

TVW Telethon Institute for Child Health Research

PRINCESS MARGARET HOSPITAL FOR CHILDREN
Perth Western Australia
PO Box 855
West Perth WA 6872

CHOLK

Assignment No.					
File No.					
CD					
Dwelling					
Household					
Family					
Information from Person					

WA Aboriginal Child Health Survey

IN CONFIDENCE

CHILD HEALTH QUESTIONNAIRE (0 - 3 YEARS)

A Introductory Statement

The questions on this form are about the health and wellbeing of children under the age of 4 years. We want to know about any health problems which they may have and the kinds of services they need. We also want to know about how children are growing, learning and behaving. This information is needed to understand what is important for Aboriginal families and what needs to be done so their children get a good start in life. It will also be used to develop services for Aboriginal children and families.

B Confidentiality

The survey is voluntary and it is OK if there are some questions you would rather not answer. All information will be kept private by the research team.

C Fully Responding

Non-Response

- Full refusal
- Part refusal
- Full non-contact
- Part non-contact
- Language problem
- Death/illness

<input type="checkbox"/>	1
<input type="checkbox"/>	2
<input type="checkbox"/>	3
<input type="checkbox"/>	4
<input type="checkbox"/>	5
<input type="checkbox"/>	6
<input type="checkbox"/>	7

<p>Interviewer: Complete information for Q1 and use information to confirm Household Record Form.</p>	<p>1a Person Number of Child</p> <p>1b Name of Child</p> <p>1c Age of Child</p> <p>1d Sex</p> <p>1e Name of Carer/s</p> <p>1f Person Number of Carer</p>
	<p>The next questions are about’s birth and first months of life.</p>
	<p>2a Are you’s natural/birth mother?</p> <p style="text-align: right;">No (Go to Q6a)</p> <p style="text-align: right;">Yes</p>
	<p>2b What was your full name at the time was born?</p> <p style="text-align: right;">Full name</p>
	<p>3a Was breastfed?</p> <p style="text-align: right;">No (Go to Q3e)</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don’t know (Go to Q3e)</p>
	<p>3b How long was breastfed?</p> <p style="text-align: right;">0 - <3 months</p> <p style="text-align: right;">3 months - < 6 months</p> <p style="text-align: right;">6 months - < 9 months</p> <p style="text-align: right;">9 months - < 12 months</p> <p style="text-align: right;">12 months or more</p> <p style="text-align: right;">Still being breast fed</p> <p style="text-align: right;">Don’t know</p>

	Child 1	Child 2	Child 3	Child 4
Person No. of Child	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Age	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Male	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Female	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Carer/s	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Person No. of Carer	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
No (Go to Q6a)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Full name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
No (Go to Q3e)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Don't know (Go to Q3e)	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99
0 - <3 months	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
3 - < 6 months	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
6 - < 9 months	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
9 - < 12 months	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
12 months or more	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Still being breast fed	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
Don't know	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99

	<p>3c Is still being given <u>only</u> breast milk?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Go to Q3f)</p>
	<p>3d For how long was given <u>only</u> breast milk?</p> <p style="text-align: right;">Write in months</p> <p style="text-align: right;">Don't know</p>
	<p>3e At what age was <u>solid food</u> first given to?</p> <p style="text-align: right;">Write in months</p> <p style="text-align: right;">Not yet given - too young</p> <p style="text-align: right;">Don't know</p>
	<p>3f Do you have problems with drinking or eating well?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	<p>4 Beforewas 4 years old did he/she live away from you for a month or more?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don't know</p>
<p>Interviewer: Alternate wording for marijuana = gunjah.</p>	<p>5 During your pregnancy with, did you:</p> <p style="text-align: right;">Smoke cigarettes?</p> <p style="text-align: right;">Chew tobacco?</p> <p style="text-align: right;">Smoke gunjah?</p> <p style="text-align: right;">Drink alcohol?</p> <p style="text-align: right;">Use other drugs?</p>

