FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

INFORMATION ABOUT YOUR CHILD AND HOUSEHOLD

Parent, Guardian OR Caregiver: Please complete all 10 pages of this form. When completing this form, consider the child who will participate in CHL Center. Thank you!

SEX (Circle One)		BIRTHDATE Month	Day	Year	AGE In Years
Boy	Girl			20_ _	

GRADE IN SCHOOL (Circle One)		
Head Start	Day Care	Preschool
Kindergarten	Elementary	None

HOUSEHOLD COMPOSITION

1. What is your relationship to this child? (*Please check which applies to you*:)			
☐	Birth mother	☐	Birth father
☐	Step mother	☐	Step father
☐	Adoptive mother	☐	Adoptive father
☐	Grandmother	☐	Grandfather
☐	Legal Guardian, Caregiver, Other: If related, please indicate the relationship: (e.g., uncle, sibling)		

2. What is your current Marital Status: (*Please choose the one that applies best to your current status.)*			
☐	Married	☐	Widowed
☐	Divorced	☐	Single and NOT living with boyfriend, girlfriend, partner
☐	Separated	☐	Single and living with boyfriend, girlfriend, partner
☐	Other	If Other is checked, please describe:	

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	CHL Center Information About Your Child	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ____/__ __/__ __ MM DD YEAR Checked by: _____

3. Please check all of the adults who live in the household of child.

☐	Birth mother		☐	Birth father	
☐	Step mother		☐	Step father	
☐	Adoptive mother		☐	Adoptive father	
☐	Foster mother		☐	Foster father	
☐	Grandmother	How many?	☐	Grandfather	How many?
☐	Aunt	How many?	☐	Uncle	How many?
☐	Great aunt	How many"	☐	Great uncle	How many?
☐	Other adult				How many?

HOUSEHOLD COMPOSITION (CONTINUED)

4. Please check all other children (for example; siblings, cousins, friends) who live In the household.

Age of other child(ren)		How Many?
☐	0 – 1 years	
☐	2 – 5 years	
☐	6 – 8 years	
☐	9 – 18 years	

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FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

HOUSEHOLD INFORMATION (OTHER)

5. What is the highest grade or year of school you completed?

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 up to 8 (Elementary to middle school)
- ☐ Grades 9 up to 11 (Some high school)
- ☐ Grade 12 or GED (High school graduate)
- ☐ College or technical school 1 year to 3 years
- ☐ College 4 years or more (College graduate)

6. Your current employment status? (*Please select all that apply.*)

- ☐ Employed for wages/salary (full-time/part-time/seasonal)
- ☐ Self-employed
- ☐ Fishing/Farming
- ☐ A Student
- ☐ Out of work for more than 1 year
- ☐ Subsistence
- ☐ Retired
- ☐ Out of work for less than 1 year
- ☐ A Homemaker
- ☐ Unable to work

7. Do you have more than one job at this time?

☐ Yes ☐ No

8. Based on everyone that lives under one roof or house, what is the annual household income from all sources over the past 12 months?

- ☐ Under $10,000
- ☐ From $10,000 to less than $20,000
- ☐ From $20,000 to less than $35,000
- ☐ From $35,000 to less than $60,000
- ☐ From $60,000 to less than $75,000
- ☐ $75,000 or more
- ☐ No Response

9. How confident are you filling out medical forms by yourself?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Extremely ☐ Don't know ☐ No Response

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

CHILD INFORMATION

1.	Do you consider your child to be of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish cultural heritage?		
☐	Yes	☐	No

Which category(s) below best describes your child?

2. You may check (✓) <u>more than one box</u>.

☐ **Black or African American-** A person having origins of any of the original peoples of Africa.

☐ **White -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **American Indian or Alaska Native -** A person having origin in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.

