10b.</i></p> <p><b>d. What would you call the disorder -- has?</b><br/><i>If more than one other disorder, probe for the "Main" one causing difficulty.</i></p> | <p><b>10a.</b></p> <p>1 <input type="checkbox"/> Yes (10b)<br/>2 <input type="checkbox"/> No } (11)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Other disorder</p> <p><b>d.</b></p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (10d for NP with<br/>2 <input type="checkbox"/> Not in C2 } 10b, or 11)</p> | <p>37</p> <p>38</p> <p>39</p> |                 |
| <p><b>11a. DURING THE PAST 12 MONTHS, did (any of/either of) you take any prescription medication for any ongoing mental or emotional condition?</b></p> <p><b>b. Who is this?</b><br/><i>Mark (X) "Medication" box in person's column.</i></p> <p><b>c. Anyone else?</b>      <input type="checkbox"/> Yes (Reask 11b and c)      <input type="checkbox"/> No (Item E2)</p>   | <p><b>11a.</b></p> <p>1 <input type="checkbox"/> Yes (11b)<br/>2 <input type="checkbox"/> No } (Item E2)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Medication</p>   | <p>40</p> <p>41</p>           |                 |
| <p><b>ITEM E2</b></p> <p><i>Refer to age or questions 1b, 2b, 3b, 4b, 5b, 6b, 7b, 9b, 10b, and 11b on pages 98-105 for each person.</i></p>  | <p><b>E2</b></p> <p>0 <input type="checkbox"/> Under 18 (NP, or Part F on page 106)<br/>1 <input type="checkbox"/> Any box marked (12)<br/>2 <input type="checkbox"/> No box marked (NP, or Part F on page 106)</p>  | <p>42</p>                     |                 |
| <p><b>12a. Because of [this/any of these] mental or emotional problem(s), is -- UNABLE TO WORK OR LIMITED IN THE KIND OR AMOUNT OF WORK -- CAN DO?</b></p> <p><b>b. Because of [this/any of these] mental or emotional problem(s), does -- have trouble FINDING OR KEEPING A JOB OR DOING JOB TASKS?</b></p>   | <p><b>12a.</b></p> <p>1 <input type="checkbox"/> Yes (13)<br/>2 <input type="checkbox"/> No } (12b)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Yes<br/>2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> DK</p>   | <p>43</p> <p>44</p>           |                 |
| <p><b>13. Because of [this/any of these] mental or emotional problem(s), during the past 12 months, has -- received any services from a mental health community support program?</b></p> <p><i>Read if necessary: A community support program for clients with mental or emotional problems is a program that makes available mental health, health, social and support services based on individual need.</i></p>   | <p><b>13.</b></p> <p>1 <input type="checkbox"/> Yes } (E2 for NP, or Part F<br/>2 <input type="checkbox"/> No } on page 106)<br/>9 <input type="checkbox"/> DK }</p>   | <p>45</p>                     |                 |

| <b>Section II - DISABILITY - Continued</b>  |            | RT 73  |
|---|------------|--|
| <b>Part F - SERVICES AND BENEFITS</b>   |            | PERSON 1   |
| <b>1a. Some programs help people with disabilities to develop skills and opportunities for paid employment. During the past 12 months, did <i>(read names of persons 18+)</i> participate in a sheltered workshop, transitional work training, or supported employment?</b> | <b>1a.</b> | <input type="checkbox"/> Yes (1b)<br><input type="checkbox"/> No } (1d)<br><input type="checkbox"/> DK }   |
| <b>b. Who is this?</b><br><br><i>Ask if necessary: In which programs did -- participate during the past 12 months, sheltered workshop, transitional work training, or supported employment?</i><br><br><i>Mark (X) appropriate box(es) in person's column.</i>              | <b>b.</b>  | <input type="checkbox"/> Sheltered workshop <b>6</b><br><input type="checkbox"/> Transitional work training <b>7</b><br><input type="checkbox"/> Supported employment <b>8</b> |
| <b>c. Did anyone else participate in any of these programs during the past 12 months?</b><br><input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No (1d)   |            |  |
| <b>d. Are <i>(names of persons 18+)</i> now on a waiting list for any of these programs?</b>  | <b>d.</b>  | <input type="checkbox"/> Yes (1e)<br><input type="checkbox"/> No } (2 on page 108)<br><input type="checkbox"/> DK }  |
| <b>e. Who is this?</b>  | <b>e.</b>  | <input type="checkbox"/> Waiting list  |
| <b>f. Anyone else?</b><br><input type="checkbox"/> Yes (Reask 1e and f) <input type="checkbox"/> No (2 on page 108)   |            |  |
| Notes   |            |  |

| <b>Section II - DISABILITY - Continued</b>   |   |                  |
|--|---|------------------|
| <b>Part F - SERVICES AND BENEFITS - Continued</b>  |   | <b>PERSON 1</b>  |
| <p><b>2a. During the past 12 months, did (read names of persons 18+) go to a day activity center for persons with disabilities which provides social, recreational and developmental activities during normal working hours?</b></p> | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (2d)</p>           | <p><b>11</b></p> |
| <p><b>b. Who is this?</b></p> <p>Mark (X) "Day activity center" box in person's column.</p>  | <p><b>b.</b></p> <p>1 <input type="checkbox"/> Day activity center</p>  | <p><b>12</b></p> |
| <p><b>c. Anyone else?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes (Reask 2b and c)      <input type="checkbox"/> No (2d)</p>   |   |                  |
| <p><b>d. Are (names of persons 18+) now on a waiting list for a day activity center?</b></p>   | <p><b>d.</b></p> <p>1 <input type="checkbox"/> Yes (2e)<br/>                 2 <input type="checkbox"/> No<br/>                 9 <input type="checkbox"/> DK } (3 on page 110)</p> | <p><b>13</b></p> |
| <p><b>e. Who is this?</b></p> <p>Mark (X) "Waiting list" box in person's column.</p>   | <p><b>e.</b></p> <p>1 <input type="checkbox"/> Waiting list</p>   | <p><b>14</b></p> |
| <p><b>f. Anyone else?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes (Reask 2e and f)      <input type="checkbox"/> No (3 on page 110)</p>  |   |                  |
| <p>Notes</p>   |   |                  |

| <b>Section II – DISABILITY – Continued</b>  |   |
|---|---|
| <b>Part F – SERVICES AND BENEFITS – Continued</b>   |   |
|   | <b>PERSON 1</b>   |
| <p><b>3a. During the past 12 months, have (names of persons 18+) received any physical therapy?</b></p>   | <p><b>3a.</b> <span style="float: right;">15</span><br/>                     1 <input type="checkbox"/> Yes (3b)<br/>                     2 <input type="checkbox"/> No } (4a)<br/>                     9 <input type="checkbox"/> DK }</p>   |
| <p><b>b. Who is this?</b><br/>                     (Anyone else?)<br/>                     Mark (X) "Physical therapy" box in person's column.<br/>                     Ask 3c-d for each person with box marked in 3b.</p>     | <p><b>b.</b> <span style="float: right;">16</span><br/>                     1 <input type="checkbox"/> Physical therapy</p>   |
| <p><b>c. Has the condition for which -- gets physical therapy been going on or is it expected to go on for at least 12 months?</b></p>  | <p><b>c.</b> <span style="float: right;">17</span><br/>                     1 <input type="checkbox"/> Yes (3d)<br/>                     2 <input type="checkbox"/> No } (NP with 3b, or 4)<br/>                     9 <input type="checkbox"/> DK }</p>  |
| <p><b>d. What is the main condition for which -- gets physical therapy?</b></p>   | <p><b>d.</b> <span style="float: right;">18</span><br/>                     (Enter condition in X1 and mark box)<br/>                     1 <input type="checkbox"/> In C2 } (3c for NP with<br/>                     2 <input type="checkbox"/> Not in C2 } 3b, or 4)</p>                                      |
| <p><b>4a. During the past 12 months, have (names of persons 18+) received any occupational therapy?</b></p>   | <p><b>4a.</b> <span style="float: right;">19</span><br/>                     1 <input type="checkbox"/> Yes (4b)<br/>                     2 <input type="checkbox"/> No } (5 on page 112)<br/>                     9 <input type="checkbox"/> DK }</p>  |
| <p><b>b. Who is this?</b><br/>                     (Anyone else?)<br/>                     Mark (X) "Occupational therapy" box in person's column.<br/>                     Ask 4c-d for each person with box marked in 4b.</p> | <p><b>b.</b> <span style="float: right;">20</span><br/>                     1 <input type="checkbox"/> Occupational therapy</p>   |
| <p><b>c. Has the condition for which -- gets occupational therapy been going on or is it expected to go on for at least 12 months?</b></p>  | <p><b>c.</b> <span style="float: right;">21</span><br/>                     1 <input type="checkbox"/> Yes (4d)<br/>                     2 <input type="checkbox"/> No } (NP with 4b, or 5 on<br/>                     9 <input type="checkbox"/> DK } page 112)</p>  |
| <p><b>d. What is the main condition for which -- gets occupational therapy?</b></p>   | <p><b>d.</b> <span style="float: right;">22</span><br/>                     (Enter condition in X1 and mark box)<br/>                     1 <input type="checkbox"/> In C2 } (4c for NP with<br/>                     2 <input type="checkbox"/> Not in C2 } 4b, or 5 on page<br/>                     112)</p> |
| <p>Notes</p>  |   |