	Child 1	Child 2	Child 3	Child 4																																																																																																
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<p>Interviewer: All natural mothers now go to Q10.</p>	<p>6a Is it OK to ask the name of 's natural mother?</p> <p style="text-align: right;">No (Go to Q7a)</p> <p style="text-align: right;">Yes</p>
<p>Interviewer: If more than one name change put other names on 'Field Query' sheet.</p>	<p>6b What was 's natural mother's full name?</p> <p style="text-align: right;">Full name</p>
	<p>7a Was breastfed?</p> <p style="text-align: right;">No (Go to Q7e)</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don't know (Go to Q7e)</p>
	<p>7 b How long was breastfed?</p> <p style="text-align: right;">0 - <3 months</p> <p style="text-align: right;">3 months - < 6 months</p> <p style="text-align: right;">6 months - < 9 months</p> <p style="text-align: right;">9 months - < 12 months</p> <p style="text-align: right;">12 months or more</p> <p style="text-align: right;">Still being breast fed</p> <p style="text-align: right;">Don't know</p>
	<p>7c Is still being given <u>only</u> breast milk?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Go to Q7f)</p>
	<p>7d For how long was given <u>only</u> breast milk?</p> <p style="text-align: right;">Write in months</p> <p style="text-align: right;">Don't know</p>

	Child 1	Child 2	Child 3	Child 4
No (Go to Q7a) Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
Full name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
No (Go to Q7e) Yes Don't know (Go to Q7e)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
0 - <3 months 3 - < 6 months 6 - < 9 months 9 - < 12 months 12 months or more Still being breast fed Don't know	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 99
No Yes (Go to Q7f)	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
Write in months Don't know	<input type="text"/> <input type="text"/> <input type="checkbox"/> 99	<input type="text"/> <input type="text"/> <input type="checkbox"/> 99	<input type="text"/> <input type="text"/> <input type="checkbox"/> 99	<input type="text"/> <input type="text"/> <input type="checkbox"/> 99

	<p>7e At what age was <u>solid food</u> first given to</p> <p style="text-align: right;">Write in months</p> <p style="text-align: right;">Not yet given - too young</p> <p style="text-align: right;">Don't know</p>
	<p>7f Do you have problems with drinking or eating well?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
<p>Interviewer: Alternate wording for marijuana = gunjah.</p>	<p>8 During the pregnancy with did his/her mother:</p> <p style="text-align: right;">Smoke cigarettes?</p> <p style="text-align: right;">Chew tobacco?</p> <p style="text-align: right;">Smoke gunjah?</p> <p style="text-align: right;">Drink alcohol?</p> <p style="text-align: right;">Use other drugs?</p>
<p>Interviewer: Ask of all CARERS</p>	<p>10 How long have you been looking after</p> <p style="text-align: right;">Months</p> <p style="text-align: right;">Years</p> <p style="text-align: right;">Since birth</p>
	<p>11a Since was born how many different homes has he/she lived in?</p> <p style="text-align: right;">Number</p> <p style="text-align: right;">Don't know</p>

	Child 1	Child 2	Child 3	Child 4
Write in months	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Too young	<input type="text"/> 91	<input type="text"/> 91	<input type="text"/> 91	<input type="text"/> 91
Don't know	<input type="text"/> 99	<input type="text"/> 99	<input type="text"/> 99	<input type="text"/> 99
No	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1
Yes	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2
Smoke cigarettes?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99
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Use other drugs?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 99
Months	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Years	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Since birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Number	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Don't know	<input type="text"/> 99	<input type="text"/> 99	<input type="text"/> 99	<input type="text"/> 99

	GENERAL HEALTH
	I am now going to ask you some questions about medicines may be taking and what they are for.
	<p>30a Today, is taking <u>antibiotics</u> prescribed by a doctor or nurse?</p> <p style="text-align: right;">No (Go to Q32a)</p> <p style="text-align: right;">Yes</p>
Interviewer: Ask to see medication for correct spelling.	30b What are the <u>antibiotics</u> called?

	Child 1	Child 2	Child 3	Child 4
No (Go to Q32a) Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
Antibiotic name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Antibiotic name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Antibiotic name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Antibiotic name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Comments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Interviewer: Remind Carer that we will be seeking consent to access medical and birth information.

There is a form to sign at the end of the interview. Only remind once per interview session not for each child.

32a I am going to read you a list of health problems that some children have,

Please tell me if has any of them.

A A heart problem

B Epilepsy (fits)

C Kidney/Renal disease

E Cerebral palsy

K Any stiffness or deformity

L Missing fingers, hands, arm, toes, feet or legs

M Spina bifida

N Recurring chest infection

O Recurring gastro infection

P Recurring skin infections (school sores, scabies)
Excluding eczema

Q Recurring ear infections

R Anaemia or lack of iron (thin blood)

S Allergies

I now want to ask you some questions about any accidents/ injuries which may have had.

33a Has ever broken any bones?

