



Questionnaire No:

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BEING A GIRL

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Hayley

This questionnaire is for the study child's mother or the person taking the role of the mother.

All answers are confidential

12.11.02

This questionnaire is for the study child's mother or person taking the role of mother.

To answer simply tick the box which is most accurate in your opinion.

If you do not want to answer a question or if it does not apply to you, put a line through it. There are no good or bad answers. Just tell us what is true for you.

THANK YOU FOR YOUR HELP

SECTION A: YOUR CHILD'S HEALTH

The health of your study child is still of great importance to us. We would like to know about any recent illnesses or medical treatments.

A1. How would you assess the health of your child nowadays?

	(i) in the past month	(ii) in the past year
very healthy, no problems	<div>1</div>	<div>1</div>
healthy, but a few minor problems	<div>2</div>	<div>2</div>
sometimes quite ill	<div>3</div>	<div>3</div>
almost always unwell	<div>4</div>	<div>4</div>

A2. a) **In the past 12 months** has the doctor been called to your home because your daughter was unwell?

Yes

1

 No

2

 → **If no, go to A3 below**

If yes,

b) how many times?

once

1

 2 times

2

 3-4 times

3

 5 or more times

4

A3. Has she **ever** had any of the following operations?
(Please tick all that apply)

	Yes	
a) hernia repair	<div>1</div>	→ If <u>yes</u>, please give type
b) tonsils out	<div>1</div>	
c) adenoids out	<div>1</div>	
d) appendicectomy (appendix out)	<div>1</div>	
e) tubes (grommets) put in her ears	<div>1</div>	

	Yes
A3. f) squint repair (to put eyes straight)	<div>1</div>
g) teeth pulled out	<div>1</div>
h) other operations (please tick and describe)	<div>1</div>

.....

A4. How many days has she had to take off school for health reasons?
 [If you can't remember, make a guess and tick the guess box as well]

In the past 12 months:	(i) No. of days off school	(ii) Guess?
a) For one or more infections (including colds, cough, flu)	<div></div>	<div>1</div>
(i) please describe		
.....		
b) For hospital investigation including admission	<div></div>	<div>1</div>
(i) please describe		
.....		
c) For other investigation(s)	<div></div>	<div>1</div>
(i) please describe		
.....		
d) For asthma	<div></div>	<div>1</div>
e) For eczema or itchy rash	<div></div>	<div>1</div>
f) For hayfever or allergic rhinitis	<div></div>	<div>1</div>

In the past 12 months:		(i) No. of days off school	(ii) Guess?
A4.	g) For other reasons:		
	please describe: (i)	<div><div></div><div></div></div>	<div>1</div>
	(ii)	<div><div></div><div></div></div>	<div>1</div>
	(iii)	<div><div></div><div></div></div>	<div>1</div>

A5. Has she had a skin reaction in the past year (e.g. redness or itching) which you thought was due to some food that she had eaten?

Yes

1

 No

2

 → If **no**, go to A6 below

If **yes**,

a) please describe the food(s)

b) how long after the food was eaten did the reaction appear?.....

c) where was the reaction? mouth

1

other part

2

(please describe)

A6. a) Has she had vomiting spells in the past year?

Yes

1

 No

2

 → If **no**, go to A7a on page 6

If **yes**,

b) How many times?

once

1

 twice

2

 3-9 times

3

 10 or more times

4

c) How often have these been associated with:

	Always	Frequently	Sometimes	Rarely	Never
(i) diarrhoea	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
(ii) chestiness (wheezing or coughing or grunting)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

A7. a) In the past year has she had diarrhoea or gastro-enteritis?
Yes 1 No 2 → If **no**, go to A8a below

If **yes**,

b) how many times in the past 12 months?

c) how many days did the worst attack last?

A8. a) In the past year has your child ever had a time when she has coughed off and on for at least 2 days?

Yes 1 No 2 → If **no**, go to A9 below

If **yes**,

b) How many times has this happened in the past year?

once 1 twice 2 3-9 3 times 10 or more 4
times times

c) Did she have a fever at any of these times?

Yes for all 1 Yes for some 2 No, not at all 3

d) Did she have a runny nose during any of these spells?

Yes for all 1 Yes for some 2 No, not at all 3

A9. Has pus or sticky mucus (not ear wax) leaked out of her ear in the past year?

never 1
once 2
more than once 3
don't know 9

A10. Does she breathe through her mouth rather than through her nose?

	(i) when asleep	(ii) when awake
all the time	<input type="text" value="1"/>	<input type="text" value="1"/>
much of the time	<input type="text" value="2"/>	<input type="text" value="2"/>
sometimes	<input type="text" value="3"/>	<input type="text" value="3"/>
rarely	<input type="text" value="4"/>	<input type="text" value="4"/>
never	<input type="text" value="5"/>	<input type="text" value="5"/>
don't know	<input type="text" value="9"/>	<input type="text" value="9"/>

A11. Does she snore for more than a few minutes at a time?

most nights	<input type="text" value="1"/>
quite often	<input type="text" value="2"/>
sometimes	<input type="text" value="3"/>
only rarely	<input type="text" value="4"/>
never	<input type="text" value="5"/>
don't know	<input type="text" value="9"/>

A12. a) Have there been times in the past year when she has had a pain in her stomach?

Yes No → If **no**, go to A13a on page 8

If **yes**,

b) How many separate times has this happened in the past year?

once twice 3-4 times 5 or more times don't know

c) Did she have vomiting or diarrhoea at the same time as the pain?

yes every time yes, for some of the times no, not at all

A12. d) What do you think were the causes of her stomach pains? (Tick all that apply)

- (i) something she ate ☐ 1
- (ii) an infection ☐ 1
- (iii) constipation ☐ 1
- (iv) other (please describe) ☐ 1
- (v) don't know ☐ 1

A13. a) Does she often have aches and pains in her arms or legs?

yes arm(s) ☐ 1 yes leg(s) ☐ 2 yes both ☐ 3 no, not often ☐ 4

↓
**If no,
go to A14a
below**

If yes,

(i) does this happen especially when she is tired? Yes ☐ 1 No ☐ 2

(ii) what do you think is the cause ?

.....

(iii) do you find any particular treatment helps ?

Yes ☐ 1 No ☐ 2

iv) **If yes,** please describe.....