| <b>Section II - DISABILITY - Continued</b>   |  |   |
|--|--|---|
| <b>Part F - SERVICES AND BENEFITS - Continued</b>  |  | <b>PERSON 1</b>   |
| <p style="text-align: center;"><b>Vocational rehabilitation provides equipment and services to people with disabilities to improve their ability to work or live independently.</b></p> <p><b>5a. Have (read names of persons 18+) EVER received any equipment or services through vocational rehabilitation?</b></p> <p>-----</p> <p><b>b. Who is this?</b></p> <p>Mark (X) "Vocational rehabilitation" box in person's column.</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 5b and c)                    <input type="checkbox"/> No (6)</p> |  | <p><b>5a.</b> <span style="float: right;">23</span></p> <p>1 <input type="checkbox"/> Yes (5b)<br/>2 <input type="checkbox"/> No } (6)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">24</span></p> <p>1 <input type="checkbox"/> Vocational rehabilitation</p>       |
| <p style="text-align: center;"><b>A case manager coordinates personal care, and social or medical services for persons with special needs.</b></p> <p><b>6a. During the past 12 months, did (read names of persons 18+) have a case manager?</b></p> <p>-----</p> <p><b>b. Who is this?</b></p> <p>Mark (X) "Case manager" box in person's column.</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 6b and c)                    <input type="checkbox"/> No (7)</p>   |  | <p><b>6a.</b> <span style="float: right;">25</span></p> <p>1 <input type="checkbox"/> Yes (6b)<br/>2 <input type="checkbox"/> No } (7)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">26</span></p> <p>1 <input type="checkbox"/> Case manager</p>                    |
| <p style="text-align: center;"><i>Ask only for persons 18+ without 6b marked; otherwise, go to 8.</i></p> <p><b>7a. During the past 12 months, did (persons 18+ without 6b marked) NEED a case manager to coordinate personal care or social or medical services?</b></p> <p>-----</p> <p><b>b. Who is this?</b></p> <p>Mark (X) "Needs case manager" box in person's column.</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 7b and c)                    <input type="checkbox"/> No (8)</p>  |  | <p><b>7a.</b> <span style="float: right;">27</span></p> <p>1 <input type="checkbox"/> Yes (7b)<br/>2 <input type="checkbox"/> No } (8)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">28</span></p> <p>1 <input type="checkbox"/> Needs case manager</p>              |
| <p><b>8a. Do (read names of persons 18+) have a court-appointed legal guardian?</b></p> <p>-----</p> <p><b>b. Who has a legal guardian?</b></p> <p>Mark (X) "Legal guardian" box in person's column.</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 8b and c)                    <input type="checkbox"/> No (Part G on page 114)</p>  |  | <p><b>8a.</b> <span style="float: right;">29</span></p> <p>1 <input type="checkbox"/> Yes (8b)<br/>2 <input type="checkbox"/> No } (Part G on page 114)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">30</span></p> <p>1 <input type="checkbox"/> Legal guardian</p> |

| <b>Section II - DISABILITY - Continued</b>   |                                     | RT 74    |
|--|-------------------------------------|----------|
| <b>Part G - SPECIAL HEALTH NEEDS OF CHILDREN</b>   |                                     | PERSON 1 |
| <b>ITEM G1</b>   | <i>Refer to family composition.</i> | 5        |
| <p><b>The next questions refer to family members who are under 18 years old, that is (read names of nondeleted persons under 18).</b></p> <p><b>1a. Do (names of persons under 18) NOW go to a medical doctor or specialist on a regular basis for anything other than routine physical exams?</b></p> |                                     | 6        |
| <p><b>b. Who is this?</b><br/>(Anyone else?)<br/><i>Mark (X) "Regular visits" box in person's column.</i><br/><i>Ask 1c-d for each person with box marked in 1b.</i></p>   |                                     | 7        |
| <p><b>c. Has any problem or condition for which -- sees a doctor regularly been going on or is it expected to go on for at least 12 months?</b></p> <p><i>Ask only if "Yes" in 1c.</i></p>   |                                     | 8        |
| <p><b>d. What is the main problem or condition for which -- goes to a doctor regularly?</b></p>  |                                     | 9        |
| <p><b>2a. Do you think that (names of persons under 18) have any significant problems or delays in physical development?</b></p>   |                                     | 10       |
| <p><b>b. Who is this?</b><br/>(Anyone else?)<br/><i>Mark (X) "Problem or delay" box in person's column.</i><br/><i>Ask 2c for each person with box marked in 2b.</i></p>   |                                     | 11       |
| <p><b>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in physical development?</b></p>   |                                     | 12       |
| Notes  |                                     |          |

| <b>Section II – DISABILITY – Continued</b>   |   |
|--|---|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>   | <b>PERSON 1</b>   |
| <p><b>3a. Do (names of persons under 18) NOW have a physical, mental, or emotional problem for which they regularly take prescription medication?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Prescription medication" box in person's column.<br/>Ask 3c-d for each person with box marked in 3b.</p> <p><b>c. Has the problem or condition for which -- regularly takes prescription medication been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p>Ask only if "Yes" in 3c.</p> <p><b>d. What is the main problem or condition for which -- regularly takes prescription medication?</b></p> | <p><b>3a.</b> <span style="float: right;">13</span><br/> <input type="checkbox"/> Yes (3b)<br/> <input type="checkbox"/> No } (4)<br/> <input type="checkbox"/> DK }</p> <p><b>b.</b> <span style="float: right;">14</span><br/> <input type="checkbox"/> Prescription medication</p> <p><b>c.</b> <span style="float: right;">15</span><br/> <input type="checkbox"/> Yes (3d)<br/> <input type="checkbox"/> No } (NP with 3b, or 4)<br/> <input type="checkbox"/> DK }</p> <p><b>d.</b> <span style="float: right;">16</span><br/>                     (Enter condition in X1 and mark box)<br/> <input type="checkbox"/> In C2 } (3c for NP with<br/> <input type="checkbox"/> Not in C2 } 3b, or 4)</p> |
| <p><b>4a. Has (names of persons under 18) ever been a patient in a hospital overnight for a physical, mental, or emotional condition that they STILL HAVE or GET FROM TIME TO TIME?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Hospital overnight" box in person's column.<br/>Ask 4c-d for each person with box marked in 4b.</p> <p><b>c. Has the problem or condition for which -- was hospitalized been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p>Ask only if "Yes" in 4c.</p> <p><b>d. What is the main condition which caused -- hospitalization(s)?</b></p>                        | <p><b>4a.</b> <span style="float: right;">17</span><br/> <input type="checkbox"/> Yes (4b)<br/> <input type="checkbox"/> No } (5)<br/> <input type="checkbox"/> DK }</p> <p><b>b.</b> <span style="float: right;">18</span><br/> <input type="checkbox"/> Hospital overnight</p> <p><b>c.</b> <span style="float: right;">19</span><br/> <input type="checkbox"/> Yes (4d)<br/> <input type="checkbox"/> No } (NP with 4b, or 5)<br/> <input type="checkbox"/> DK }</p> <p><b>d.</b> <span style="float: right;">20</span><br/>                     (Enter condition in X1 and mark box)<br/> <input type="checkbox"/> In C2 } (4c for NP with<br/> <input type="checkbox"/> Not in C2 } 4b, or 5)</p>      |
| <p><b>5a. Do (names of persons under 18) NOW have any life-threatening allergic reactions to any foods?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Allergic reaction" box in person's column.</p>   | <p><b>5a.</b> <span style="float: right;">21</span><br/> <input type="checkbox"/> Yes (5b)<br/> <input type="checkbox"/> No } (6 on page 118)<br/> <input type="checkbox"/> DK }</p> <p><b>b.</b> <span style="float: right;">22</span><br/> <input type="checkbox"/> Allergic reaction</p>   |

| <b>Section II - DISABILITY - Continued</b>   |   |   |
|--|---|---|
| <b>Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued</b>   |   | <b>PERSON 1</b>                         |
| <p><b>6a. Are (names of persons under 18) following a special diet ordered by a doctor because of a serious ongoing medical condition?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Special diet" box in person's column.<br/>Ask 6c-d for each person with box marked in 6b.</p> <p><b>c. Would going off this diet cause -- to have a serious life-threatening reaction or illness?</b></p> <p>-----</p> <p>Ask only if "Yes" in 6c.</p> <p><b>d. What is the main problem or condition for which -- follows a special diet?</b></p>                          | <p><b>6a.</b> 1 <input type="checkbox"/> Yes (6b)<br/>2 <input type="checkbox"/> No } (7)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b> 1 <input type="checkbox"/> Special diet</p> <p><b>c.</b> 1 <input type="checkbox"/> Yes (6d)<br/>2 <input type="checkbox"/> No } (NP with 6b, or 7)<br/>9 <input type="checkbox"/> DK }</p> <p><b>d.</b> (Enter condition in X1 and mark box)<br/>1 <input type="checkbox"/> In C2 } (6c for NP with<br/>2 <input type="checkbox"/> Not in C2 } 6b, or 7)</p>  | <p>23</p> <p>24</p> <p>25</p> <p>26</p> |
| <p><b>7a. Do (names of persons under 18) NOW need special medical equipment in order to breathe?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Special equipment" box in person's column.<br/>Ask 7c-d for each person with box marked in 7b.</p> <p><b>c. Has the problem or condition for which -- needs this equipment been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p>Ask only if "Yes" in 7c.</p> <p><b>d. What is the main problem or condition for which -- needs medical equipment in order to breathe?</b></p> | <p><b>7a.</b> 1 <input type="checkbox"/> Yes (7b)<br/>2 <input type="checkbox"/> No } (8 on page 120)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b> 1 <input type="checkbox"/> Special equipment</p> <p><b>c.</b> 1 <input type="checkbox"/> Yes (7d)<br/>2 <input type="checkbox"/> No } (NP with 7b, or 8<br/>9 <input type="checkbox"/> DK } on page 120)</p> <p><b>d.</b> (Enter condition in X1 and mark box)<br/>1 <input type="checkbox"/> In C2 } (7c for NP with<br/>2 <input type="checkbox"/> Not in C2 } 7b, or 8 on page<br/>120)</p> | <p>27</p> <p>28</p> <p>29</p> <p>30</p> |
| Notes  |   |   |





