

*Finding cures. Saving children.*



# SJLIFE

## Health Habits Survey

### 11-17 Years of Age Parent Report

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

Parent  Other: \_\_\_\_\_

Today's date:

		/			/				
m	m		d	d		y	y	y	y

**Our mailing address is:**  
St. Jude Children's Research Hospital  
Department of Epidemiology  
Mail Stop 735  
262 Danny Thomas Place  
Memphis, TN 38105-3678

**Toll-free phone number:**  
1-800-775-2167

**e-mail:**  
SJLIFE@stjude.org

Please! Do not mark below this line

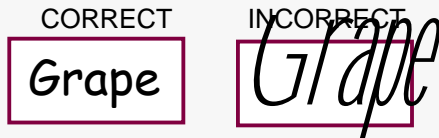
Survey #227

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Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:



### MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

#### Example 1

1. During the past month, did your child participate in any physical activities or exercises such as running, aerobics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

No  Yes

	Not sure	
	Yes	If yes, age at first use
No		
		<input type="checkbox"/>
		<input checked="" type="checkbox"/>

#### Example 2

2. Has your child ever taken. . .

- a. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

- b. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS such as Ritalin, Adderall, Concerta, Strattera, Aricept (donepezil), or Provigil (modafinil)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

*ritalin*

#### Example 3

3. When was this condition diagnosed?

04

Month (mm)

2000

Year (yyyy)

Please! Do not mark below this line

**Sun Sensitivity**

**A1. How would you describe your child's natural skin color on parts of child's body not exposed to the sun?**

- Pale or milky white
- Very light brown, sometimes freckles
- Light tan, brown, or olive
- Brown, dark brown, or black

**A2. What color are your child's eyes?**

- Blue
- Blue-grey
- Hazel
- Green
- Light brown
- Dark brown/black
- Mixed/other

**A3. What is your child's natural hair color? (check only one)**

- Light blond
- Blond
- Light brown
- Medium brown
- Red-brown
- Strawberry (reddish) blond
- Red
- Dark brown/black
- Jet black

**Sunburn is a reddening of the skin that lasts at least 12 hours after you have been outdoors in the sun.**

**A4. Suppose that after several months of not being in the sun, your child went out in the sun without a hat, sunscreen, or protective clothing for an hour. Would your child . . . (check only one)**

- Never tan, always burn
- Sometimes tan, usually burn
- Usually tan, sometimes burn
- Always tan, rarely burn

**A5. How often has your child had a severe, painful sunburn on each of these areas of the body?**

	Never	1-2 times	3-5 times	6+ times
Back and shoulders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face or arms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All over. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A6. Has your child ever sunbathed or sat outside by the water?**

- No **→ Go to Question A8.**
- Yes **↓**

**A7. If yes, how many days in the last 12 months has your child sunbathed or sat outside by the water?**

- None
- 1-5 days
- 6-10 days
- 11 or more days

**A8. Has your child ever used artificial tanning devices such as a sunlamp, or gone to a tanning booth?**

- No **→ Go to Question A10, next page.**
- Yes

**Continue on next page.**

**A9. If yes, how many days in the last 12 months has your child used any artificial tanning devices such as a sunlamp, or gone to a tanning booth?**

- None
- 1-5 days
- 6-10 days
- 11 or more days

**A10. When your child was outside last summer for more than 15 minutes, how often did he/she protect themselves from the sun by . . .**

	Never	Rarely	Sometimes	Often	Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing protective clothing such as long-sleeved shirts and long pants. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing a hat. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limiting exposure to the sun during the mid-day hours. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying in the shade. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A11. Has a medical doctor or nurse ever examined all or most of your child's skin for signs of skin cancer, not just looked at a certain spot?**