A14. a) **Since her 9th birthday** has she had any form of convulsion, fit, seizure or other turn in which consciousness was lost or any part of the body made an abnormal movement?

Yes ☐ 1 No ☐ 2 Not known ☐ 9

→ **If no, or not known,
go to A15a on page 10**

If yes,

A14. b) Please describe the first attack **since her 9th birthday**:

.....
.....

c) Did the child have a high temperature at the time?

Yes No Not known

d) How old was she at the time?

9 years 10 years 11 years

e) How many attacks has she had altogether **since her 9th birthday**?

one two 3-4 5 or more

f) By whom was she seen for these attack(s)? (Tick all that apply)

Yes


(i) general practitioner at home	<input type="text" value="1"/>
(ii) general practitioner at surgery	<input type="text" value="1"/>
(iii) hospital outpatient department	<input type="text" value="1"/>
(iv) admitted to hospital	<input type="text" value="1"/>
(v) no-one	<input type="text" value="1"/>

g) What investigations, if any, have been carried out?

.....

h) Did any later attacks differ from the first one **since her 9th birthday**?

yes no Has only had the one attack since 9th birthday


go to (j) on page 10

A14. h) **If yes**, please describe

.....
.....

j) What was/were the attack(s) thought to be due to? (Tick all that apply)

- | | | | |
|-------|----------------------------------|--------------------------|---------|
| (i) | febrile convulsions | <input type="checkbox"/> | 1 |
| (ii) | fainting and blackouts | <input type="checkbox"/> | 1 |
| (iii) | epilepsy | <input type="checkbox"/> | 1 |
| (iv) | breath holding | <input type="checkbox"/> | 1 |
| (v) | reaction to immunisation | <input type="checkbox"/> | 1 |
| (vi) | other (please tick and describe) | <input type="checkbox"/> | 1 |
| (vii) | don't know | <input type="checkbox"/> | 1 |

A15. a) **In the past year** has she had any periods when there was wheezing with whistling on her chest when she breathed?

Yes ☐ 1 No ☐ 2 → **If no**, go to A15k on page 11

If yes,

b) How many separate times has this happened in the past 12 months?

once ☐ 1 twice ☐ 2 3-4 ☐ 3 5 or more ☐ 4 times don't ☐ 9
know

c) How many days altogether would you say she has wheezed in the past 12 months?

1 ☐ 1 2-3 ☐ 2 4-9 ☐ 3 10-19 ☐ 4 20 or ☐ 5 don't ☐ 9
day days days days more know
days

d) Was she breathless during any of these times?

Yes for ☐ 1 Yes for ☐ 2 No not ☐ 3
all some at all

A15. e) Did she have a cold during any of these times?

Yes for all 1 Yes for some 2 No not at all 3

f) How often, on average, has your child's sleep been disturbed due to wheezing in the past 12 months?

Never woken with wheezing 1 Less than one night per week 2 One or more nights per week 3

g) Has wheezing ever been severe enough to limit your child's speech to only one or two words at a time between breaths in the past 12 months?

Yes 1 No 2

h) Do you think the wheezing attacks are worse during any particular time of year?

yes, worse in spring and/or summer 1
yes, worse in autumn and/or winter 2
not particularly 3
other (please tick & describe) 4

.....

j) What do you think brings on the wheezing attacks ?

	Yes	No
(i) chest infection or bronchitis	<input type="text"/> 1	<input type="text"/> 2
(ii) being in a smoky room	<input type="text"/> 1	<input type="text"/> 2
(iii) cold weather	<input type="text"/> 1	<input type="text"/> 2
(iv) I don't know	<input type="text"/> 1	
(v) other (please tick & describe)	<input type="text"/> 1	<input type="text"/> 2

.....

k) In the past 12 months has your child's chest sounded wheezy during or after exercise?

Yes 1 No 2

A15. l) In the past 12 months has your child had a dry cough at night, apart from a cough associated with a cold or chest infection?

Yes 1 No 2

m) Have any of your other children ever had spells of wheezing with whistling on the chest?

Yes 1 No 2 have no other children 7

A16. a) Has your child had any itchy, dry skin rash in the joints and creases of her body (e.g. behind the knees, elbows, under the arms) in the past year?

Yes 1 No 2 → **If no, go to A17a below**

If yes,

b) How bad was this?

very bad 1 quite bad 2 mild 3 no problem 4

	Yes	No
c) Does she have this sort of rash now?	<input type="text"/> 1 <input type="text"/>	<input type="text"/> 2 <input type="text"/>
d) Did the rash ever become sore and oozy?	<input type="text"/> 1 <input type="text"/>	<input type="text"/> 2 <input type="text"/>
e) Was it made worse by irritants such as bubble bath, soap, wool or nylon clothing?	<input type="text"/> 1 <input type="text"/>	<input type="text"/> 2 <input type="text"/>
f) Did the rash clear up completely at any time in the past 12 months?	<input type="text"/> 1 <input type="text"/>	<input type="text"/> 2 <input type="text"/>

A17. a) Has she had an itchy, dry, rash on her hands in the past year?

Yes 1 No 2

b) Has she had an itchy, dry rash on her feet in the past year?

Yes 1 No 2 → **If no, go to A17c on page 13**

If yes, please describe which parts of her feet

.....

A17. c) In the past 12 months how often, on average, has your child been kept awake at night by an itchy rash?

Never in the past 12 months

Less than one night per week

One or more nights per week

d) Does her skin get itchy when she gets sweaty? (e.g. in a hot room or when she has been playing?)

Yes

No

A18. This question is about problems which occur when your child **does not** have a cold or the flu.

a) Has your child ever had sneezing episodes, or a runny or blocked nose, when she did not have a cold or the flu?

Yes

No

→ If **no**, go to A18c below

b) In the past 12 months, has your child had sneezing episodes, or a runny or blocked nose, when she did not have a cold or the flu?

Yes

No

c) In the past 12 months, has she had itchy-watery eyes?

Yes

No

d) In which of the past 12 months did these nose and/or eye problems occur? (Please tick all that apply)

(i) Hasn't had a nose or eye problem

→ go to Section B on page 15

(ii)

January

May

September

February

June

October

March

July

November

April

August

December

A18. e) In the past 12 months, how much did these nose and eye problems interfere with your child's activities?

