CARES
Communities Actively Researching Exposure Study

Study ID: ___-___-___-_
Date: ___/____/____

Calculation of Child's Age

	Year	Month	Day
Date of Testing			
Date of Birth			
Age at Testing			

Interviewer Name: _____ (Interviewer Code: ___ ___)

Today's Date: ___/___/___

1. **What is your name? Last _____, First_____**

2. **What is your [CHILD'S PARENT]'s date of birth? ___/___/___**

3. **What is your relationship to the [CHILD'S NAME]? (RELTOCLD)**
   - ○ Biological Father (0)
   - ○ Biological Mother (1)
   - ○ Grandparent(s) (2)
   - ○ Other Biological Relative: (3) _____
   - ○ Adoptive Parent or legal guardian (4)
   - ○ Other: _____ (5)

4. **Do you consider yourself a lifetime resident of this area?**
   - ○ Yes (0)
   - ○ No (1)

5. **Which way can we reach you? (Can select more than one.)**
   - ○ US Postal address
   - ○ Home Phone
   - ○ Work Phone
   - ○ Cell Phone
   - ○ Email

6. **Other Parent/Guardian Information: Please provide the contact information for your child's other parent/guardian.**
   a. **What is the name of the child's other parent/guardian?**

   Last _____, First_____

b. Does the child's other parent/guardian live at the child's current address?

- ○ Yes (0)
- ○ No (1)

_____ ____ _____ ___ ___
Street Address Apt. # City State

Zip Code: __ __ __ __ __ (_____) ___ ___ ___-___ ___ ___ ___
Primary Phone

7. Relative Contact Information: Please provide contact information for two individuals who will always know how to get in touch with your [THE CHILD]'s family. In the event that you move or change phone numbers, it would be helpful to have contact information for a person(s) who will know how to reach you—like a grandparent or other family member.

a. _____ _____
First Name **Last Name**

Relationship to child:

- ○ Grandparent(s) (1)
- ○ Other Biological Relative: (2)

_____

- ○ Other: _____ (3)

_____ ____ _____ _____
Street Address **Apt. #** **City** **State**

Zip Code: ___ ___ ___ ___ ___

(_____) ___ ___ ___-___ ___ ___ ___
Home Phone

(_____) ___ ___ ___-___ ___ ___ ___
Work Phone

(_____) ___ ___ ___-___ ___ ___ ___
Cell Phone

_____
E-mail address (optional)

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b. _____ _____
First Name **Last Name**

Relationship to child:

- ○ Grandparent(s) (1)
- ○ Other Biological Relative: (2)

  _____

- ○ Other: _____ (3)

_____ ____ _____ _____
Street Address **Apt. #** **City** **State**

Zip Code: ___ ___ ___ ___ ___

(_____) ___ ___ ___-___ ___ ___ ___
Home Phone

(_____) ___ ___ ___-___ ___ ___ ___
Work Phone

(_____) ___ ___ ___-___ ___ ___ ___
Cell Phone

_____
E-mail address (optional)

Child's Residences

8. When was [CHILD'S NAME]'s current home built? ___ ___ ___ ___ (year)

9. Is this home rented or owned?

- ○ Rented (0)
- ○ Owned (1)
- ○ Don't know (2)

10. In the last 6 months, has the home that [CHILD'S NAME] currently lives in gone under any remodeling or repair work during the time that [CHILD'S NAME] has lived there? [If no, skip to question 11]

- ○ Yes (0)
- ○ No (1)
- ○ Don't know (2)

a. If yes, was [CHILD'S NAME] in the home during renovations?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

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b.Were any of the following procedures done:

- ○ Sanding (0)
- ○ Open flame paint removal (1)
- ○ Chemical paint removal (2)
- ○ Paint scraping (3)
- ○ Water blasting of exterior paint (4)
- ○ Demolition (5)
- ○ Don't know (6)

11. What is the primary source of drinking water for [CHILD'S NAME]?

- ○ Tap water (0)
- ○ Cistern (1)
- ○ Well water (2)
- ○ Bottled water (3)
- ○ Don't know (4)

12. What is the [CHILD'S NAME]'s current address?

_____ ____ _____ ____ ___
Street Address **Apt. #** **City** **State**

Zip Code: ___ ___ ___ ___ ___

(_____) ___ ___ ___-___ ___ ___ ___
Child Cell Phone

(_____) ___ ___ ___-___ ___ ___ ___
Home Phone

(_____) ___ ___ ___-___ ___ ___ ___
Guardian's Work Phone

(_____) ___ ___ ___-___ ___ ___ ___
Guardian's Cell Phone (optional)

_____
Guardian's email (optional)

13. Other than [CHILD'S NAME]'s current address, where else has [CHILD'S NAME] resided in the past? Please begin with the home [CHILD'S NAME] lived in at birth.

- ○ **[CHILD'S NAME] was born at current address (address provided on page 1).**

a.