No

Yes

Don't know

	Child 1	Child 2	Child 3	Child 4
	No Yes Don't know	No Yes Don't know	No Yes Don't know	No Yes Don't know
A Heart problem	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
B Fits	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
C Kidney disease	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
E Cerebral palsy	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
K Stiffness/deform	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
L Missing limbs	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
M Spina bifida	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
N Chest infection	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
O Gastro infection	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
P Skin infections	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
Q Ear infections	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
R Lack of iron	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
S Allergies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
No Yes Don't know	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99

Interviewer: Not knocked out by medication	<p>33b Has ever been knocked out <u>because of an injury</u>?</p> <p>No</p> <p>Yes</p> <p>Don't know</p>
	<p>The next questions are about difficulties which kids may have because of their health, disabilities, emotions or behaviour.</p>
	<p>SEEING</p>
	<p>40c Is blind or unable to see in one or both eyes?</p> <p>No</p> <p>Yes, one eye only</p> <p>Yes, both eyes</p>
	<p>HEARING</p>
	<p>41a Has ever had runny ears (tropical ear or glue ear)?</p> <p>No</p> <p>Yes</p> <p>Don't know</p>
	<p>SPEAKING</p>
	<p>42a Does talk using words?</p> <p>No</p> <p>Yes</p> <p>Too young yet</p>
	<p>WALKING</p>
	<p>42e Do you think is/was walking late?</p> <p>No</p> <p>Yes</p> <p>Too young yet</p>

	Child 1	Child 2	Child 3	Child 4
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Don't know	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes, one eye only	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Yes, both eyes	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Don't know	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Too young yet	<input type="checkbox"/> 91	<input type="checkbox"/> 91	<input type="checkbox"/> 91	<input type="checkbox"/> 91
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Too young yet	<input type="checkbox"/> 91	<input type="checkbox"/> 91	<input type="checkbox"/> 91	<input type="checkbox"/> 91

	BREATHING
	<p>44a Has <u>ever</u> had asthma?</p> <p style="text-align: right;">No Yes</p>
	<p>44b In the past 12 months has sounded wheezy during or after exercise or running around?</p> <p style="text-align: right;">No Yes</p>
	<p>44c Has <u>ever</u> had wheezing or whistling in the chest?</p> <p style="text-align: right;">No Yes</p>
	<p>44d In the past 12 months has taken any medication for wheezing or asthma (medicine/pills/puffers)?</p> <p style="text-align: right;">No (Go to Q44f) Yes</p>
<p>Interviewer:</p> <p>1. Ask to see medication for correct spelling. Regularly means every day for 2 months or more.</p> <p>2. Show Asthma Medications Picture.</p>	<p>44e Were they only taken when wheezing or regularly?</p> <p style="margin-left: 40px;">A Name of medication</p> <p style="margin-left: 80px;">When wheezing Regularly</p> <p style="margin-left: 40px;">B Name of medication</p> <p style="margin-left: 80px;">When wheezing Regularly</p> <p style="margin-left: 40px;">C Name of medication</p> <p style="margin-left: 80px;">When wheezing Regularly</p>

	Child 1	Child 2	Child 3	Child 4
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
No (Go to Q44f)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
A				
Name of medication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Use Only	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
When wheezing	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Regularly	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
B				
Name of medication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Use Only	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
When wheezing	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Regularly	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
C				
Name of medication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Use Only	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
When wheezing	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Regularly	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2

	<p>44f Has <u>ever</u> had hayfever?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	<p>44g In the past 12 months has had a dry cough at night, apart from a cough associated with a cold or chest infection?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	SLEEPING
	<p>45b Does have trouble getting enough sleep?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	TEETH
	<p>46a Does have any holes in his/her teeth because they are bad?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	<p>46b Has ever had any teeth removed because they were bad?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	<p>46c Has had any fillings because of bad teeth?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>
	<p>46d Has ever had a problem with sore or bleeding gums?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>

	Child 1	Child 2	Child 3	Child 4
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2

	<p>46e Have you had any problems getting help from the dentist for?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Not applicable</p>
	IMMUNISATION
	<p>I would now like to ask some questions about immunisations/ needles which has had since he/she was born.</p>
<p>Interviewer: Show IMMUNISATION Prompt Card.</p>	<p>47a Do you think is up to date with immunisations/needles?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Go to Q51a)</p> <p style="text-align: right;">Not applicable</p> <p style="text-align: right;">Don't know</p>
	<p>47b What is the <u>main</u> reason that is not up to date?</p> <p style="text-align: center;">Advised against it by doctor/nurse</p> <p style="text-align: center;">Child sick when vaccination/needles due</p> <p style="text-align: center;">Too young to have had any</p> <p style="text-align: center;">Worried about the possible side effects</p> <p style="text-align: center;">Too expensive</p> <p style="text-align: center;">Don't like immunisation</p> <p style="text-align: center;">Haven't got around to it</p> <p style="text-align: center;">Advised against it by family/friends</p> <p style="text-align: center;">No transport to get there</p> <p style="text-align: center;">Other (Please specify)</p>