Not at all

1

A little

2

A moderate amount

3

A lot

4

SECTION B: PROBLEMS AND INVESTIGATIONS

B1. a) **Since her 9th birthday** has anyone thought there might be a new problem with her hearing?

Yes ₁ No ₂

b) Has your child been seen by a hearing specialist **since she was 9?**

Yes ₁ No ₂ → If **no**, go to B2a below

If **yes**,

c) At what age?

9 years old ₁ 10 years old ₂ 11 years old ₃

d) What was decided?
.....

B2. a) Has your child been seen by an eye specialist for a new problem **since her 9th birthday?**

Yes ₁ No ₂ → If **no**, go to B3a below

If **yes**,

b) at what age?

9 years old ₁ 10 years old ₂ 11 years old ₃

c) What was decided?
.....

d) What treatment was given?
.....

B3. a) Has anyone **ever** thought that there might be a problem with her talking?

Yes ₁ No ₂ → If **no**, go to B4a on page 16

If yes,

B3. b) Has she ever been seen by a speech therapist?

Yes 1 No 2 → If **no**, go to B3c below

If yes,

(i) how old was she? years

(ii) what was decided?.....

.....

c) Are there still any worries about her talking?

Yes 1 No 2

If yes, please describe

.....

B4. a) Has anyone **ever** thought she might have a problem with clumsiness, movement or coordination?

Yes 1 No 2 → If **no**, go to B5a on page 17

If yes,

b) Has she ever been seen by a specialist about this?

Yes 1 No 2 → If **no**, go to B4e below

If yes,

c) how old was she? years (If less than 12 months put 00)

d) what was decided?.....

.....

e) Are there still worries about this?

Yes 1 No 2

If yes, please describe.....

.....

- B5. a) Has anyone **ever** thought there might be a problem with other aspects of her development?

Yes 1 No 2 → If **no**, go to B6a below

If **yes**,

- b) Has she ever been seen by a specialist about this?

Yes 1 No 2 → If **no**, go to B5e below

If **yes**,

- c) how old was she? years (If less than 12 months put 00)

- d) what was decided?.....

.....

- e) Are there still worries about this?

Yes 1 No 2

If **yes**, please describe.....

.....

- B6. a) Has anyone **ever** thought there might be a problem with her behaviour or personality?

Yes 1 No 2 → If **no**, go to B7a on page 18

If **yes**,

- b) Has she ever been seen by a specialist about this?

Yes 1 No 2 → If **no**, go to B6e on page 18

If **yes**,

- c) how old was she? years (If less than 12 months put 00)

- d) what was decided?.....

.....

B6. e) Are there still worries about this?

Yes 1 No 2

If yes, please describe.....

.....

B7. a) Has anyone **ever** thought there might be a problem with aches and pains, including headache?

Yes 1 No 2 → **If no, go to B8a on page 19**

If yes,

b) Has she ever been seen by a specialist about this?

Yes 1 No 2 → **If no, go to B7e below**

If yes,

c) how old was she? years (If less than 12 months put 00)

d) what was decided?.....

.....

e) Are there still worries about this?

Yes 1 No 2

If yes, please describe.....

.....

B8. a) Have there been any **other** problems for which your child saw (or is going to see) a specialist **since her 9th birthday**?

Yes ₁ No ₂ → If **no**, go to section C on page 20

If **yes**,

b) For how many different problems?

Please list, for each problem, what has happened:

	Problem No.1	Problem No.2	Problem No.3
c) What was thought to be the problem?	.....	.....	.....
d) Has she seen a specialist?	Yes <input type="text"/> ₁ No <input type="text"/> ₂ Not yet <input type="text"/> ₃	Yes <input type="text"/> ₁ No <input type="text"/> ₂ Not yet <input type="text"/> ₃	Yes <input type="text"/> ₁ No <input type="text"/> ₂ Not yet <input type="text"/> ₃
e) What age was she the first time she was seen for this problem ? (put 00 if less than 12 months)	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
f) What was decided?	..... .....	..... .....	..... .....
g) What treatment was given?	..... .....	..... .....	..... .....

If more than 3 problems, continue below or on a separate sheet.

SECTION C: ACCIDENTS AND INJURIES

However careful a parent is, most children have accidents at some time or other. Please list on the next pages the times your child has had an accident, whether or not she was injured as a result.

C1. a) Has she been burnt or scalded **since her 9th birthday**?

Yes 1 No 2 → If **no**, go to C2a on page 21

If **yes**, b) how many times?

For each accident please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g.kitchen, park, school)	.....	.....	.....
d) What was she burnt with? (e.g. tea, iron, electric fire, bonfire, fireworks)	.....	.....	.....
e) Date of accident (month, year).....	.....	.....	.....
f) Injuries caused (if no injury write none)	.....	.....	.....
g) Who was with her?	.....	.....	.....
h) What did the person with her do?	.....	.....	.....
Nothing	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1
Treated her themselves	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2
Took to doctor	<input type="text"/> 3	<input type="text"/> 3	<input type="text"/> 3
Took to hospital	<input type="text"/> 4	<input type="text"/> 4	<input type="text"/> 4
Other (please describe)	<input type="text"/> 5	<input type="text"/> 5	<input type="text"/> 5

i) What treatment did the person with her give?	.....	.....	.....
j) What other treatment did she have?	.....	.....	.....
k) Please describe how each accident happened:			

Burn 1.....

Burn 2.....

Burn 3.....

C2. a) Has she had an accident while playing sports or games **since her 9th birthday**?

Yes 1 No 2 → If **no**, go to C3a on page 22

If **yes**, b) how many times?

For each accident please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place it happened (e.g. playground, street, school)	.....	.....	.....
d) What happened (e.g. hit by ball, fell off trampoline)?	.....	.....	.....
e) Date of accident (month, year).....	.....	.....	.....
f) Injuries caused (if no injury write none)	.....	.....	.....
g) Who was with her?	.....	.....	.....
h) What did the person with her do?			
Nothing	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1
Treated her themselves	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2
Took to doctor	<input type="text"/> 3	<input type="text"/> 3	<input type="text"/> 3
Took to hospital	<input type="text"/> 4	<input type="text"/> 4	<input type="text"/> 4
Other (please describe)	<input type="text"/> 5	<input type="text"/> 5	<input type="text"/> 5

i) What treatment did the person with her give?	.....	.....	.....
j) What other treatment did she have?	.....	.....	.....

k) Please describe how each accident happened:

Accident 1

Accident 2

Accident 3

C3. a) Has she swallowed anything she shouldn't have (such as pills, buttons, disinfectant) **since her 9th birthday?**

Yes 1 No 2 → If **no**, go to C4a on page 23

If **yes**, b) how many times?