- No
- Yes
- Don't know

**A12. Has your child ever had a health care professional remove a skin growth?**

- No
- Yes

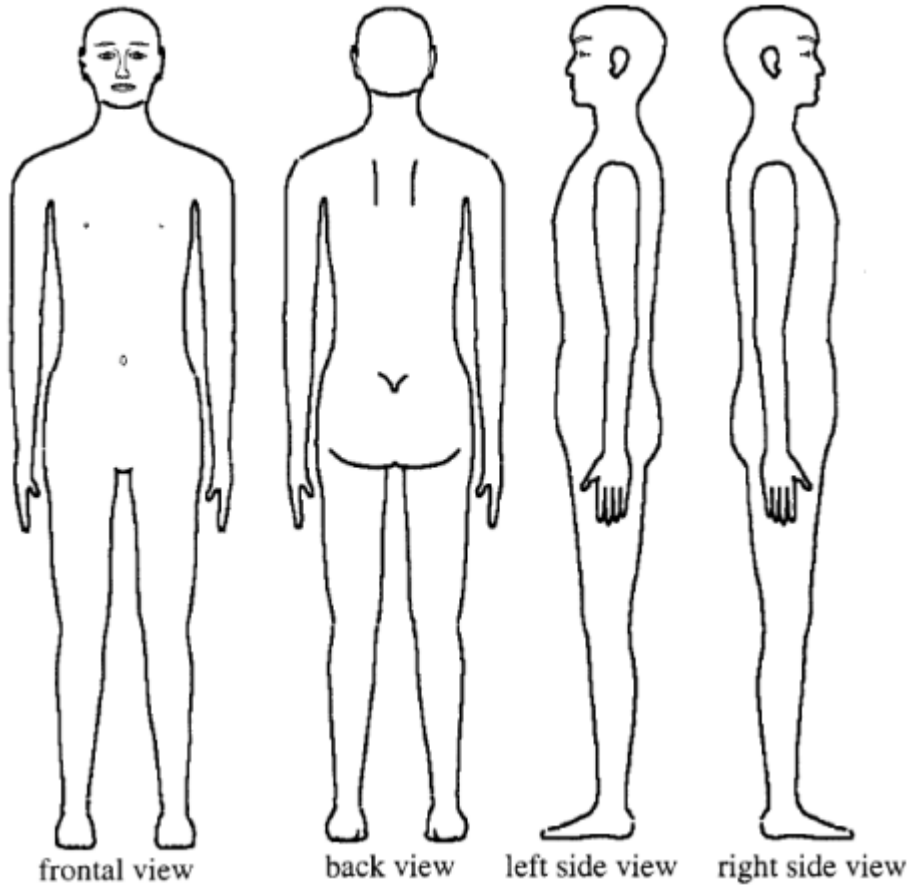
**A13. Has your child ever been told that he/she had skin cancer? This includes basal cell, squamous cell, and melanoma.**

- No → Go to Question B1 on page 6.
- Yes ↴

What was the name of the disease?

Where was the skin cancer located on your child's body? (Example: upper right arm, left ear)

Please mark an "X" at the location(s) of your child's skin cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



When was this diagnosed?

--	--

Month (mm)

--	--	--	--

Year (yyyy)

If you don't remember the date when the skin cancer was diagnosed, please give your child's approximate age at the time, or a time period when it happened (*for example*, between 1980 and 1983).

---

Please! Do not mark below this line

**A13. (Cont.) Where was this diagnosed?**

Doctor's name
Hospital or clinic
Address
City, State, Zip code

*If your child had more than one occurrence of skin cancer, please use a separate sheet of paper.*

**Smoking**

**B1. Does your child smoke cigarettes now?**

- No  
 Yes

**B2. Has your child smoked cigarettes in the last month?**

- No  
 Yes

**B3. Has your child used smokeless tobacco in the last month?**

- No  
 Yes

**B4. How old was your child when he/she started smoking?**

Years    or     my child has never smoked

**B5. In the past year, has your child ever used any of these tobacco products?  
 (Mark all that apply)**

		Never used	No longer use	Occasionally use	Regularly use
Chewing tobacco . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff tobacco. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipes. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-Cigarettes. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Continue on next page.*