	Child 1	Child 2	Child 3	Child 4
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Not applicable	<input type="checkbox"/> 90	<input type="checkbox"/> 90	<input type="checkbox"/> 90	<input type="checkbox"/> 90
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes (Go to Q51a)	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Not applicable	<input type="checkbox"/> 90	<input type="checkbox"/> 90	<input type="checkbox"/> 90	<input type="checkbox"/> 90
Don't know	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99
Doctor/nurse advice	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Child sick at time	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Too young	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Side effects	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Too expensive	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Don't like	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
Haven't got round	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
Family/friends advice	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8
No transport	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9
Other	<input type="checkbox"/> 10	<input type="checkbox"/> 10	<input type="checkbox"/> 10	<input type="checkbox"/> 10
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Use Only	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

	The next questions are about being able to join in daily activities.
	<p>51a Does have any physical pain or discomfort?</p> <p style="text-align: right;">No (Go to Q61a)</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don't know (Go to Q61a)</p>
	<p>51b Does have a little pain, some pain or a lot of pain?</p> <p style="text-align: right;">A little</p> <p style="text-align: right;">Some</p> <p style="text-align: right;">A lot</p>
	<p>61a Are there any games or sports involving strong exercise which can't do because of an illness or disability?</p> <p style="text-align: right;">Too young</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Please specify)</p>
	Overall, thinking about’s special needs,
Interviewer: Please use EQUIVALENCE SCALE Prompt Card.	<p>62 Does he/she have any disability, chronic illness or pain that put a burden on you or the family as a whole:</p> <p style="text-align: right;">Not at all</p> <p style="text-align: right;">A little</p> <p style="text-align: right;">Some</p> <p style="text-align: right;">Quite a lot</p> <p style="text-align: right;">Very much</p>

	Child 1	Child 2	Child 3	Child 4
No (Go to Q61a) Yes Don't know (Go to Q61a)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
A little Some A lot	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Too young No Yes (Please specify) <i>Office Use Only</i>	<input type="checkbox"/> 91 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 91 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 91 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 91 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Not at all A little Some Quite a lot Very much	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

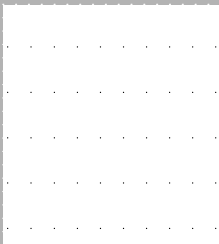

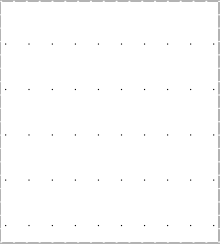
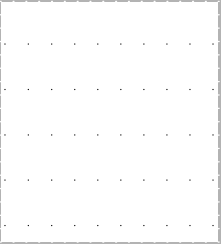
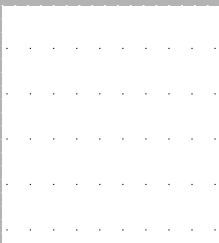
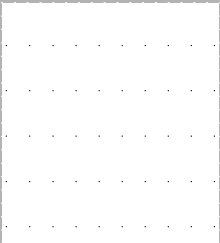


	<p>63 Does have any <u>other</u> serious health problems that we haven't talked about?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Please specify)</p>
	<p style="text-align: center;">USE OF HOSPITALS AND OTHER SERVICES</p> <p style="text-align: center;">I now have a few questions about the services you may have used for</p>
<p>Interviewer: Remind Carers that we will be seeking consent to access medical and birth information.</p> <p>There is a form to sign at the end of the interview. Only <u>remind</u> once per interview session not for each child.</p>	<p>70a Was born in a hospital?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Please specify FULL NAME of HOSPITAL)</p> <p style="text-align: right;">Don't know</p>

	Child 1	Child 2	Child 3	Child 4
No Yes (Please specify)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2
	<i>Office Use Only</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
No Yes (Please specify)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2
	Don't know	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99