For each time please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g. your home, school) at friend's)	.....	.....	.....
d) What did she swallow? (e.g. bleach, aspirin, marble)	.....	.....	.....
e) Date of accident (month, year).....	.....	.....	.....
f) Who was with her? .....	.....	.....	.....
g) What did the person with her do?			
Nothing	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1
Treated her themselves	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2
Took to doctor	<input type="text"/> 3	<input type="text"/> 3	<input type="text"/> 3
Took to hospital	<input type="text"/> 4	<input type="text"/> 4	<input type="text"/> 4
Other (please describe)	<input type="text"/> 5	<input type="text"/> 5	<input type="text"/> 5

h) What treatment did the person with her give?	.....	.....	.....
i) What other treatment did she have?	.....	.....	.....
j) Please describe how each accident happened:			

Accident 1

Accident 2

Accident 3

C4. a) Has she had any injuries involving traffic **since her 9th birthday?**

Yes 1 No 2 → If **no**, go to C5a on page 24

If **yes**, b) how many times?

For each accident or injury please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Where was she and what was she doing (e.g. sitting in car, riding a bicycle)?	.....	.....	.....
d) What happened (e.g. car hit tree, fell off bike)	.....	.....	.....
e) Date of accident (month, year).....	.....	.....	.....
f) Injuries caused (if no injury write none)	.....	.....	.....
g) Who was with her?	.....	.....	.....
h) What did the person with her do?			
Nothing	<input type="text"/> 1	<input type="text"/> 1	<input type="text"/> 1
Treated her themselves	<input type="text"/> 2	<input type="text"/> 2	<input type="text"/> 2
Took to doctor	<input type="text"/> 3	<input type="text"/> 3	<input type="text"/> 3
Took to hospital	<input type="text"/> 4	<input type="text"/> 4	<input type="text"/> 4
Other (please describe)	<input type="text"/> 5	<input type="text"/> 5	<input type="text"/> 5

i) What treatment did the person with her give?	.....	.....	.....
j) What other treatment did she have?	.....	.....	.....

k) Please describe how each accident happened:

Accident 1

Accident 2

Accident 3

C5. a) Has she been injured by the action of another person, whether intentionally or not **since her 9th birthday**? (Don't include sports injuries here but include them in C2).

Yes No → If **no**, go to C6a on page 25

If **yes**, b) how many times?

For each accident please describe below what happened:

	1st injury	2nd injury	3rd injury
c) Person involved (e.g. stranger, sister, child's father)
d) What happened?
e) Date of injury (month, year).....
f) Who else was with her?
g) What did the person with her do?			
Nothing	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
Treated her themselves	<input type="text" value="2"/>	<input type="text" value="2"/>	<input type="text" value="2"/>
Took to doctor	<input type="text" value="3"/>	<input type="text" value="3"/>	<input type="text" value="3"/>
Took to hospital	<input type="text" value="4"/>	<input type="text" value="4"/>	<input type="text" value="4"/>
Other (please describe)	<input type="text" value="5"/>	<input type="text" value="5"/>	<input type="text" value="5"/>

h) What treatment did the person with her give?
i) What other treatment did she have?
j) Please describe how each accident happened:			

Injury 1

Injury 2

Injury 3

C6. a) Has she had any other accidents or injuries **since her 9th birthday?**

Yes No → If **no**, go to C7 on page 26

If **yes**, b) how many times?

For each time please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g. kitchen, garden, street, school)
d) What happened?
e) Date of injury (month, year).....
f) Injuries caused (if no injury write none)
g) What did the person with her do?			
Nothing	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
Treated her themselves	<input type="text" value="2"/>	<input type="text" value="2"/>	<input type="text" value="2"/>
Took to doctor	<input type="text" value="3"/>	<input type="text" value="3"/>	<input type="text" value="3"/>
Took to hospital	<input type="text" value="4"/>	<input type="text" value="4"/>	<input type="text" value="4"/>
Other (please describe)	<input type="text" value="5"/>	<input type="text" value="5"/>	<input type="text" value="5"/>

h) What treatment did the person with her give?
i) What other treatment did she have?
j) Please describe how each accident happened:			

Accident 1

Accident 2

Accident 3

C7. Has she had any of the following happen **since she was born**? (tick all questions and all time periods that apply)

	(i) Yes, aged 0 - 4 years	(ii) Yes, aged 5-8 years	(iii) Yes, since her 9 th birthday
a) Broken arm/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Broken leg/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Broken/cracked skull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Other broken bone (please describe).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Unconscious because of a head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Cut(s) requiring stitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Burn or scald needing a skin graft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) A road traffic accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) An accident in a playground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) An accident at school, nursery, crèche	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Stung by wasp or bee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Bitten by animal or human (please tick and describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Badly sunburnt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Nearly drowned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Front tooth (teeth) knocked out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Front tooth (teeth) chipped or injured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Other tooth/teeth knocked out or chipped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C8. Has the study child ever had an accident that has had effects that are still present?
(Please tick all that apply)

- | | | |
|----|-----------------------------|--|
| a) | yes, a scar | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| b) | yes, a behaviour difference | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| c) | yes, other | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |

For any of the above, please describe

.....

.....

SECTION D: DISCIPLINE & LIFESTYLE

D1. a) Are there rules in your home about what your study child can and cannot do?

No, not
at all

Yes for
some things

Yes, for
many things

b) Does she refuse to do what she does not want to do?

Yes
usually

Yes
sometimes

No, not
at all

	(i) I do	(ii) My husband/ partner does	(iii) Her teacher does	(iv) Someone else ? please describe
c) Who has most control over your study child?	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
d) Who usually tells her off?	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
e) Who usually punishes her?	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>

f) How often is she punished?

every day

several times
a week

once or twice
a week

once or twice
a month

rarely

never

g) How often do you slap or hit her?

every day

several times
a week

once or twice
a week

once or twice a
month

rarely

never

D2. Has she ever run away from home?