| <b>Section II – DISABILITY – Continued</b>  |   |   |
|---|---|---|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>  |   | <b>PERSON 1</b>   |
| <p><b>10a. During the past 12 months, have (names of persons under 18) received any occupational therapy?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/>Mark (X) "Occupational therapy" box in person's column.<br/>Ask 10c-d for each person with box marked in 10b.</p> <p><b>c. Has the problem or condition for which -- gets occupational therapy been going on or is it expected to go on for at least 12 months?</b></p> <p>Ask only if "Yes" in 10c.</p> <p><b>d. What is the main problem or condition for which -- gets occupational therapy?</b></p> | <p><b>10a.</b> <span style="float: right;">38</span></p> <p>1 <input type="checkbox"/> Yes (10b)<br/>2 <input type="checkbox"/> No } (Item G2)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">39</span></p> <p>1 <input type="checkbox"/> Occupational therapy</p> <hr/> <p><b>c.</b> <span style="float: right;">40</span></p> <p>1 <input type="checkbox"/> Yes (10d)<br/>2 <input type="checkbox"/> No } (NP with 10b, or G2)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>d.</b> <span style="float: right;">41</span></p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (10c for NP with<br/>2 <input type="checkbox"/> Not in C2 } 10b, or G2)</p> |   |
| <b>ITEM G2</b>  | Refer to age or 9c and 10c on pages 120-123 for each person.  | <p><b>G2.</b> <span style="float: right;">42</span></p> <p>2 <input type="checkbox"/> 18+ (NP, or 14 on page 132)<br/>1 <input type="checkbox"/> Yes in 9c or 10c (11)<br/>2 <input type="checkbox"/> Other (NP, or 14 on page 132)</p> |
| <p><b>11a. Does -- NOW receive any physical or occupational therapy AT HOME? THIS INCLUDES THERAPY GIVEN BY YOU, OTHER FAMILY MEMBERS, FRIENDS, VOLUNTEERS, OR PAID PROFESSIONALS.</b></p> <p>-----</p> <p><b>b. What are the names of all persons who give -- therapy at home?</b></p> <p>-----</p> <p>Ask 11c and d only if 4 names were entered in Table T for this person; otherwise, go to 11e in Table T.</p> <p><b>c. Are there any other persons who give -- physical or occupational therapy at home?</b></p> <p>-----</p> <p><b>d. How many others?</b></p>                   | <p><b>11a.</b> <span style="float: right;">43</span></p> <p>1 <input type="checkbox"/> Yes (11b)<br/>2 <input type="checkbox"/> No } (12 on page 128)<br/>9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">44</span></p> <p>(Record up to 4 names in Table T on page 124, then return to 11c)</p> <hr/> <p><b>c.</b> <span style="float: right;">45-46</span></p> <p>1 <input type="checkbox"/> Yes (11d)<br/>2 <input type="checkbox"/> No } (11e in Table T<br/>9 <input type="checkbox"/> DK } on page 124)</p> <hr/> <p><b>d.</b> <span style="float: right;">45-46</span></p> <p>____ Therapist(s)<br/>(Number) (11e in Table T on page 124)</p>   |   |
| Notes   |   |   |

| <b>Section II – DISABILITY – Continued</b>  |   | RT 75                    |
|---|---|--------------------------|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>  |   | <b>THERAPIST AT HOME</b> |
| <b>TABLE T</b>  |   |                          |
|   | Child's name<br><br>Child's number <span style="float: right;">3-4</span><br><br>Therapist name <span style="float: right;">5-6</span>  |                          |
| <b>11e. Does (therapist) do physical or occupational therapy with --?</b><br><br><hr style="border-top: 1px dashed black;"/> <p style="text-align: center;"><i>HAND CARD DG1. Read categories if telephone interview.</i></p> <b>f. What is (therapist) relationship to --?</b><br>Mark (X) only one. | <b>11e.</b> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Physical</li> <li>2 <input type="checkbox"/> Occupational</li> <li>3 <input type="checkbox"/> Both</li> <li>9 <input type="checkbox"/> DK</li> </ul> <span style="float: right;">7</span>   |                          |
| <b>g. Is this therapy paid for?</b>   | <b>f.</b> <ul style="list-style-type: none"> <li>0 <input type="checkbox"/> Parent (11k)</li> <li>1 <input type="checkbox"/> Other relative who lives here</li> <li>2 <input type="checkbox"/> Other relative who does not live here</li> <li>3 <input type="checkbox"/> Non-relative who lives here</li> <li>4 <input type="checkbox"/> Friend/neighbor</li> <li>5 <input type="checkbox"/> Unpaid volunteer from an organization or business (11j)</li> <li>6 <input type="checkbox"/> Paid employee of an organization or business (11h)</li> <li>7 <input type="checkbox"/> Paid employee of yours</li> <li>8 <input type="checkbox"/> Other (11g)</li> <li>9 <input type="checkbox"/> DK (11g)</li> </ul> <span style="float: right;">8</span> |                          |
| <b>g.</b> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Yes (11h on page 126)</li> <li>2 <input type="checkbox"/> No</li> <li>9 <input type="checkbox"/> DK (11j on page 126)</li> </ul> <span style="float: right;">9</span>   |   |                          |
| Notes   |   |                          |

| <b>Section II - DISABILITY - Continued</b>   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
|--|---|--|-------|---|--|--|-------------------------------|---|-------|--|-------|--------------------------------------|-------|--|-------|---|-------|--|-------|-----------------------------------|-------|---|-------|
| <b>Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued</b>   | <b>THERAPIST AT HOME</b>  |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <b>TABLE T - Continued</b>   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <i>HAND CARD DG2. Read categories if telephone interview.</i>  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><b>11h. Who pays for this therapy?</b><br/> <b>(Anyone else?)</b><br/> <i>Mark (X) all that apply.</i></p>  | <p><b>11h.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> 00 Parent</td> <td style="text-align: right;">10-11</td> </tr> <tr> <td><input type="checkbox"/> 01 Other relative who lives here</td> <td style="text-align: right;">12-13</td> </tr> <tr> <td><input type="checkbox"/> 02 Other relatives who do not live here</td> <td style="text-align: right;">14-15</td> </tr> <tr> <td><input type="checkbox"/> 03 Private insurance</td> <td style="text-align: right;">16-17</td> </tr> <tr> <td><input type="checkbox"/> 04 Rehabilitation program</td> <td style="text-align: right;">18-19</td> </tr> <tr> <td><input type="checkbox"/> 05 Medicaid</td> <td style="text-align: right;">20-21</td> </tr> <tr> <td><input type="checkbox"/> 06 Public school system</td> <td style="text-align: right;">22-23</td> </tr> <tr> <td><input type="checkbox"/> 07 Other public source</td> <td style="text-align: right;">24-25</td> </tr> <tr> <td><input type="checkbox"/> 08 Other private source</td> <td style="text-align: right;">26-27</td> </tr> <tr> <td><input type="checkbox"/> 09 Other</td> <td style="text-align: right;">28-29</td> </tr> <tr> <td><input type="checkbox"/> 99 DK or Refused</td> <td style="text-align: right;">30-31</td> </tr> </table> | <input type="checkbox"/> 00 Parent               | 10-11 | <input type="checkbox"/> 01 Other relative who lives here | 12-13  | <input type="checkbox"/> 02 Other relatives who do not live here | 14-15                         | <input type="checkbox"/> 03 Private insurance | 16-17 | <input type="checkbox"/> 04 Rehabilitation program | 18-19 | <input type="checkbox"/> 05 Medicaid | 20-21 | <input type="checkbox"/> 06 Public school system | 22-23 | <input type="checkbox"/> 07 Other public source | 24-25 | <input type="checkbox"/> 08 Other private source | 26-27 | <input type="checkbox"/> 09 Other | 28-29 | <input type="checkbox"/> 99 DK or Refused | 30-31 |
| <input type="checkbox"/> 00 Parent   | 10-11   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 01 Other relative who lives here  | 12-13   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 02 Other relatives who do not live here   | 14-15   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 03 Private insurance  | 16-17   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 04 Rehabilitation program   | 18-19   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 05 Medicaid   | 20-21   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 06 Public school system   | 22-23   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 07 Other public source  | 24-25   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 08 Other private source   | 26-27   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 09 Other  | 28-29   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 99 DK or Refused  | 30-31   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| -----  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><i>Ask 11i only if box 00 or 01 is marked in 11h; otherwise, skip to 11j.</i></p> <p><b>i. How much did [you/the family] pay for this therapy during the past 2 weeks? Do not count money that will be reimbursed by insurance, an HMO, or other source.</b><br/><br/> <i>If none, enter 0; otherwise, enter amount in whole dollars.</i></p> | <p><b>i.</b> \$ _____<br/>                 (Dollars)</p>  |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| -----  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><b>j. How satisfied are you with this therapy? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?</b><br/><br/> <i>If respondent is not a parent or guardian, explain, if necessary, that "you" refers to the family in general.</i></p>  | <p><b>j.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> 1 Very satisfied</td> <td rowspan="5" style="text-align: right; vertical-align: middle;">36</td> </tr> <tr> <td><input type="checkbox"/> 2 Somewhat satisfied</td> </tr> <tr> <td><input type="checkbox"/> 3 Somewhat dissatisfied</td> </tr> <tr> <td><input type="checkbox"/> 4 Very dissatisfied</td> </tr> <tr> <td><input type="checkbox"/> 9 DK</td> </tr> </table>  | <input type="checkbox"/> 1 Very satisfied        | 36    | <input type="checkbox"/> 2 Somewhat satisfied             | <input type="checkbox"/> 3 Somewhat dissatisfied | <input type="checkbox"/> 4 Very dissatisfied                     | <input type="checkbox"/> 9 DK |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 1 Very satisfied  | 36  |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 2 Somewhat satisfied  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 3 Somewhat dissatisfied   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 4 Very dissatisfied   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 9 DK  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| -----  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><b>k. How many days during the past 2 weeks did (therapist) work with -- ?</b></p>  | <p><b>k.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> 00 None in past 2 weeks</td> <td style="text-align: right;">37-38</td> </tr> <tr> <td>_____ Days<br/>(Number)</td> <td></td> </tr> </table>  | <input type="checkbox"/> 00 None in past 2 weeks | 37-38 | _____ Days<br>(Number)                                    |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 00 None in past 2 weeks   | 37-38   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| _____ Days<br>(Number)   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| -----  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><b>l. Please estimate the hours per day that (therapist) did therapy with -- . Include therapy that is part of another activity such as play.</b></p>   | <p><b>l.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td>_____ Hours/Day</td> <td style="text-align: right;">39-40</td> </tr> <tr> <td><input type="checkbox"/> 00 Less than 1 hour/day</td> <td></td> </tr> </table>  | _____ Hours/Day                                  | 39-40 | <input type="checkbox"/> 00 Less than 1 hour/day          |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| _____ Hours/Day  | 39-40   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <input type="checkbox"/> 00 Less than 1 hour/day   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p><b><i>If another therapist in Table T for this person, ask 11e on page 124 for the next therapist; otherwise, continue with 12a on page 128 for this person.</i></b></p>  |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |
| <p>Notes</p>   |   |  |       |   |  |  |                               |   |       |  |       |                                      |       |  |       |   |       |  |       |                                   |       |   |       |