Child lived here from:
_____ - _____
(e.g. 1996-1997)

Child lived here for ____ yrs and ____ mos.

_____ _____ _____
Street **Apt. #**

_____ _____ __ __ __ __ __
City **State** **Zip Code**

b.

Child lived here from:
_____ - _____
(e.g. 1996-1997)

Child lived here for ____ yrs and ____ mos.

_____ _____ _____
Street **Apt. #**

_____ _____ __ __ __ __ __
City **State** **Zip Code**

c.

Child lived here from:
_____ - _____
(e.g. 1996-1997)

Child lived here for ____ yrs and ____ mos.

_____ _____ _____
Street **Apt. #**

_____ _____ __ __ __ __ __
City **State** **Zip Code**

Child's School

14. What school does [CHILD'S NAME] currently attend? _____

15. One of your child's teachers will complete a questionnaire regarding your child's communication and social skills. Can you please provide the name of your child's Science teacher? (Alternatively, collect the name of English teacher)

_____

16. Has a TEACHER ever recommended [CHILD'S NAME] for Special Education?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when recommended? _____ years old

- ○ Don't know (2)

17. Has a TEACHER ever suggested that [CHILD'S NAME] has a speech or language disorder?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when this was suggested? _____ years old

- ○ Don't know (2)

Health History

Has a <u>doctor or other health professional</u> ever diagnosed [CHILD'S NAME] with any of the following conditions?

18. Diabetes?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes,

a. Type 1?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

b. Type 2?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

c. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

d. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

19. Peripheral neuropathy (numbness, pain, or tingling in the feet, legs, arms, or hands)?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

20. Rheumatoid arthritis or other joint disease?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

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21. Scoliosis (curvature of the spine)?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

22. Epilepsy or seizure disorder?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

23. Other neurological disease or condition (e.g., stroke, Tourette's syndrome, meningitis, encephalitis)?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes,

a. What is the name of the condition? _____

b. How old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

24. Muscle disease or condition (e.g., fibromyalgia, chronic fatigue syndrome)?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes,

a. What is the name of the condition? _____

b. How old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

c. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

25. Disorder that affects balance or causes dizziness such as Meniere's disease or inner ear disorder?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes,

a. What is the name of the condition? _____

b. How old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

c. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

26. ADD or ADHD?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

- ○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

27. Autism Spectrum Disorder?

- ○ No (0)
- ○ Yes (1)

○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication for this condition?

○ No (0)
○ Yes (1)
○ Don't know (2)

28. Asthma?

○ No (0)
○ Yes (1)
○ Don't know (2)

a. If yes, how old was [CHILD'S NAME] when diagnosed? _____years old

○ Don't know (2)

b. If yes, does [CHILD'S NAME] take medication or use an inhaler for this condition?

○ No (0)
○ Yes (1)
○ Don't know (2)

Prompt parent with these: (Common asthma medications: Singular, Inhaled Bronchiodialtor (Albuterol, Ventolin, Proventil, Levalbuterol, Xopenex, Alupent, Metaproterenol), Oral Steriods (Prednisone, Medrol, Pediapred, Prelone, Solumedrol), Primatene Mist Inhaler, Inhaled Corticosteriods (Pulmicort, Turbohaler, Flovent, Advair, QVAR))

29. Any other major medical problem not mentioned already?

○ No (0)
○ Yes (1)
○ Don't know (2)

If yes,

a. What is the name of the condition? _____

b. How old was [CHILD'S NAME] when diagnosed? _____years old

○ Don't know (2)

c. If yes, does [CHILD'S NAME] take medication for this condition or any other condition not previously mentioned?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

d. What is the medication? ----------

30. Has [CHILD'S NAME] ever had a serious head, neck, or back injury for example a concussion or a herniated disk? This may have been a result of a car accident, sports injury, etc.

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes, a. Describe injury and how it occurred: _____

_____

b. How old was [CHILD'S NAME] when this occurred? _____

c. Does [CHILD'S NAME] continue to have problems as a result of the injury (i.e., pain, discomfort, weakness, or limitations in movement)?

- ○ No (0)
- ○ Yes (1) Describe: _____
- ○ Don't know (2)

31. Has [CHILD'S NAME] ever had a serious injury or disability to his/her arms, legs, or feet (broken bone, ligament tear, etc.)?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

If yes, a. Describe injury/disability and how it occurred: _____

_____

b. How old was [CHILD'S NAME] when this occurred? _____

c. Does [CHILD'S NAME] continue to have problems with his/her arms, legs or feet (i.e., pain, discomfort, weakness, or limitations in movement)?

- ○ No (0)
- ○ Yes (1) Describe: _____
- ○ Don't know (2)

32. Has [CHILD'S NAME] had any surgeries or hospitalizations in the past year?

- ○ No (0)

- ○ Yes (1)
- ○ Don't know (2)

If yes, a. When (date)? _____

b. Reason (diagnosis): _____

c. Has [CHILD'S NAME] completely recovered (i.e., no pain, discomfort, weakness, or limitations in movement)?