Yes

No, but has tried to

No, but has thought
of doing so

No,
never

Don't know

D3. a) On normal school days what time in the morning does your child usually wake up?

hours		minutes		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	a.m.

b) On normal school days what time in the evening does your child usually go to sleep?

hours		minutes		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	p.m.

c) On weekends what time in the morning does your child usually wake up?

hours		minutes		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	a.m.

d) On weekends what time in the evening does your child usually go to sleep?

hours		minutes		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	p.m.

D4. a) Does she understand the concept of right and wrong?

Yes	<input type="text"/>	No	<input type="text"/>
-----	----------------------	----	----------------------

b) Can she determine herself what is proper behaviour?

Yes usually	<input type="text"/>	Yes sometimes	<input type="text"/>	No	<input type="text"/>	Don't know	<input type="text"/>
----------------	----------------------	------------------	----------------------	----	----------------------	---------------	----------------------

D5. What does she consider important in her life? (tick all that apply)

	Yes
a) school results	<input type="text"/>
b) relationship between herself and her teachers	<input type="text"/>
c) relationship between herself and her friends	<input type="text"/>

		Yes
D5.	d) family relationships	<input type="checkbox"/>
	e) hobbies, interests	<input type="checkbox"/>
	f) friends	<input type="checkbox"/>
	g) clothes	<input type="checkbox"/>
	h) money	<input type="checkbox"/>
	i) material possessions	<input type="checkbox"/>
	j) holidays, trips	<input type="checkbox"/>

D6. What does she really like to do best? (tick all that apply)

	Yes
a) sports	<input type="checkbox"/>
b) playing a musical instrument	<input type="checkbox"/>
c) singing	<input type="checkbox"/>
d) dancing	<input type="checkbox"/>
e) reading	<input type="checkbox"/>
f) drawing	<input type="checkbox"/>
g) making things	<input type="checkbox"/>
h) other	<input type="checkbox"/>
(please tick and describe)

D7. Does she understand the concept of death as an irreversible event with all its emotional consequences?

Yes, understands	<input type="checkbox"/>	Yes, more or less understands	<input type="checkbox"/>
Not really	<input type="checkbox"/>	Not at all	<input type="checkbox"/>

D8. Does she take an interest?

	Yes, very interested	Yes, somewhat interested	No, not interested	Not sure
a) in nationalism	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) in politics	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) in the meaning of life	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) in law and order	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) in religion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

f) Does she attend a place of worship (church, mosque, etc)?

Yes often Yes sometimes No, not at all

g) Does she pray?

Yes often Yes sometimes No, not at all

Don't know

D9. a) What friends does she prefer?

boys	<input type="text" value="1"/>
girls	<input type="text" value="2"/>
she doesn't mind	<input type="text" value="3"/>
she doesn't have friends	<input type="text" value="4"/>

b) Does she have a favourite friend of the other sex?

Yes No

D10. Is she at ease with children of her own age?

	Yes
yes, fully	<div>1</div>
prefers younger children	<div>2</div>
prefers older children	<div>3</div>

D11. How much is she influenced by her friends/mates?

very strongly	<div>1</div>
fairly strongly	<div>2</div>
sometimes	<div>3</div>
rarely	<div>4</div>
never	<div>5</div>

D12. Has she ever been offered:

	Yes and I know about it	Probably	Possibly	I do not think so
a) alcohol	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) cigarettes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) drugs	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

D13. (i) Has she ever tried:

	Yes and I know about it	Probably	Possibly	I do not think so
a) alcohol	<div>1<div></div></div>	<div>2<div></div></div>	<div>3<div></div></div>	<div>4<div></div></div>
b) cigarettes	<div>1<div></div></div>	<div>2<div></div></div>	<div>3<div></div></div>	<div>4<div></div></div>
c) drugs	<div>1<div></div></div>	<div>2<div></div></div>	<div>3<div></div></div>	<div>4<div></div></div>

↓
If yes to any of the above,

(ii) At what age was she when she tried them? (put 99 if you don't know)

a)	alcohol	<div><div></div><div></div></div>	years
b)	cigarettes	<div><div></div><div></div></div>	years
c)	drugs	<div><div></div><div></div></div>	years

SECTION E: PILLS AND POTIONS

E1. Please indicate below any **medicines** (pills, syrups, inhalers, drops, sprays, suppositories, ointments etc including homeopathic and herbal remedies) that your study child has used **in the last 12 months**.

Include medicines prescribed by your doctor and those you may have bought over the counter. If you need more lines for a particular category please include the additional medicines under the 'Other conditions' section at the end of the question on Page 36.

Try to give the full name of the medicine and say how often it was used.

Regularly: most days for at least 3 months, or several times every month
Few days: for a few days at a time for one or more episodes
Odd occasions: on a few odd occasions
Once or twice: on one or two isolated occasions only

In the past 12 months

How often?

**medicine, pills
drops or
ointment for:**

Yes
↓

**Name of
medicine etc.**

Regularly
↓

**Few
days**

**Odd
occasions**

**Once or
twice**

a) Headache

☐

.....

☐☐☐☐

b) Stomach ache

☐

.....

☐☐☐☐

c) Earache

☐

.....

☐☐☐☐

d) Other ache
or pain

☐

.....

☐☐☐☐

e) Vomiting

☐

.....

☐☐☐☐

f) Diarrhoea

☐

.....

☐☐☐☐

g) Constipation

☐

.....

☐☐☐☐

h) Travel sickness

☐

.....

☐☐☐☐

i) Insect bites

☐

.....

☐☐☐☐

E1.

**In the past 12 months
medicine, pills
drops or
ointment for:**

How often?

	Yes ↓	Name of medicine etc.	Regularly ↓	Few days	Odd occasions	Once or twice
j) Bruising	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k) A 'cold'	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l) Cough	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
m) Sore throat	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
n) 'Flu'	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
o) Infection requiring antibiotics	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
p) Athlete's foot	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
q) Wart or verruca	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
r) Head lice	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
s) Worms	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
t) Eye infection	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
u) Psoriasis	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
v) Eczema	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
w) Asthma	<div>1</div>	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

E1.

**In the past 12 months
medicine, pills
drops or
ointment for:**

How often?