| <b>Section II - DISABILITY - Continued</b>  |  | RT 76   |
|---|--|---|
| <b>Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued</b>  |  | PERSON 1<br>3-4   |
| <p><b>12a. Does -- receive any physical or occupational therapy at any other place, that is, OTHER THAN AT HOME?</b></p> <p>-----</p> <p><b>b. Does -- receive this therapy at school, at a location other than school or both places?</b><br/><i>Mark (X) only one.</i></p> <p>-----</p> <p><b>c. Is the therapy -- receives at school physical therapy, occupational therapy or both?</b><br/><i>Mark (X) only one.</i></p> | <p><b>12a.</b><br/>                     1 <input type="checkbox"/> Yes (12b)<br/>                     2 <input type="checkbox"/> No<br/>                     9 <input type="checkbox"/> DK } (G2 on page 122 for NP, or 14 on page 132)</p> <p><b>b.</b><br/>                     1 <input type="checkbox"/> School (12c)<br/>                     2 <input type="checkbox"/> Location other than school (13 on page 130)<br/>                     3 <input type="checkbox"/> Both (12c)</p> <p><b>c.</b><br/>                     1 <input type="checkbox"/> Physical therapy<br/>                     2 <input type="checkbox"/> Occupational therapy<br/>                     3 <input type="checkbox"/> Both</p> | <p>5</p> <p>6</p> <p>7</p>  |
| <p><b>ITEM G3</b></p>   | <p><i>Refer to 12b for this person.</i></p>  | <p><b>G3</b><br/>                     1 <input type="checkbox"/> School only (G2 on page 122 for NP, or 14 on page 132)<br/>                     2 <input type="checkbox"/> All others (13 on page 130)</p> |
| <p>Notes</p>  |  |   |

| <b>Section II – DISABILITY – Continued</b>  |             |  |
|---|-------------|--|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>  |             | <b>PERSON 1</b>  |
| <p><b>These questions are about therapy that -- receives OTHER THAN AT HOME AND AT SCHOOL.</b></p>  |             | <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto; text-align: center; line-height: 20px;">9</div>  |
| <p><b>13a. Is this physical therapy, occupational therapy, or both?</b><br/><i>Mark (X) only one.</i></p>   | <b>13a.</b> | <p>1 <input type="checkbox"/> Physical therapy<br/>2 <input type="checkbox"/> Occupational therapy<br/>3 <input type="checkbox"/> Both</p>   |
| <p><b>b. During the past 2 weeks how often did -- receive [physical/(and)occupational] therapy NOT COUNTING THERAPY AT HOME OR SCHOOL?</b></p> <p><i>SHOW CARD DG2. Read categories if telephone interview.</i></p>   | <b>b.</b>   | <p>00 <input type="checkbox"/> None <span style="float: right;">10-11</span></p> <p style="text-align: center;">_____ Times<br/>(Number)</p>   |
| <p><b>c. Who pays for this therapy?</b><br/><i>Mark (X) all that apply.</i></p>   | <b>c.</b>   | <p>00 <input type="checkbox"/> Parent <span style="float: right;">12-13</span><br/>01 <input type="checkbox"/> Other family member in HH <span style="float: right;">14-15</span><br/>02 <input type="checkbox"/> Other family member not in HH <span style="float: right;">16-17</span><br/>03 <input type="checkbox"/> Private insurance <span style="float: right;">18-19</span><br/>04 <input type="checkbox"/> Rehabilitation program <span style="float: right;">20-21</span><br/>05 <input type="checkbox"/> Medicaid <span style="float: right;">22-23</span><br/>06 <input type="checkbox"/> Public school system <span style="float: right;">24-25</span><br/>07 <input type="checkbox"/> Other public source <span style="float: right;">26-27</span><br/>08 <input type="checkbox"/> Other private source <span style="float: right;">28-29</span><br/>09 <input type="checkbox"/> Other <span style="float: right;">30-31</span><br/>99 <input type="checkbox"/> DK or Refused <span style="float: right;">32-33</span></p> |
| <p><i>Ask 13d only if box 00 or 01 is marked in 13c; otherwise, skip to 13e.</i></p> <p><b>d. How much did [you/the family] pay for this therapy during the past 2 weeks. Do not count money that will be reimbursed by insurance, an HMO, or other source.</b><br/><i>If none, enter 0; otherwise enter amount in whole dollars.</i></p> | <b>d.</b>   | <p>\$ _____ <span style="float: right;">34-37</span><br/>(Dollars)</p>   |
| <p><b>e. How satisfied are you with this therapy? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?</b><br/><i>If respondent is not a parent or guardian, explain, if necessary, that "you" refers to the family in general.</i></p>   | <b>e.</b>   | <p>1 <input type="checkbox"/> Very satisfied<br/>2 <input type="checkbox"/> Somewhat satisfied<br/>3 <input type="checkbox"/> Somewhat dissatisfied<br/>4 <input type="checkbox"/> Very dissatisfied</p> <p style="text-align: right; font-size: small;">} (G2 on page 122 for NP, or 14 on page 132)</p> <div style="text-align: right; border: 1px solid black; width: 20px; height: 20px; margin: 0 auto; text-align: center; line-height: 20px;">38</div>  |
| <p>Notes</p>  |             |  |