Please! Do not mark below this line

**Drug Use**

**B6. During your child's life, how many times has he/she used...**

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Marijuana/Hashish/Cannabis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack/Freebase . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin/Smack/Junk/White China . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B7. During your child's life, how many times has he/she used without a doctor's prescription . . .**

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Steroid Pills or Shots . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B8. During the past 30 days, how many times has your child used...**

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Marijuana/Hashish/Cannabis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack/Freebase . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin/Smack/Junk/White China . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B9. During the past 30 days, how many times did your child use without a doctor's prescription...**


	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Steroid Pills or Shots . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

**Alcohol**

**B10. In your child's entire life, has he/she ever had at least 2 drinks of any kind of alcoholic beverage?**

No  **Go to Question C1, next page.**

Yes 

**B11. How old was your child when he/she first started drinking alcohol?**

Years

**B12. During the last 12 months, what is the largest number of drinks your child had on any single day?**

**Was it. . .**

- 24+ drinks
- 12-23 drinks
- 8-11 drinks
- 5-7 drinks
- 4 drinks
- 3 drinks
- 2 drinks
- 1 drink
- 0 drinks

**Continue on next page.**



## **Body Weight**

**C1. Is your child trying to lose weight?**

- No
- Yes → **Go to Question C3.**
- Don't know / Not sure

**C2. Is your child trying to maintain his/her current weight, that is, to keep from gaining weight?**

- No → **Go to Question C5.**
- Yes
- Don't know / Not sure → **Go to Question C5.**

**C3. Is your child eating either fewer calories or less fat to lose weight?**

- No
- Yes, fewer calories
- Yes, less fat
- Yes, fewer calories and less fat
- Don't know / Not sure

**Continue on next page.**

**C4. Is your child using physical activity or exercise to lose weight or keep from gaining weight?**

- No
- Yes
- Don't know / Not sure

**C5. In the past 12 months, has a doctor, nurse or other health professional given your child advice about his/her weight?**

- No
- Yes, lose weight
- Yes, gain weight
- Yes, maintain current weight
- Don't know / Not sure

## Physical Activity

The following questions are about exercise, recreation, or physical activities other than your child's school or work activities.

D1. During the past month, did your child participate in any physical activities or exercises such as running, aerobics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

- No  
 Yes

We are interested in three types of physical activity: vigorous, moderate, and light.

- Vigorous activities cause large increases in breathing or heart rate.
- Moderate activities cause small increases in breathing or heart rate.
- Light activities cause no increase in breathing or heart rate.

D2. Now thinking about the vigorous physical activities your child does in a usual week, does your child do vigorous activities for at least 10 minutes at a time, such as running, aerobics, wheelchair basketball, heavy yard work, or anything else that causes large increases in breathing or heart rate?

No → **Go to Question D3.**

Yes ↓

D2a. How many days per week does your child do these vigorous activities for at least 10 minutes at a time?

days per week

D2b. On days when your child does vigorous activities for at least 10 minutes at a time, how much total time per day does your child spend doing these activities?

minutes per day

D3. Now thinking about moderate physical activities your child does in a usual week, does your child do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, gardening, manual operation of a wheelchair, or anything else that causes small increases in breathing or heart rate?

No → **Go to Question D4.**

Yes ↓

D3a. How many days per week does your child do these moderate activities for at least 10 minutes at a time?

days per week

D3b. On days when your child does moderate activities for at least 10 minutes at a time, how much total time per day does your child spend doing these activities?

minutes per day

D4. Now thinking about light physical activities your child does in a usual week, does your child do light activities for at least 10 minutes at a time, such as a slow casual walk, or anything else that does not cause an increase in your child's breathing or heart rate?