	Yes ↓	Name of medicine etc.	Regularly ↓	Few days	Odd occasions	Once or twice
x) Hay fever	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
y) Other allergies	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
z) Diabetes	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
za) Epilepsy	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zb) Sleeping	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zc) Fever, high temperature	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
Other conditions (Please tick and describe)						
zd).....	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
ze).....	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zf).....	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zg)	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zh)	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zi)	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
zj) No medicines, pills, drops or ointment used at all	<input type="text" value="1"/>					

E2. Please describe below any vitamins, minerals such as iron, or other supplements given for your study child's health in the **past month** and indicate how often they were taken.

To describe supplements containing a mixture of things e.g. calcium and vitamins, or vitamins and iron etc., please write them under "Other" in part d) below.

(Please say which and give brand name)	Every day	Most days ↓	About 1-2 times a week	Less than once a week	Not at all ↓
a) Vitamins					
i)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Mineral supplements (e.g. iron, calcium)					
i)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Oil supplements (e.g. cod liver oil, evening primrose oil)					
i)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Other tonic or supplement					
i)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

E3. Please describe below any treatment your child has taken for asthma or wheezing in the past month and indicate how often they were taken.

In the past month:	Every day	Most days ↓	About 1-2 times a week	Less than once a week	Not at all ↓
a) "Reliever" inhaler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) "Preventer" inhaler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Other inhaler or medicine for asthma	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION F: MOODS AND FEELINGS

These questions are about how your child may have been feeling or acting recently.

For each question, please say how much you think she has felt or acted this way in the past two weeks.

In the past 2 weeks:		True	Sometimes true	Not true
F1.	She felt miserable or unhappy	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F2.	She didn't enjoy anything at all	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F3.	She felt so tired that she just sat around and did nothing	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F4.	She was very restless	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F5.	She felt she was no good any more	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F6.	She cried a lot	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F7.	She found it hard to think properly or concentrate	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F8.	She hated herself	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F9.	She felt she was a bad person	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F10.	She felt lonely	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F11.	She thought nobody really loved her	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F12.	She thought she could never be as good as other kids	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
F13.	She felt she did everything wrong	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

SECTION G: STRENGTHS AND DIFFICULTIES

Please think how your child has been in the past 6 months

	In the last six months:	Not true	Somewhat true	Certainly true	Don't know
G1.	She has been considerate of other people's feelings	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G2.	She has been restless, overactive, cannot stay still for long	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G3.	She has often complained of headaches, stomach aches or sickness	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G4.	She has shared readily with other children (treats, toys, pencils etc.)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G5.	She has often had temper tantrums or hot tempers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G6.	She is rather solitary, tends to play alone	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G7.	She is generally obedient, usually does what adults request	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G8.	She has many worries, often seems worried	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G9.	She is helpful if someone is hurt, upset or feeling ill	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G10.	She is constantly fidgeting or squirming	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G11.	She has at least one good friend	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G12.	She often fights with other children or bullies them	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G13.	She is often unhappy, down-hearted or tearful	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G14.	She is generally liked by other children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G15.	She is easily distracted, her concentration wanders	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G16.	She is nervous or clingy in new situations, easily loses confidence	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>

In the last six months:		Not true	Somewhat true	Certainly true	Don't know
G17.	She is kind to younger children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G18.	She often lies or cheats	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G19.	She is picked on or bullied by other children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G20.	She often volunteers to help others (parents, teachers, other children)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G21.	She thinks things out before acting	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G22.	She steals from home, school or elsewhere	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G23.	She gets on better with adults than with other children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G24.	She has many fears, is easily scared	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
G25.	She sees tasks through to the end, has good attention span	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>

It's two years since we asked you about your daughter's school days, so now we need to update our information

Thank you so much for helping us with this questionnaire. We really do appreciate all the help you are giving to the study.

SECTION H: SCHOOL

H1. a) Does she go to school?

Yes No → If **no**, go to H11a on page 46

b) How many different schools has she gone to? (don't count nursery school or kindergarten)

different schools

c) Please describe reasons for child being at current school (tick all that apply):

- i) It was the only available choice
- ii) It was the best available
- iii) There were medical reasons → please describe
- iv) There were psychological reasons → please describe
- v) Other (please tick and describe)
-

H2. How does she get to school?

		(i) Going			(ii) Coming back	
		every or most days	some days		every or most days	some days
a)	She walks	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
b)	She goes in a wheelchair	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
c)	By public transport	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
d)	School bus/ coach	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
e)	By car	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
f)	Rides bicycle	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
g)	Other (please tick & describe)	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>

.....

H3. a) How far away is the school?

less than ½ mile (1 km) away

½ - 1 mile (1-2 km) away

1 - 5 miles (2-8 km) away

more than 5 miles (8 km) away

b) How long does it take to get there in the morning?

minutes

H4. We would like to know what happens after school.

a) Does she usually go straight home?

No Yes
most days

↓

Yes
always

→ If yes always,
go to H4c below

b) If no, or most days, where else does she go?

	Every day	Some days	Never
i) to a relative's home	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) to a friend's home	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) to a childminder	<input type="text"/>	<input type="text"/>	<input type="text"/>
iv) school club	<input type="text"/>	<input type="text"/>	<input type="text"/>
v) plays outside	<input type="text"/>	<input type="text"/>	<input type="text"/>
vi) other (please tick and describe)	<input type="text"/>	<input type="text"/>	<input type="text"/>

.....

c) If she goes straight home is an adult always there?

yes, always yes, usually yes, sometimes
no, hardly ever

H5. How do you think she feels about school?

		Always	Usually	Sometimes	Not at all
a)	She looks forward to seeing her teachers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b)	She enjoys school	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c)	She is stimulated by it	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d)	She is frightened by the teachers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e)	She is frightened by her school mates	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f)	She is afraid of failure	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g)	She seems bored by school	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h)	She likes her school mates	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i)	She looks forward to lessons	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

H6. At school how much do you think she likes:

		She likes it a lot	She quite likes it	She does not like it	Does not do this
a)	Science	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b)	Maths	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c)	English	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d)	Games/PE	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e)	Foreign language	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f)	Art	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g)	Music	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h)	Geography	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i)	History	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

		She likes it a lot	She quite likes it	She does not like it	Does not do this
H6.	j) I.T. (Information technology)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
	k) D.T. (Design and technology)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
	l) Humanities	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
	m) Citizenship/P.S.E./P.S.D.	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
	n) Other topic (please tick & describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	

.....