| <b>Section II – DISABILITY – Continued</b>  |   |  |  |
|---|---|--|--|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>  |   | <b>PERSON 1</b>  |  |
| <p><b>14a. (Besides physical or occupational therapy) do (names of persons under 18) NOW have any (other) medical or health procedures done AT HOME?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/>                     Mark (X) "Medical Procedures" box in person's column.<br/>                     Ask 14c – d for each person with box marked in 14b.</p> <p>-----</p> <p><b>c. Has the problem or condition for which -- has (other) medical procedures done AT HOME been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p>Ask only if "Yes" in 14c.</p> <p><b>d. What is the main problem or condition for which -- gets medical procedures done AT HOME?</b></p> |   | <p><b>14a.</b> <span style="float: right;">39</span></p> <p>1 <input type="checkbox"/> Yes (14b)<br/>                     2 <input type="checkbox"/> No } (Item G4)<br/>                     9 <input type="checkbox"/> DK</p> <hr/> <p><b>b.</b> <span style="float: right;">40</span></p> <p>1 <input type="checkbox"/> Medical procedures</p> <hr/> <p><b>c.</b> <span style="float: right;">41</span></p> <p>1 <input type="checkbox"/> Yes (14d)<br/>                     2 <input type="checkbox"/> No } (NP with 14b, or G4)<br/>                     9 <input type="checkbox"/> DK</p> <hr/> <p><b>d.</b> <span style="float: right;">42</span></p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (14c for NP with<br/>                     2 <input type="checkbox"/> Not in C2 } 14b, or G4)</p> |  |
| <b>ITEM G4</b>  | <p>Refer to ages of all family members.</p> | <p><b>G4</b> <span style="float: right;">43</span></p> <p>1 <input type="checkbox"/> Any 1–17 years (15)<br/>                     2 <input type="checkbox"/> All others (Item G6 on page 136)</p>  |  |
| <p><b>15a. Do you think that (names of persons 1–17 years old) NOW have any problems or delays in understanding things, that is, delays in cognitive or mental development?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/>                     Mark (X) "Mental development" box in person's column.<br/>                     Ask 15c for each person with box marked in 15b.</p> <p>-----</p> <p><b>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in understanding things?</b></p>   |   | <p><b>15a.</b> <span style="float: right;">44</span></p> <p>1 <input type="checkbox"/> Yes (15b)<br/>                     2 <input type="checkbox"/> No } (16)<br/>                     9 <input type="checkbox"/> DK</p> <hr/> <p><b>b.</b> <span style="float: right;">45</span></p> <p>1 <input type="checkbox"/> Mental development</p> <hr/> <p><b>c.</b> <span style="float: right;">46</span></p> <p>1 <input type="checkbox"/> Yes<br/>                     2 <input type="checkbox"/> No } (NP with 15b, or 16)<br/>                     9 <input type="checkbox"/> DK</p>  |  |
| <p><b>16a. Do you think that (names of persons 1–17 years old) NOW have any problems or delays in speech or language development?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/>                     Mark (X) "Speech" box for each appropriate person.<br/>                     Ask 16c for each person with box marked in 16b.</p> <p>-----</p> <p><b>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in speech or language development?</b></p>  |   | <p><b>16a.</b> <span style="float: right;">47</span></p> <p>1 <input type="checkbox"/> Yes (16b)<br/>                     2 <input type="checkbox"/> No } (17 on page 134)<br/>                     9 <input type="checkbox"/> DK</p> <hr/> <p><b>b.</b> <span style="float: right;">48</span></p> <p>1 <input type="checkbox"/> Speech</p> <hr/> <p><b>c.</b> <span style="float: right;">49</span></p> <p>1 <input type="checkbox"/> Yes<br/>                     2 <input type="checkbox"/> No } (NP with 16b, or 17<br/>                     9 <input type="checkbox"/> DK } on page 134)</p>  |  |

| <b>Section II – DISABILITY – Continued</b>   |  |   |
|--|--|---|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>   |  | <b>PERSON 1</b>   |
| <p><b>17a. Do you think that</b><i>(names of persons 1–17 years old)</i> <b>NOW have any problems or delays in emotional or behavioral development?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/><b>(Anyone else?)</b><br/><i>Mark (X) "Behavior" box in person's column.</i><br/><i>Ask 17c for each person with box marked in 17b.</i></p> <p>-----</p> <p><b>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in emotional or behavioral development?</b></p>  | <p><b>17a.</b></p> <p>-----</p> <p><b>b.</b></p> <p>-----</p> <p><b>c.</b></p>                               | <p style="text-align: right;">50</p> <p>1 <input type="checkbox"/> Yes (17b)<br/>2 <input type="checkbox"/> No } <i>(Item G5)</i><br/>9 <input type="checkbox"/> DK }</p> <p style="text-align: right;">51</p> <p>1 <input type="checkbox"/> Behavior</p> <p style="text-align: right;">52</p> <p>1 <input type="checkbox"/> Yes } <i>(NP with 17b, or G5)</i><br/>2 <input type="checkbox"/> No }<br/>9 <input type="checkbox"/> DK }</p>  |
| <p><b>ITEM G5</b></p>  | <p><i>Refer to ages of all family members.</i></p>   | <p style="text-align: right;">53</p> <p><b>G5</b></p> <p>1 <input type="checkbox"/> Any 2–17 (18)<br/>2 <input type="checkbox"/> Others (Item G6 on page 136)</p>   |
| <p><b>18a. Because of a physical, mental, or emotional problem, do</b> <i>(names of persons 2–17 years old)</i> <b>NOW have any difficulty participating in strenuous activity, such as running or swimming, compared to other children their age?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/><b>(Anyone else?)</b><br/><i>Mark (X) "Activity" box in person's column.</i><br/><i>Ask 18c–d for each person with box marked in 18b.</i></p> <p>-----</p> <p><b>c. Has the problem or condition which causes -- to have difficulty participating in strenuous activity been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p><i>Ask only if "Yes" in 18c.</i></p> <p><b>d. What is the main problem or condition which causes -- to have difficulty participating in strenuous activity?</b></p> | <p><b>18a.</b></p> <p>-----</p> <p><b>b.</b></p> <p>-----</p> <p><b>c.</b></p> <p>-----</p> <p><b>d.</b></p> | <p style="text-align: right;">54</p> <p>1 <input type="checkbox"/> Yes (18b)<br/>2 <input type="checkbox"/> No } <i>(19 on page 136)</i><br/>9 <input type="checkbox"/> DK }</p> <p style="text-align: right;">55</p> <p>1 <input type="checkbox"/> Activity</p> <p style="text-align: right;">56</p> <p>1 <input type="checkbox"/> Yes (18d)<br/>2 <input type="checkbox"/> No } <i>(NP with 18b, or 19 on page 136)</i><br/>9 <input type="checkbox"/> DK }</p> <p style="text-align: right;">57</p> <p><b>d.</b> <i>(Enter condition in X1 and mark box)</i><br/>1 <input type="checkbox"/> In C2 } <i>(18c for NP with 18b, or 19 on page 136)</i><br/>2 <input type="checkbox"/> Not in C2 }</p> |
| <p>Notes</p>   |  |   |



| <b>Section II – DISABILITY – Continued</b>  |  |   |   |
|---|--|---|---|
| <b>Part G – SPECIAL HEALTH NEEDS OF CHILDREN – Continued</b>  |  | <b>PERSON 1</b>   |   |
| <p><b>19a. Because of a physical, mental, or emotional problem, do (names of persons 2-17 years old) NOW have any difficulty playing or getting along with others their age?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/><i>Mark (X) "Getting along" box in person's column.</i><br/><i>Ask 19c-d for each person with box marked in 19b.</i></p> <p><b>c. Has the problem or condition which causes -- to have difficulty getting along with others been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p><i>Ask only if "Yes" in 19c.</i></p> <p><b>d. What is the main problem or condition which causes -- to have difficulty getting along with others?</b></p> |  | <p><b>19a.</b></p> <p>1 <input type="checkbox"/> Yes (19b)<br/>2 <input type="checkbox"/> No } (Item G6)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Getting along</p> <p><b>c.</b></p> <p>1 <input type="checkbox"/> Yes (19d)<br/>2 <input type="checkbox"/> No } (NP with 19b, or G6)<br/>9 <input type="checkbox"/> DK }</p> <p><b>d.</b> (Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (19c for NP with<br/>2 <input type="checkbox"/> Not in C2 } 19b, or G6)</p>   | <p>58</p> <p>59</p> <p>60</p> <p>61</p> |
| <p><b>ITEM G6</b>      <i>Refer to ages of all family members.</i></p>  |  | <p><b>G6</b></p> <p>1 <input type="checkbox"/> Any persons under 5 (20)<br/>2 <input type="checkbox"/> None under 5<br/>    <i>(Part J on page 146)</i></p>   | <p>62</p>                               |
| <p><b>20a. Do (names of persons under 5) NOW have any physical, mental, or emotional problems which makes it difficult to chew, swallow, or digest?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>(Anyone else?)<br/><i>Mark (X) "Digest" box in person's column.</i><br/><i>Ask 20c-d for each person with box marked in 20b.</i></p> <p><b>c. Has the problem or condition which causes -- to have difficulty chewing, swallowing, or digesting been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p><i>Ask only if "Yes" in 20c.</i></p> <p><b>d. What is the main problem or condition which causes -- to have difficulty chewing, swallowing, or digesting?</b></p>                 |  | <p><b>20a.</b></p> <p>1 <input type="checkbox"/> Yes (20b)<br/>2 <input type="checkbox"/> No } (21 on page 138)<br/>9 <input type="checkbox"/> DK }</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Digest</p> <p><b>c.</b></p> <p>1 <input type="checkbox"/> Yes (20d)<br/>2 <input type="checkbox"/> No } (NP with 20b, or 21<br/>9 <input type="checkbox"/> DK } on page 138)</p> <p><b>d.</b> (Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (20c for NP with<br/>2 <input type="checkbox"/> Not in C2 } 20b, or 21 on<br/>                          page 138)</p> | <p>63</p> <p>64</p> <p>65</p> <p>66</p> |
| Notes   |  |   |   |