- ○ No (0) **If no, explain:** _____
- ○ Yes (1)
- ○ Don't know (2)

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Demographics

33. How many people live in the same residence as [CHILD'S NAME]? ____

34. How many of these people smoke cigarettes? _____ For each collect the following.

a. number of cigarettes/day ___

Does this person smoke in the home?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

In the car?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

b. number of cigarettes/day ___

Does this person smoke in the home?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

In the car?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

c. number of cigarettes/day ___

Does this person smoke in the home?

- ○ No (0)
- ○ Yes (1)

- ○ Don't know (2)

In the car?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

d. number of cigarettes/day ___

Does this person smoke in the home?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

In the car?

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

35. Is your child exposed to cigarette smoke on a regular basis (at least one time a week) from anyone outside those living at the residence? This includes grandparents, step-parents, other relatives, friends, neighbors, after school care, etc.

- ○ No (0)
- ○ Yes (1)
- ○ Don't know (2)

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36.

Circle the appropriate number for your Mother's, your Father's, your Spouse / Partner's, and your level of school completed and occupation. If you grew up in a single parent home, circle only the score from your one parent. If you are neither married nor partnered circle only your score. If you are a full time student circle only the scores for your parents.

Level of School Completed	Mother	Father	Spouse	You
Less than 7th grade	3	3	3	3
Junior high / Middle school (9th grade)	6	6	6	6
Partial high school (10th or 11th grade)	9	9	9	9
High school graduate	12	12	12	12
Partial college (at least one year)	15	15	15	15
College education	18	18	18	18
Graduate degree	21	21	21	21

Circle the appropriate number for your *Mother's*, your Father's , your Spouse / Partner's, and your occupation. If you grew up in a single parent home, use only the score from your parent. If you are not married or partnered circle only your score. If you are still a full-time student only circle the scores for your parents. If you are retired use your most recent occupation.

Occupation	Mother	Father	Spouse	You
Day laborer, janitor, house cleaner, farm worker, food counter sales, food preparation worker, busboy.	5	5	5	5
Garbage collector, short-order cook, cab driver, shoe sales, assembly line workers, masons, baggage porter.	10	10	10	10
Painter, skilled construction trade, sales clerk, truck driver, cook, sales counter or general office clerk.	15	15	15	15
Automobile mechanic, typist, locksmith, farmer, carpenter, receptionist, construction laborer, hairdresser.	20	20	20	20
Machinist, musician, bookkeeper, secretary, insurance sales, cabinet maker, personnel specialist, welder.	25	25	25	25
Supervisor, librarian, aircraft mechanic, artist and artisan, electrician, administrator, military enlisted personnel, buyer.	30	30	30	30
Nurse, skilled technician, medical technician, counselor, manager, police and fire personnel, financial manager, physical, occupational, speech therapist.	35	35	35	35
Mechanical, nuclear, and electrical engineer, educational administrator, veterinarian, military officer, elementary, high school and special education teacher,	40	40	40	40
Physician, attorney, professor, chemical and aerospace engineer, judge, CEO, senior manager, public official, psychologist, pharmacist, accountant.	45	45	45	45

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37. What is your total household annual income?

- ○ Less than $10,000
- ○ $10,000 - $19,999
- ○ $20,000 - $29,999
- ○ $30,000 – $39,999
- ○ $40,000 – $49,999
- ○ $50,000 – $59,999
- ○ $60,000 – $69,999
- ○ $70,000 – $79,999
- ○ $80,000 or more
- ○ Don't know

38. Which best describes your health insurance?

- ○ Private Health Insurance (0)
- ○ Medicare (1)
- ○ Medi-gap (2)
- ○ Medicaid (3)
- ○ Other (4) Please list type: _____
- ○ No coverage of any kind (5)
- ○ Don't know (6)

39. How best would you describe your ethnicity?

- ○ Hispanic or Latino (0)
- ○ Not Hispanic or Latino (1)

40. How best would you describe your race? (mark all that apply)

- ○ White/Caucasian (0)
- ○ Black/African American (1)
- ○ American Indian (2)
- ○ Pacific Islander (3)
- ○ Asian (4)
- ○ Other _____
- ○ Don't know (6)

41. What is your gender?

- ○ Male
- ○ Female

42. How best would you describe [YOUR CHILD'S] ethnicity?

- ○ Hispanic or Latino (0)
- ○ Not Hispanic or Latino (1)

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43. How best would you describe [YOUR CHILD'S] race?

- ○ White/Caucasian (0)
- ○ Black/African American (1)
- ○ American Indian (2)
- ○ Pacific Islander (3)
- ○ Asian (4)
- ○ Other _____
- ○ Don't know (6)

44. What is [YOUR CHILD'S] gender?

- ○ Male
- ○ Female