H7. a) Are you interested in what your child does at school?

Yes very Yes mostly No, not really

b) Are you happy with the teaching your daughter is getting at school?

Yes very Yes mostly No, not really

c) Are you happy with the progress your daughter is making at school?

Yes very Yes mostly No, not really

d) Are you happy with her behaviour at school?

Yes very Yes mostly No, not really

H8. Has she been identified as having any particular problems at school?

Yes No → **If no, go to H11 on page 46**

If yes, which problems? (tick all that apply)

- H8. a) disciplinary ☐
 b) learning ☐
 c) in relationships ☐
 d) emotional ☐
 e) other ☐
 f) Please describe each type of school problem:

.....
.....
.....

H9. Have you been invited to the school to talk about any of these problems?

Yes ☐ No ☐

H10 a) Was the child investigated by a health specialist or educational psychologist for any of these problems?

Yes ☐ No ☐ → **If no, go to H11 on page 46**

If yes, what was the result?

.....
.....
.....

b) Did this investigation result in extra help for the child?

Yes ☐ No ☐ → **If no, go to H11 on page 46**

If yes, describe what:

.....
.....

H11. a) Do you think that your study child has any particular talents?

Yes ☐1 No ☐2 → If **no**, go to H12 below

b) If **yes**, please describe

.....

H12. Does your child show any interest in taking up any particular occupation when she is an adult?

Yes ☐1 No ☐2 → If **no**, go to H13 below

If **yes**, please describe.....

H13. Is there an occupation you really hope your child will choose?

Yes ☐1 No ☐2 → If **no**, go to H14 below

If **yes**, please describe.....

H14. What sort of education do you hope your child will have? (tick just one)

- | | |
|----------------------------|--|
| <input type="checkbox"/> 1 | the minimum – and leave school as soon as possible |
| <input type="checkbox"/> 2 | to get some good GCSE's and then leave |
| <input type="checkbox"/> 3 | to take at least one A level |
| <input type="checkbox"/> 4 | to go to University |
| <input type="checkbox"/> 5 | other (please tick and describe) |
| <input type="checkbox"/> 6 | don't really mind |

SECTION J: LISTENING SKILLS

- J1. a) Does your child have difficulty listening on the telephone?
 Yes No Never allowed to do this
- b) Does your child have difficulty knowing the direction a noise is coming from?
 Yes No
- c) Is it often necessary to repeat things to your child before she understands?
 Yes No
- d) Does your child say “huh” or “what” or something similar 5 times or more a day?
 Yes No

J2. If listening in a room where there is **background noise** (e.g. TV, music, others talking etc.) how much difficulty does your child have in hearing and understanding:

Difficulty hearing and: understanding	No difficulty	Slight difficulty	Moderate difficulty	Severe difficulty	Don't know
a) When paying attention	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
b) When being asked a question	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
c) When being given simple instructions	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
d) When not paying attention	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
e) When involved in other activities (e.g. reading)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>

J3. If listening in a **quiet room**, how much difficulty does your child have in hearing and understanding:

	No difficulty	Slight difficulty	Moderate difficulty	Severe difficulty	Don't know
a) When paying attention	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
b) When being asked a question	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
c) When being given simple instructions	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
d) When not paying attention	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
e) When involved in other activities (e.g. reading)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>

J4. When listening in a quiet room, no distractions, face-to-face, and with good eye contact, how much difficulty does your child have in hearing and understanding:

	No difficulty	Slight difficulty	Moderate difficulty	Severe difficulty	Don't know
a) When being asked a question	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
b) When being given simple instructions	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>
c) When being given complicated instructions	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>

J5. If asked to remember something she has heard, how much difficulty does your child have:

	No difficulty	Slight difficulty	Moderate difficulty	Severe difficulty	Don't know
Immediately remembering:					
a) Something such as a word, spelling, numbers etc.	1	2	3	4	9
b) Simple instructions	1	2	3	4	9
c) Complex instructions	1	2	3	4	9
d) Remembering all the information and the order of the information	1	2	3	4	9
Remembering after an hour or so:					
e) Something such as a word, spelling, numbers etc	1	2	3	4	9
f) Simple instructions	1	2	3	4	9
g) Complex instructions	1	2	3	4	9
Remembering after a day:					
h) Any information	1	2	3	4	9

J6. If there is something she should listen to, how much difficulty does your child have, in paying attention to what is said?

	No difficulty	Slight difficulty	Moderate difficulty	Severe difficulty	Don't know
Difficulty listening:					
a) For less than 5 minutes	1	2	3	4	9
b) For 5-10 minutes	1	2	3	4	9
c) In a quiet room	1	2	3	4	9
d) In a noisy room	1	2	3	4	9
e) First thing in the morning	1	2	3	4	9
f) Near the end or before the evening meal	1	2	3	4	9
g) In a room where there are also visual distractions (e.g. TV on without the sound)	1	2	3	4	9

SECTION K: THE CHILD'S ACTIVITIES

K1. About how often does your child do the following:

How often does she:	Nearly every day	2-5 times a week	Once a week	1-3 times a month	Less than once per month	Not at all
a) Go swimming	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b) Play a musical instrument (e.g. piano, recorder)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c) Go to special groups (such as Scouts or Youth Clubs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

Please tick and describe.....

d) Go to Sunday School	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
e) Go to special classes or clubs for some activity (e.g. dancing, judo, football, other sports)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

Please tick and describe.....

f) Go to special classes because of learning difficulty	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
---	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Please tick and describe.....

g) Classes for foreign languages	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
----------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Please tick and describe.....

h) Singing group	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Please tick and describe.....

i) Other type of classes or group e.g. drama	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Please tick and describe.....

K1.		Nearly every day	2-5 times a week	Once a week	1-3 times a month	Less than once per month	Not at all
	How often does she:						
j)	See her grandparents	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
k)	Play computer games	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
l)	Help in the house	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>

K2. How often does her mother or other adult female do these activities with her?