| <b>Section II - DISABILITY - Continued</b>  |   |
|---|---|
| <b>Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued</b>  |   |
|   | <b>PERSON 1</b>   |
| <p><b>21a. Do (names of persons under age 5) NOW need special medical equipment to assist with eating or toileting?</b></p> <p>-----</p> <p><b>b. Who is this? (Anyone else?)</b><br/>                     Mark (X) "Eating or toileting" box in person's column.<br/>                     Ask 21c-d for each person with box marked in 21b.</p> <p>-----</p> <p><b>c. Has the problem or condition which causes -- to need special medical equipment been going on or is it expected to go on for at least 12 months?</b></p> <p>-----</p> <p>Ask only if "Yes" in 21c.</p> <p><b>d. What is the main problem or condition which causes -- to need special medical equipment to assist with eating or toileting?</b></p> | <p><b>21a.</b> <span style="float: right;">67</span></p> <p>1 <input type="checkbox"/> Yes (21b)<br/>                     2 <input type="checkbox"/> No } (Part H on page 140)<br/>                     9 <input type="checkbox"/> DK }</p> <hr/> <p><b>b.</b> <span style="float: right;">68</span></p> <p>1 <input type="checkbox"/> Eating or toileting</p> <hr/> <p><b>c.</b> <span style="float: right;">69</span></p> <p>1 <input type="checkbox"/> Yes (21d)<br/>                     2 <input type="checkbox"/> No } (NP with 21b, or Part H<br/>                     9 <input type="checkbox"/> DK } on page 140)</p> <hr/> <p><b>d.</b> <span style="float: right;">70</span></p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (21c for NP with<br/>                     2 <input type="checkbox"/> Not in C2 } 21b, or Part H<br/>                     on page 140)</p> |
| <p>Notes</p>  |   |

| <b>Section II – DISABILITY – Continued</b>   |  | RT 77  |
|--|--|--|
| <b>Part H – EARLY CHILD DEVELOPMENT</b>  |  | 3-4  |
|  |  | <b>PERSON 1</b>  |
| <b>ITEM H1</b>   | Refer to age for each family member.   | 5<br>H1<br>1 <input type="checkbox"/> 5+ (NP, or Part J on page 146)<br>2 <input type="checkbox"/> Under 5 (H2)  |
| <b>ITEM H2</b>   | Refer to child's date of birth and date of interview.<br>Calculate age in months or convert with card MC in HIS-501.1 Information Booklet. | 6-7<br>H2<br>_____ Months<br><input type="checkbox"/> Birthdate unknown (1)  |
| <b>ITEM H3</b>   | Refer to H2.   | 8<br>H3<br>1 <input type="checkbox"/> Under 4 months (H1 for NP, or Part J on page 146)<br>2 <input type="checkbox"/> 4-8 months (2)<br>3 <input type="checkbox"/> 9-15 months (5)<br>4 <input type="checkbox"/> 16-29 months (11 on page 142)<br>5 <input type="checkbox"/> 30-59 months (18 on page 142) |
| HAND CARD DH1. Read categories if telephone interview.   |  | 9  |
| <b>1. Which age group do you think -- belongs in?</b>  |  | 1<br>1 <input type="checkbox"/> Under 4 months (H1 for NP, or Part J on page 146)<br>2 <input type="checkbox"/> 4-8 months (2)<br>3 <input type="checkbox"/> 9-15 months (5)<br>4 <input type="checkbox"/> 16-29 months (11 on page 142)<br>5 <input type="checkbox"/> 30-59 months (18 on page 142)       |
| <b>2. Does -- usually show an interest in things around -- by looking at sights or by turning toward sounds?</b> |  | 10<br>2<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>3. Does -- usually seem happy or pleased when -- sees -- favorite people?</b>                                 |  | 11<br>3<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>4. Can -- hold -- head up without support?</b>  |  | 12<br>4<br>1 <input type="checkbox"/> Yes } (H1 for NP, or Part J on page 146)<br>2 <input type="checkbox"/> No }  |
| <b>5. Does -- usually show an interest in things around -- by looking at sights or by turning toward sounds?</b> |  | 13<br>5<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>6. Does -- usually seem happy or pleased when -- sees -- favorite people?</b>                                 |  | 14<br>6<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>7. Can -- sit upright without leaning against anything?</b>   |  | 15<br>7<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>8. Has -- ever crawled or crept on hands or stomach?</b>  |  | 16<br>8<br>1 <input type="checkbox"/> Yes } (9 on page 142)<br>2 <input type="checkbox"/> No }   |

| <b>Section II - DISABILITY - Continued</b>   |             |  |
|--|-------------|--|
| <b>Part H - EARLY CHILD DEVELOPMENT - Continued</b>  |             | <b>PERSON 1</b>  |
| <b>9. Is -- able to show what -- wants by pointing at something, reaching out to be picked up, making special noises, or saying words?</b>                             | <b>9.</b>   | 17<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>10. Does -- ever respond to people talking or playing with -- by making sounds, faces, or saying words?</b>   | <b>10.</b>  | 18<br>1 <input type="checkbox"/> Yes } (H1 on page 140 for NP,<br>2 <input type="checkbox"/> No } or Part J on page 146) |
| <b>11. Does -- usually pay attention to things that interest -- such as toys, picture books, or a person -- likes for as long as a minute?</b>                         | <b>11.</b>  | 19<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>12. Does -- usually seem happy or pleased when -- sees -- favorite people?</b>  | <b>12.</b>  | 20<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>13. Can -- sit upright without leaning against anything?</b>  | <b>13.</b>  | 21<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>14. Is -- able to show what -- wants by pointing at things, reaching out to be picked up, making special noises, or saying words?</b>                               | <b>14.</b>  | 22<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>15a. Does -- walk without holding on to anything?</b>   | <b>15a.</b> | 23<br>1 <input type="checkbox"/> Yes (16)<br>2 <input type="checkbox"/> No (15b)   |
| <b>b. Has -- ever crawled or crept on hands or stomach?</b>  | <b>b.</b>   | 24<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>16. Is -- able to show what -- wants or needs by using actions or words, such as leading you by the hand to open a door or saying words like "juice" or "that"?</b> | <b>16.</b>  | 25<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>17. Does -- ever respond to people talking or playing with -- by making sounds or faces or by saying words?</b>   | <b>17.</b>  | 26<br>1 <input type="checkbox"/> Yes } (H1 on page 140 for NP,<br>2 <input type="checkbox"/> No } or Part J on page 146) |
| <b>18. Does -- usually pay attention for as long as a minute to things that interest --, such as toys, picture books, or a person -- likes?</b>                        | <b>18.</b>  | 27<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>19. Does -- usually seem happy or pleased when -- sees -- favorite people?</b>  | <b>19.</b>  | 28<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No  |
| <b>20. Does -- walk rapidly or run?</b>  | <b>20.</b>  | 29<br>1 <input type="checkbox"/> Yes (22 on page 144)<br>2 <input type="checkbox"/> No (21 on page 144)                  |

| <b>Section II - DISABILITY - Continued</b>   |             |   |
|--|-------------|---|
| <b>Part H - EARLY CHILD DEVELOPMENT - Continued</b>  |             | <b>PERSON 1</b>   |
| <b>21a.</b> Does -- walk without holding on to anything?   | <b>21a.</b> | 30<br>1 <input type="checkbox"/> Yes (22)<br>2 <input type="checkbox"/> No (21b)  |
| -----<br><b>b.</b> Has -- ever crawled or crept on hands or stomach?   | <b>b.</b>   | 31<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| -----<br><b>c.</b> Can -- sit upright without leaning against anything?  | <b>c.</b>   | 32<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>22.</b> Is -- able to show what -- wants or needs by using actions, or words, such as leading you by the hand to open a door or saying words like "juice" or "that" or talking? | <b>22.</b>  | 33<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>23a.</b> Does -- talk in phrases or sentences most of the time?   | <b>23a.</b> | 34<br>1 <input type="checkbox"/> Yes (25)<br>2 <input type="checkbox"/> No (24)<br>3 <input type="checkbox"/> Child is deaf (23b) |
| -----<br><b>b.</b> Is -- able to show that -- likes or dislikes something by actions such as shaking -- head or using gestures?  | <b>b.</b>   | 35<br>1 <input type="checkbox"/> Yes } (25)<br>2 <input type="checkbox"/> No }  |
| <b>24.</b> Is -- able to use words to show what -- likes or dislikes, such as "want that" or "no want"?  | <b>24.</b>  | 36<br>1 <input type="checkbox"/> Yes } (25)<br>2 <input type="checkbox"/> No }  |
| <b>25.</b> Does -- ever play "make believe," such as feeding a doll, playing house, or pretending to be a TV or movie superstar?   | <b>25.</b>  | 37<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No   |
| <b>26.</b> Can -- play with another person? For example, can -- help another person build with blocks or feed a baby doll?   | <b>26.</b>  | 38<br>1 <input type="checkbox"/> Yes } (H1 on page 140 for NP,<br>2 <input type="checkbox"/> No } or Part J on page 146)          |
| Notes  |             |   |