<p>Interviewer: Remind carer that we want this information for each child.</p> <p>‘Nurse’ includes, community nurse, child health nurse and midwife.</p>	<p>70b During the past 6 months, how many times have you or your partner had any contact with the following about?</p> <p>A A doctor</p> <p>B A dentist</p> <p>C A specialist</p> <p>D A nurse</p> <p>E Aboriginal Health Worker</p> <p>F Hospital emergency department or outpatients clinic</p> <p>G A speech pathologist</p>
	<p>70c During the past 6 months have you needed to contact Aboriginal Medical Services about?</p> <p style="text-align: right;">No (Go to Q70e)</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don't know (Go to Q70e)</p>
	<p>70d Were you happy with the service you received at your local Aboriginal Medical Service about?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>

	Child 1	Child 2	Child 3	Child 4
	None Once Two or three Four or more	None Once Two or three Four or more	None Once Two or three Four or more	None Once Two or three Four or more
A Doctor	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
B Dentist	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
C Specialist	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
D Nurse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
E Aboriginal Health Worker	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
F Hospital emergency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
F Speech Pathologist	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
No (Go to Q70e)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Don't know (Go to Q70e)	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99	<input type="checkbox"/> 99
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2

	<p>70e How do you think your local Aboriginal Medical Service could be made better?</p>
<p>Interviewer: Some of these programs are not available in all areas of the State.</p>	<p>70f During the past 6 months has been to, or used, any of the following agencies:</p> <ul style="list-style-type: none"> A A 'Family Futures' program B The 'Best Start' program C Disability Services (Local Area Co-ordinator) D Family and Children's Services I Other (elder, minister/priest, physio) (please specify)

	Child 1	Child 2	Child 3	Child 4																																
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‘Family Futures’	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉																																
‘Best Start’	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉																																
Disability Services	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉																																
Family and Children’s Services	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉																																
Other	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₉₉																																
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	<p>The next questions are about kids needing to stay overnight at certain places because of a family crisis or behaviour problems. This may not have happened in your family but it does sometimes happen to kids.</p>
<p>Interviewer: Not a 'sleep over' at friends for fun but a stay because of an emergency.</p>	<p>72 In the past 6 months has <u>needed</u> to stay away overnight?</p> <p>A With other family or friends</p> <p>C At a hostel or other supported accommodation</p> <p>G Other (Please specify: eg. temporary foster home)</p>
	<p>LEARNING and DAY CARE</p>
	<p>The next questions are about day care and learning.</p>
	<p>80a At home, how often does someone from this house look at a book with?</p> <p>Several times a day</p> <p>Once a day</p> <p>2 - 3 times a week</p> <p>Hardly ever</p> <p>Don't know</p>

	<p>80b Has ever been in day care?</p> <p style="text-align: right;">No (Go to Q80f)</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">Don't know (Go to Q80f)</p>
<p style="color: red;">(Write years OR months in box)</p>	<p>80c How old was when he/she first went to day-care (for half a day or longer)?</p> <p style="text-align: right;">Months</p> <p style="text-align: right;">Years</p> <p style="text-align: right;">Don't know</p>
	<p>80f Do you usually have family around who will help you take care of if <u>you</u> are sick?</p> <p style="text-align: right;">No</p> <p style="text-align: right;">Yes</p>

	Child 1	Child 2	Child 3	Child 4
No (Go to Q80f) Yes Don't know (Go to Q80f)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 99
Months Years Don't know	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 99	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 99	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 99	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 99
No Yes	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2

	<p>The next questions are about’s behaviour and how you deal with it.</p>
<p>Interviewer: Record relationship to the child NOT the carer</p> <p>If response is ‘ whole family’ then note this in the comments section.</p>	<p>120a Whose job is it to teach to show respect, do the right thing and stay out of trouble?</p> <p style="text-align: center;">Comments</p>
<p>Interviewer: Please use FREQUENCY SCALE Prompt Card, and enter the number associated with the response.</p>	<p>120b In bringing up, over the past 6 months how often would you have:</p> <ul style="list-style-type: none"> (i) Reminded about how he/she should behave? (iv) Told off when he/she did something wrong? (v) Made sure that did what you told him/her to do? (vi) Praised for doing something good? (vii) Hit or smacked for doing something wrong? (viii) Laughed together?

	Child 1	Child 2	Child 3	Child 4
Person	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Person	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Comments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Use Only</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(i) Reminded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Told off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) Made sure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vi) Praised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vii) Hit or smacked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(viii) Laughed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	That finishes all the questions we have about
	140 Is there anything else about his/her health and development that you would like to tell us? <p style="text-align: right;">No</p> <p style="text-align: right;">Yes (Please specify)</p>

	Child 1	Child 2	Child 3	Child 4
No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Yes (Please specify)	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2

Area with horizontal dashed lines for providing details or specifications.

INTERVIEWER: Complete consent form (Over page)