	Adult female:	Nearly every day	2-5 times a week	Once a week	Less than once a week	Never ↓
a)	makes things with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	sings with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	reads to/with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>4</div>
d)	plays with toys, board games, computer games	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	cuddles her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	active play (e.g. ball games, wrestling, hide and seek)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	goes with her to the park or playground	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	kisses her goodnight	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	takes her swimming, fishing or other activity	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	draws or paints with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	prepares food with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

K2.		Nearly every day	2-5 times a week	Once a week	Less than once a week	Never ↓
	Adult female:					
l)	takes her to classes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	takes her shopping	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	takes her to watch sports/ football	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	does homework with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	has conversations with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	helps her prepare things for school	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	other (please tick & describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

.....

s) Who are the women involved in any of these activities with the study child? (tick all that apply)

i)	Her mother	<div>1</div>
ii)	Her stepmother/father's partner	<div>1</div>
iii)	Her grandmother	<div>1</div>
iv)	Her grown-up sister (16 years or older)	<div>1</div>
v)	Another relative	<div>1</div>
vi)	A family friend	<div>1</div>
vii)	A lodger	<div>1</div>
viii)	A baby sitter/nanny	<div>1</div>
ix)	Other (please tick and describe)	<div>1</div>

.....

K3. How often does a male adult (e.g. her father/mother's husband or partner) do these activities with your child?

		Nearly every day	2-5 times a week	Once a week	Less than once a week	Never ↓
Adult male:						
a)	makes things with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	sings with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	reads to/with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	plays with toys, board games, computer games	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	cuddles her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	active play (e.g. ball games, wrestling, hide and seek)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	goes with her to the park or playground	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	kisses her goodnight	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	takes her swimming, fishing or similar activity	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	draws or paints with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	prepares food with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	takes her to classes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	takes her shopping	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	take her to watch sports/ football	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	does homework with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	has conversations with her	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	helps her prepare things for school	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

K3.

		Nearly every day	2 - 5 times a week	Once a week	Less than once a week	Never ↓
	Adult male:					
r)	other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

.....

s) Who are the men involved in any of these activities with the study child? (tick all that apply)

i)	Her father	<div>1</div>
ii)	Her stepfather/mother's partner	<div>1</div>
iii)	Her grandfather	<div>1</div>
iv)	Her grown-up brother (16 years or older)	<div>1</div>
v)	Another relative	<div>1</div>
vi)	A family friend	<div>1</div>
vii)	A lodger	<div>1</div>
viii)	A baby sitter/nanny	<div>1</div>
ix)	Other (please tick and describe)	<div>1</div>

.....

K4. Help in the house:

a) Does your daughter help in the home (cleaning, washing dishes etc.)?

Yes, but only if made to	<div>1</div>
Yes, sometimes offers to and sometimes is made to	<div>2</div>
Yes, always offers to	<div>3</div>
No, refuses to help	<div>4</div>
No, is not allowed to help	<div>5</div>

K4. b) If **not allowed**, why is this?.....
.....

K5. Does she have a space in which she can do things on her own?

Yes, her own bedroom	<div>1</div>
A corner of a room	<div>2</div>
Her own table	<div>3</div>
No, there is no room for this	<div>4</div>
Something else (please tick and describe)	<div>5</div>

.....

K6. a) Does she have brothers and/or sisters living at home (include step and half-brothers and sisters)?

Yes

1

 No

2

 → If **no**, go to K7 on page 57

If **yes**,

b) How many?

i) older brothers → what age is the oldest? years
(or only older brother)

ii) younger brothers → what age is the youngest? years
(or only younger brother)

iii) twin brother

c) How many?

i) older sisters → what age is the oldest? years
(or only older sister)

ii) younger sisters → what age is the youngest? years
(or only younger sister)

iii) twin sister

K6. d) How often does the study child do the following with them?

With her brothers and sisters	Nearly every day	2-5 times a week	Once a week	Less than once a week	Never ↓
(i) Play indoor games together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(ii) Read together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(iii) Sing together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(iv) Make things, draw or paint	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(v) Go out together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(vi) Talk together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(vii) Eat together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(viii) Argue with one another	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(ix) Fight with one another	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
(x) Do sports e.g. football, gymnastics together	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

K7. a) Does she wear clothes that have been handed down free from others?
(tick all that apply)

i) yes, from older brothers & sisters	1 <input type="text"/>
ii) yes, from other relatives	1 <input type="text"/>
iii) yes, from friends	1 <input type="text"/>

b) Does she ever have clothes bought second hand for her?

Yes	1 <input type="text"/>	No	2 <input type="text"/>
-----	------------------------	----	------------------------

SECTION L: CULTURAL BACKGROUND

In order to help us find out why some children are healthier than others we are looking at many aspects of their development. So far however, we have not looked at the way this may be affected by their cultural background. We'd be grateful if you could answer these questions as best you can.

What would you consider to be the cultural background of your study child?

Choose ONE main category on these 2 pages, then tick the appropriate box(es):

L1. **White**

☐

1

Mixed

☐

2

→ Please specify:

White and Black Caribbean

White and Black African

White and Asian

Other Mixed background

(i)

☐

1

☐

2

☐

3

☐

4



(Please tick and describe)

Asian

☐

3

→ Please specify:

Indian

Pakistani

Bangladeshi

Other Asian background

(ii)

☐

1

☐

2

☐

3

☐

4



(Please tick and describe)

Black

☐

Please specify:

Caribbean

African

Other Black background

(iii)

☐☐☐

(Please tick and describe)

Other

☐

Please tick and describe:

.....

*Many thanks for the time
you have taken to fill in
this questionnaire*

*There is only the back
page to complete now*

SECTION M:

M1. This questionnaire was completed by: (tick all that apply)

- a) Child's biological mother ☐
- b) Child's mother figure ☐
- c) Child's biological father ☐
- d) Study child ☐
- e) Someone else ☐
(please tick and describe)

M2. Please give the date on which you completed this questionnaire:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2	0	0	<input type="text"/>

M3. Please give your date of birth:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1	9	<input type="text"/>	<input type="text"/>

M4. Please give the date of birth of your study child:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1	9	9	<input type="text"/>

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comment you would like to make

NB. Please remember we cannot reply to any comment unless you sign it.

When completed, please return the questionnaire to:

**Professor Jean Golding
Children of the Nineties - ALSPAC
Institute of Child Health
24 Tyndall Avenue
Bristol
BS8 1BR Tel: Bristol 928 8793**

For office use only

coder

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