| <b>Section II - DISABILITY - Continued</b> |  | RT 78  |
|--|--|--|
| <b>Part J - EDUCATION</b>                  |  | PERSON 1   |
|  |  | 3-4  |
| <b>ITEM J1</b>                             | <i>Refer to age for each family member.</i>  | 5  |
|  | <b>1a. Is -- now going to school or on vacation from school?</b><br><br><i>Hand Card DJ1. Read categories if telephone interview.</i>                        | <b>J1</b><br>1 <input type="checkbox"/> Under 3 (6 on page 150)<br>2 <input type="checkbox"/> 3-17 (1)<br>3 <input type="checkbox"/> 18+ (NP, or Part K on page 152)   |
|  | <b>1a. Is -- now going to school or on vacation from school?</b><br><br>1 <input type="checkbox"/> Yes (2 on page 148)<br>2 <input type="checkbox"/> No (1b) | 6  |
|  | <b>b. Why isn't -- going to school?</b><br><i>Mark (X) only one.</i>   | <b>7</b><br><b>b.</b> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Not old enough yet } (3 on page 148)</li> <li>2 <input type="checkbox"/> Illness }</li> <li>3 <input type="checkbox"/> Receiving home teaching by parents or others (1c)</li> <li>4 <input type="checkbox"/> Permanently expelled/suspended from school }</li> <li>5 <input type="checkbox"/> Quit school to get a job } (J1 for NP, or Part K on page 152)</li> <li>6 <input type="checkbox"/> Quit school for other reason }</li> <li>7 <input type="checkbox"/> Graduated</li> <li>8 <input type="checkbox"/> Other</li> <li>9 <input type="checkbox"/> DK</li> </ul> |
|  | <b>c. Is this because of a physical, mental, or emotional problem?</b>   | <b>8</b><br><b>c.</b> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Yes (1d)</li> <li>2 <input type="checkbox"/> No (J1 for NP, or Part K on page 152)</li> </ul>  |
|  | <b>d. Has -- had this problem for at least 12 months or is -- expected to have it for 12 months?</b>   | <b>9</b><br><b>d.</b> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Yes (3 on page 148)</li> <li>2 <input type="checkbox"/> No (J1 for NP, or Part K on page 152)</li> </ul>   |
| Notes                                      |  |  |

| <b>Section II - DISABILITY - Continued</b>  |  |   |
|---|--|---|
| <b>Part J - EDUCATION - Continued</b>   |  | <b>PERSON 1</b>   |
| <i>Hand Card DJ2.</i>   |  | 10  |
| <b>2. Does -- have significant problems at school with -</b>  |  |   |
| <b>a. Understanding instructional materials?</b>  | <b>a.</b> 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Can't do or does not apply because of limitation |   |
| <b>b. Paying attention in class?</b>  | <b>b.</b> 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Can't do or does not apply because of limitation | 11  |
| <b>c. Following rules or controlling [his/her] behavior?</b>  | <b>c.</b> 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Can't do or does not apply because of limitation | 12  |
| <b>d. Communicating with teachers and other students?</b>   | <b>d.</b> 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Can't do or does not apply because of limitation | 13  |
| <b>3. Is -- now receiving special education services? Do not include gifted or talented programs.</b><br>{Special education is teaching designed to meet the individual needs of a child with special needs. It is paid for by the public school system and may take place at a regular school, a special school, a private school, at home, or at a hospital.} |  | 14  |
| <b>4. Does -- now have an Individual Education Plan or IEP?</b><br>{An IEP, or Individual Education Plan, is a written plan for a child with special needs, describing what that child will learn.}   |  | 15  |
| <b>5. Does -- attend a special school or day camp for children with special needs?</b>  |  | 16  |
|   |  | 1 <input type="checkbox"/> Yes } (J1 on page 146 for<br>2 <input type="checkbox"/> No } NP, or Part K on<br>9 <input type="checkbox"/> DK } page 152) |
| Notes   |  |   |

| <b>Section II – DISABILITY – Continued</b>   |                                   |           |   |
|--|-----------------------------------|-----------|---|
| <b>Part J – EDUCATION – Continued</b>  |                                   |           | <b>PERSON 1</b>   |
| <p><b>{Early Intervention Services are services designed to meet the needs of very young children with special needs. They are provided by the State or school system at no cost to the parent.}</b></p> <p><b>6. Does -- now receive Early Intervention Services?</b></p> |                                   | <b>6.</b> | <input type="checkbox"/> 1 Yes<br><input type="checkbox"/> 2 No<br><input type="checkbox"/> 9 DK                            |
| <p><b>{An Individual Family Service Plan (IFSP) is a written plan of goals and services for young children with special needs and their families.}</b></p> <p><b>7. Does -- now have an Individual Family Service Plan or IFSP?</b></p>                                    |                                   | <b>7.</b> | <input type="checkbox"/> 1 Yes<br><input type="checkbox"/> 2 No<br><input type="checkbox"/> 9 DK                            |
| <b>ITEM J2</b>   | <i>Refer to this child's age.</i> | <b>J2</b> | <input type="checkbox"/> 1 1–2 years (8)<br><input type="checkbox"/> 2 Other (J1 on page 146 for NP, or Part K on page 152) |
| <p><b>8. Does -- now attend a special school or day camp for children with special needs?</b></p>  |                                   | <b>8.</b> | <input type="checkbox"/> 1 Yes } (J1 on page 146 for NP,<br><input type="checkbox"/> 2 No } or Part K on page 152)          |
| <p>Notes</p>   |                                   |           |   |



| <b>Section II - DISABILITY - Continued</b>                                    |   | RT 79           |
|---|---|-----------------|
| <b>Part K - RELATIONSHIPS TO RESPONDENT</b>                                   |   | <b>PERSON 1</b> |
| <b>ITEM K1</b>  | Enter person number of respondent for each family member.   | 3-4             |
| <b>ITEM K2</b>  | Refer to each person's age.   | 5-6             |
| Verify or ask:  |   |                 |
| <b>1a. How are you related to --?</b>   | Mark (X) only one.  | 7               |
| <b>1a.</b>  | 1 <input type="checkbox"/> Mother } (1b)<br>2 <input type="checkbox"/> Father }<br>3 <input type="checkbox"/> Brother/Sister (1d)<br>4 <input type="checkbox"/> Grandparent } (2 on page 154)<br>5 <input type="checkbox"/> Other relative }<br>6 <input type="checkbox"/> Nonrelative } (K1 for NP, or Part L on page 156)<br>7 <input type="checkbox"/> Self }<br>8 <input type="checkbox"/> Spouse } | 8               |
| <b>b. Are you -- biological or natural, adoptive, step, or foster parent?</b> | Mark (X) only one.  | 9               |
| <b>b.</b>   | 1 <input type="checkbox"/> Biological/Natural (2 on page 154)<br>2 <input type="checkbox"/> Adoptive } (1c)<br>3 <input type="checkbox"/> Step }<br>4 <input type="checkbox"/> Foster }   | 9               |
| <b>c. How old was -- when -- first started living with you?</b>               |   | 10-12           |
| <b>c.</b>   | _____ { 1 <input type="checkbox"/> Months }<br>{ 2 <input type="checkbox"/> Years } (2 on page 154)<br>000 <input type="checkbox"/> Since birth<br>999 <input type="checkbox"/> DK  | 10-12           |
| <b>d. Are you -- full, half, step, adoptive, or foster [brother/sister]?</b>  | Mark (X) only one.  | 13              |
| <b>d.</b>   | 1 <input type="checkbox"/> Full } (2 on page 154)<br>2 <input type="checkbox"/> Half }<br>3 <input type="checkbox"/> Step }<br>4 <input type="checkbox"/> Adoptive }<br>5 <input type="checkbox"/> Foster }   | 13              |
| Notes   |   |                 |

| <b>Section II - DISABILITY - Continued</b>  |  |   |  |            |  |           |           |  |   |
|---|--|---|--|------------|--|-----------|-----------|--|---|
| <b>Part K - RELATIONSHIPS TO RESPONDENT - Continued</b>   |  |   |  |            |  |           |           |  |   |
| <p><b>2a. Are you the person in the household who knows the MOST about -- health?</b></p> <p>-----</p> <p><b>b. Who in the household knows the MOST about -- health?</b><br/> <i>Enter name and person number, or mark (X) box.</i></p> | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;"><b>PERSON 1</b></th> </tr> </thead> <tbody> <tr> <td style="width: 10px;"><b>2a.</b></td> <td style="width: 80%;"> <p><input type="checkbox"/> 1 Yes (K1 on page 152 for NP, or Part L on page 156)</p> <p><input type="checkbox"/> 2 No (2b)</p> </td> <td style="width: 10%; text-align: center; vertical-align: top;"><b>14</b></td> </tr> <tr> <td style="width: 10px;"><b>b.</b></td> <td> <p><input type="checkbox"/> 99 No one in household or DK</p> <p>Person number _____</p> <p>First name _____</p> <p>Last name _____</p> <p style="text-align: right;"><i>(K1 on page 152 for NP, or Part L on page 156)</i></p> </td> <td style="text-align: center; vertical-align: top;"> <p><b>15-16</b></p> <p><b>17-36</b></p> <p><b>37-56</b></p> </td> </tr> </tbody> </table> | <b>PERSON 1</b>   |  | <b>2a.</b> | <p><input type="checkbox"/> 1 Yes (K1 on page 152 for NP, or Part L on page 156)</p> <p><input type="checkbox"/> 2 No (2b)</p> | <b>14</b> | <b>b.</b> | <p><input type="checkbox"/> 99 No one in household or DK</p> <p>Person number _____</p> <p>First name _____</p> <p>Last name _____</p> <p style="text-align: right;"><i>(K1 on page 152 for NP, or Part L on page 156)</i></p> | <p><b>15-16</b></p> <p><b>17-36</b></p> <p><b>37-56</b></p> |
| <b>PERSON 1</b>   |  |   |  |            |  |           |           |  |   |
| <b>2a.</b>  | <p><input type="checkbox"/> 1 Yes (K1 on page 152 for NP, or Part L on page 156)</p> <p><input type="checkbox"/> 2 No (2b)</p>   | <b>14</b>   |  |            |  |           |           |  |   |
| <b>b.</b>   | <p><input type="checkbox"/> 99 No one in household or DK</p> <p>Person number _____</p> <p>First name _____</p> <p>Last name _____</p> <p style="text-align: right;"><i>(K1 on page 152 for NP, or Part L on page 156)</i></p>   | <p><b>15-16</b></p> <p><b>17-36</b></p> <p><b>37-56</b></p> |  |            |  |           |           |  |   |
| <p>Notes</p>  |  |   |  |            |  |           |           |  |   |