No → **Go to Question D5, next page.**

Yes ↓

D4a. How many days per week does your child do these light activities for at least 10 minutes at a time?

days per week

D4b. On days when your child does light activities for at least 10 minutes at a time, how much total time per day does your child spend doing these activities?

minutes per day

Please! Do not mark below this line

D5. During the past 7 days, on how many days was your child physically active for a total of at least 60 minutes per day? Add up all the time your child spent in any kind of physical activity that increased his/her heart rate and made him/her breathe hard some of the time.

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D6. Now think about the time your child spent doing different types of physical activity in a typical week. First think about the time your child spent doing work. Work is the things that your child has to do such as paid or unpaid work, household chores, and yard work. Does your child's work involve vigorous-intensity activity that causes large increases in breathing or heart rate like carrying or lifting heavy loads, digging or construction work for at least 10 minutes continuously?

- No → Go to Question D9.
- Yes

D7. In a typical week, on how many days does your child do vigorous-intensity activities as part of his/her work? Vigorous-intensity activity causes large increases in breathing or heart rate and is done for at least 10 minutes continuously.

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D8. How much time does your child spend doing vigorous-intensity activities at work on a typical day?

hours       minutes

D9. Does your child's work involve moderate-intensity activity that causes small increases in breathing or heart rate such as brisk walking or carrying light loads for at least 10 minutes continually?

- No → Go to Question D12.
- Yes

D10. In a typical week, on how many days does your child do moderate-intensity activities as part of his/her work?

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D11. How much time does your child spend doing moderate-intensity activities at work on a typical day?

hours       minutes

D12. The next questions exclude the physical activities at work that you already mentioned and asks about the usual way your child travels to and from school, for shopping, or to work. In a typical week does your child walk or use a bicycle for at least 10 minutes continuously to get to and from places?

- No → Go to Question D15, next page.
- Yes

D13. In a typical week, on how many days does your child walk or bicycle for at least 10 minutes continuously to get to and from places?

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D14. How much time does your child spend walking or bicycling for travel on a typical day? Think about a typical day when your child walks or bicycles for travel.

hours        minutes

D15. The next questions exclude the work and transport activities that you already mentioned and ask about sports, fitness, and recreational activities. In a typical week does your child do any vigorous-intensity sports, fitness, or recreational activities that cause large increases in breathing or heart rate, such as running or basketball for at least 10 minutes continuously?

- No **→ Go to Question D18.**
- Yes

D16. In a typical week, on how many days does your child do vigorous-intensity sports, fitness or recreational activities? Vigorous-intensity activity causes large increases in breathing or heart rate and is done for at least 10 minutes continuously.

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D17. How much time does your child spend doing vigorous-intensity sports, fitness or recreational activities on a typical day?

hours        minutes

D18. In a typical week does your child do any moderate-intensity sports, fitness, or recreational activities that cause a small increase in breathing or heart rate such as brisk walking, bicycling, swimming, or volleyball for at least 10 minutes continuously?

- No **→ Go to Question D21.**
- Yes

D19. In a typical week, on how many days does your child do moderate-intensity sports, fitness or recreational activities? Moderate-intensity sports, fitness or recreational activities cause small increases in breathing or heart rate and is done for at least 10 minutes continuously.

- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

D20. How much time does your child spend doing moderate-intensity sports, fitness or recreational activities on a typical day?

hours        minutes

D21. The following question is about sitting at school, at home, getting to and from places, or with friends including time spent sitting at a desk, traveling in a car or bus, reading, playing cards, watching television, or using a computer. Do not include time spent sleeping. How much time does your child usually spend sitting on a typical day?

hours        minutes

Please! Do not mark below this line

**D22. Over the past 30 days, on average how many hours per day did your child sit and watch TV or videos? Would you say...**

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 hours
- 5 hours or more
- Doesn't watch TV or videos

**D23. Over the past 30 days, on average how many hours per day does your child use a computer or plays computer games outside of school? Include Playstation, Nintendo DS, or other portable video games. Would you say...**