| <b>Section II - DISABILITY - Continued</b>   |  | RT 80   |
|--|--|---|
| <b>Part L - PERCEIVED DISABILITY</b>   |  | PERSON 1<br>3-4   |
| <p><b>1a. Do you consider yourself (or anyone in your family) to have a disability?</b></p> <p>-----</p> <p><b>b. Who is this?</b><br/>Mark (X) "Respondent-perceived disability" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 1b and c)                    <input type="checkbox"/> No (2)</p>                                       | <p><b>1a.</b></p> <p>1 <input type="checkbox"/> Yes (1b)<br/>2 <input type="checkbox"/> No } (2)<br/>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Respondent-perceived disability</p> | <p>5</p> <p>6</p>                                       |
| <p><b>2a. Would other people consider you (or anyone in the family) to have a disability?</b></p> <p>-----</p> <p><b>b. Who would others consider to have a disability?</b><br/>Mark (X) "Others perceived disability" box in person's column.</p> <p>-----</p> <p><b>c. Anyone else?</b>                    <input type="checkbox"/> Yes (Reask 2b and c)                    <input type="checkbox"/> No (L1)</p> | <p><b>2a.</b></p> <p>1 <input type="checkbox"/> Yes (2b)<br/>2 <input type="checkbox"/> No } (L1)<br/>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p><b>b.</b></p> <p>1 <input type="checkbox"/> Others perceived disability</p>    | <p>7</p> <p>8</p>                                       |
| <p><b>ITEM<br/>L1</b></p>  | <p>Enter person number(s) of respondent(s) for Section II, Disability.</p>   | <p><b>L1</b></p> <p>Person number(s) of respondents</p> |
| <p><b>Review X1 for each person. If a condition is also in C2 on the HIS-1, enter the condition NUMBER in the triangular space. If it is not in C2, complete a Disability Condition Page in Part M for it and enter the condition LETTER in the triangular space.</b></p>  |  |   |
| <p>Notes</p>   |  |   |

**Section II - DISABILITY - Continued**

RT 31 3-4 5-6

**Part M - CONDITION A**

7

**PERSON NO.** \_\_\_\_\_

**1. Name of condition** 8

**2. When did [--/anyone] last see or talk to a doctor or assistant about -- (condition)?**

- |   |   |        |   |
|---|---|--------|---|
| <input type="checkbox"/> Interview week (Reask 2)       | <input type="checkbox"/> 2 yrs., less than 5 yrs. | } (3b) | 9 |
| <input type="checkbox"/> 2-wk. ref. pd.                 | <input type="checkbox"/> 5 yrs. or more           |        |   |
| <input type="checkbox"/> Over 2 weeks, less than 6 mos. | <input type="checkbox"/> Dr. seen, DK when        |        |   |
| <input type="checkbox"/> 6 mos., less than 1 yr.        | <input type="checkbox"/> DK if Dr. seen           |        |   |
| <input type="checkbox"/> 1 yr., less than 2 yrs.        | <input type="checkbox"/> Dr. never seen           |        |   |

**3a. Did the doctor or assistant call the (condition) by a more technical or specific name?** 10

- Yes       No       DK
- Ask 3b if "Yes" in 3a, otherwise transcribe condition name from item 1 without asking: 11-14
- \_\_\_\_\_ 15

**b. What did he or she call it?** (Specify) \_\_\_\_\_

- |   |                                       |        |    |
|---|---------------------------------------|--------|----|
| <input type="checkbox"/> Color Blindness (NC)                             | <input type="checkbox"/> Cancer (3e)  | } (3b) | 16 |
| <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | <input type="checkbox"/> Old age (NC) |        |    |
|   | <input type="checkbox"/> Other (3c)   |        |    |

**c. What was the cause of -- (condition in 3b)? (Specify) z**

Mark box if accident or injury.     Accident/injury (Probe, then 5)

**d. Did the (condition in 3b) result from an accident or injury?** 17

- Yes (Probe, then 5)       No

Ask as necessary. Record responses in 3c: (How did the accident happen?) (What was -- doing at the time of the injury?)

Ask 3e if the condition name in 3b includes any of the following words:

|                |               |                  |                 |                |                |
|----------------|---------------|------------------|-----------------|----------------|----------------|
| <b>Ailment</b> | <b>Attack</b> | <b>Condition</b> | <b>Disease</b>  | <b>Measles</b> | <b>Trouble</b> |
| <b>Anemia</b>  | <b>Bad</b>    | <b>Cyst</b>      | <b>Disorder</b> | <b>Problem</b> | <b>Tumor</b>   |
| <b>Asthma</b>  | <b>Cancer</b> | <b>Defect</b>    | <b>Growth</b>   | <b>Rupture</b> | <b>Ulcer</b>   |

**e. What kind of (condition in 3b) is it?** (Specify) \_\_\_\_\_

Ask 3f only if allergy or stroke in 3b-e:

**f. How does the [allergy/stroke] NOW affect --? (Specify) z**

Ask 3g if there is an impairment (refer to Card CP2) or any of the following entries in 3b-f:

|                                    |                     |                       |
|------------------------------------|---------------------|-----------------------|
| <b>Abscess</b>                     | <b>Growth</b>       | <b>Rupture</b>        |
| <b>Ache (except head or ear)</b>   | <b>Hemorrhage</b>   | <b>Sore(ness)</b>     |
| <b>Bleeding (except menstrual)</b> | <b>Infection</b>    | <b>Stiff(ness)</b>    |
| <b>Blood clot</b>                  | <b>Inflammation</b> | <b>Tumor</b>          |
| <b>Boil</b>                        | <b>Neuralgia</b>    | <b>Ulcer</b>          |
| <b>Cancer</b>                      | <b>Neuritis</b>     | <b>Varicose veins</b> |
| <b>Cramps (except menstrual)</b>   | <b>Pain</b>         | <b>Weak(ness)</b>     |
| <b>Cyst</b>                        | <b>Palsy</b>        |                       |
| <b>Damage</b>                      | <b>Paralysis</b>    |                       |

**g. What part of the body is affected?** \_\_\_\_\_ (Specify)

- Show the following detail:
- Head** ..... skull, scalp, face
- Back/spine/vertebrae** ..... upper, middle, lower
- Side** ..... left or right
- Ear** ..... inner or outer; left, right, or both
- Eye** ..... left, right, or both
- Arm** ... shoulder, upper, elbow, lower or wrist; left, right, or both
- Hand** ..... entire hand or fingers only; left, right, or both
- Leg** ..... hip, upper, knee, lower, or ankle; left, right, or both
- Foot** ..... entire foot, arch, or toes only; left, right, or both

Except for eyes, ears, or internal organs, ask 3h if there are any of the following entries in 3b-f:

|                  |             |                 |
|------------------|-------------|-----------------|
| <b>Infection</b> | <b>Sore</b> | <b>Soreness</b> |
|------------------|-------------|-----------------|

**h. What part of the (part of body in 3b-g) is affected by the [infection/sore/soreness] - the skin, muscle, bone, or some other part?**

(Specify) \_\_\_\_\_

Ask if there are any of the following entries in 3b-f: 18

|              |             |               |
|--------------|-------------|---------------|
| <b>Tumor</b> | <b>Cyst</b> | <b>Growth</b> |
|--------------|-------------|---------------|

**4. Is this [tumor/cyst/growth] malignant or benign?**

- Malignant       Benign       DK

**5. a. When was -- (condition in 3b) first noticed?** 19

- |   |        |    |
|---|--------|----|
| <input type="checkbox"/> 2-wk. ref. pd.           | } (3b) | 19 |
| <input type="checkbox"/> Over 2 weeks to 3 months |        |    |
| <input type="checkbox"/> Over 3 months to 1 year  |        |    |
| <input type="checkbox"/> Over 1 year to 5 years   |        |    |
| <input type="checkbox"/> Over 5 years             |        |    |

**b. When did -- (name of injury in 3b)?**

Ask probes as necessary:

- (Was it on or since (first date of 2-week ref. period) or was it before that date?)**
- (Was it less than 3 months or more than 3 months ago?)**
- (Was it less than 1 year or more than 1 year ago?)**
- (Was it less than 5 years or more than 5 years ago?)**



RT 53

**10. Response Status**

**a. Section I (Immunization)**

0  No child 0-5

**Interview:**

1  Complete }  
 2  Partial } *Mark (X) mode. Explain "Partial" in notes.*

**Noninterview:**

3  Refused }  
 4  Other } *Explain in notes*

**b. Section II (Disability)**

**Interview:**

1  Complete }  
 2  Partial } *Mark (X) mode. Explain "Partial" in notes.*

**Noninterview:**

3  Refused }  
 4  Other } *Explain in notes*

**Mode of interview:**

All or most -

1  In person  
 2  By telephone

**Mode of interview:**

All or most -

1  In person  
 2  By telephone

Notes