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 hours
- 5 hours or more
- Doesn't use a computer outside of work or school

**D24. For the next questions, think about the types of sports or physical activities your child may have done during the past 7 days. Please do not include things your child did during the school day like PE or gym class. Did your child do any physical activities during the past 7 days?**

- No **→ Go to Question D26.**
- Yes

**D25. What physical activities did your child do during the past 7 days? Don't include activities your child did during gym or PE. Did your child do any other physical activities? For example, baseball, running, or swimming.**

**D26. During the past 7 days, on how many days did your child play active video games such as Wii Sports, Wii Fit, Xbox 360, Xbox Kinect, Playstation 3, or Dance, Dance Revolution?**

- 0 days **→ Go to Question D28.**
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

**D27. On average, for how long did your child play these active video games?**

<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	hours	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	minutes
--	--	-------	--	--	---------

**D28. In this question you can include activities done in school. On how many of the past 7 days did your child exercise or participate in physical activity for at least 20 minutes that made him/her sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar activities?**

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

**D29. On how many of the past 7 days did your child do exercise to strengthen or tone his/her muscles, such as push-ups, sit-ups, or weight lifting?**

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

**D30. The next questions ask about activities during the school year. If your child is not currently in school, think about the activities when your child was last in school. Are students at his/her school allowed to use school facilities during lunch or during a free or elective period, such as the gymnasium, tennis courts, weight room, or track, during school time?**

- No **→ Go to Question D32.**
- Yes

**D31. Does your child use school facilities for physical activities during school time?**

- No
- Yes

**D32. Does your child have PE or gym during school days?**

- No **→ Go to Question D35.**
- Yes

**D33. How often does your child have PE or gym?**

- 1 day a week
- 2 days a week
- 3 days a week
- 4 days a week
- Every day

**D34. On average, how long is the PE or gym class?**

- Less than 30 minutes
- 30-45 minutes
- More than 45 minutes

**D35. The following are activities that may be done before, during, or after school other than during PE or gym class. If your child is not currently in school, think about the activities when your child was last in school. Does your child participate in school sports or physical activity clubs?**

- No **→ Go to Question D37.**
- Yes

**D36. In what school sports or physical activity clubs does your child participate?**

**D37. Over the last 2 years, how long (if at all) has your child's health limited him/her in each of the following activities? (Mark one box for each item.)**

	Not limited at all	Limited for 3 months or less	Limited for more than 3 months
a. The kinds or amounts of vigorous activities your child can do, like lifting heavy objects, running or participating in strenuous sports. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The kinds or amounts of moderate activities your child can do, like moving a table, carrying groceries or bowling . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking uphill or climbing a few flights of stairs. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bending, lifting, or stooping . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking one block . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eating, dressing, bathing, or using the toilet . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

**Daily Activity**

**D38. Which statement best describes your child's usual daily activities?**

- Your child mostly sits during the day and does not walk about very much
- Your child stands or walks about quite a lot during the day, but does not have to carry or lift things very often
- Your child carries light loads, or has to climb stairs or hills often
- Your child does heavy work or carries heavy loads

**D39. Over the past 30 days, on a typical day how much time altogether did your child spend sitting and watching TV or videos or using a computer or other electronic portable device outside of school? Would you say ...**

- Doesn't watch TV or videos or use a computer or electronic portable device
- <1 hour
- 1 - 2 hours
- 3 - 4 hours
- 5 - 6 hours
- 7 - 8 hours
- 9 hours or more

**D40. Because of any impairment or health problems, does your child need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around your child's home?**

- No
- Yes

**D41. Because of any impairment or health problems, does your child need the help of other persons in handling routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?**

- No
- Yes

**D42. Does any impairment or health problem keep your child from holding a job or attending school?**

- No
- Yes

**D43. Does your child currently have a driver's license?**

- No
- Yes

Please! Do not mark below this line

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