Please specify the one(s) you most identify with (*check all that apply*):

☐ Athabascan ☐ Siberian

☐ Cup'ik ☐ Yup'ik

☐ Inupiaq ☐ Other *(please describe)*_____

☐ **Asian**

Please specify the one(s) you most identify with (*check all that apply*):

☐ Cambodian ☐ Japanese ☐ Pakistani

☐ Chinese ☐ Korean ☐ Thai

☐ Filipino ☐ Malaysian ☐ Vietnamese

☐ Indian ☐ Other *(please describe)* _____

☐ **Native Hawaiian or other Pacific Islander:**

Please specify the one(s) you most identify with: (*check all that apply*):

☐ Chamorro ☐ Kosraean ☐ Pohnpeian ☐ Tokelaun

☐ Carolinian ☐ Marshallese ☐ Samoan ☐ Tahitian

☐ Chuukese ☐ Native Hawaiian ☐ Tongan ☐ Yapese

☐ Kiribati ☐ Palauan ☐ Other *(please describe)* _____

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

CHILD INFORMATION (CONTINUED)

3.	**What language(s) does your child speak?**	_____
4.	**What language does your child most often speak at home?**	_____
5.	**In what village/town/city and country was your child born?**	Village/Town/City: _____ Country: _____
6.	**How many years has your child lived here?** (***Enter the number of years in the space provided***)	_____

EARLY LIFE OF YOUR CHILD

1. Child's Birth Weight: _____ lb. and _____ oz. **OR** ___ . __ kilograms ☐ Unknown

2. Child's Birth Length: _____ inches **OR** ____ . __ cm ☐ Unknown

3. Was your child ever breastfed or fed breastmilk?

☐ Yes ☐ No (skip to question 4) ☐ Unknown

If yes, how old was your child when he/she completely stopped breastfeeding or being fed breastmilk?

_____ Months of age ☐ Still Breastfeeding ☐ Unknown

4. Was your child ever fed formula?

☐ Yes ☐ No (skip to question 5) ☐ Unknown

If yes, how old was the child when he/she was first fed formula?

_____ Months of age ☐ Since Birth ☐ Unknown

If your child was fed formula, how old was your child when he/she completely stopped drinking formula?

_____ Months of age ☐ Still Formula fed ☐ Unknown

5. How old was the child when he/she was first fed anything other than breast milk or formula?

(This includes juice, cow's milk, sugar water, baby food, or anything else that the child might have been given, even water)

_____ Months of age ☐ Unknown

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

OTHER INFORMATION

FOOD SECURITY/AVAILABILITY

1. In the past 12 months, how often does your money for food run out before the end of the month?

☐ Never ☐ Seldom ☐ Sometimes ☐ Most times ☐ Always ☐ Don't know ☐ No Response

2. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

☐ Often true ☐ Sometimes true ☐ Never true ☐ Don't know ☐ No Response

3. In the last 12 months, did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

☐ Yes ☐ No (Skip Question 4) ☐ Don't know (Skip Question 4) ☐ No Response (Skip Question 4)

4. If question 3 was "yes", How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

☐ Almost every month ☐ Some months but not every month ☐ Only 1 or 2 months ☐ Don't know ☐ No Response

5. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

☐ Yes ☐ No ☐ Don't know ☐ No Response

6. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

☐ Yes ☐ No ☐ Don't know ☐ No Response

7. In the past 12 months, how often does your money for household utilities (e.g., water, fuel oil, electricity) run out before the end of the month?

☐ Never ☐ Seldom ☐ Sometimes ☐ Most times ☐ Always ☐ Don't know ☐ No Response

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

8. In the past 12 months, do you receive assistance to pay for food (e.g., food stamps, WIC coupons)?

☐ Yes ☐ No ☐ No Response

9. If yes, which benefits does this household receive? (*Check all that apply*)

☐ EBT/ SNAP/NAP (formerly called Food Stamps)

☐ Food Assistance (Food Bank/Food Pantries or Commodity foods)

☐ WIC benefits

☐ Free or reduced-cost breakfasts or lunches at school

☐ Don't know

☐ Not applicable

☐ Other *(please specify)* _____

10. Where do you get the water you use at home? Include water for all purposes (e.g., drinking, cooking, cleaning, gardening, etc.) *(Check all that apply)*

☐ Purchased Bottled Water

☐ River/Stream /Creek

☐ Spring

☐ Neighbor's tap

☐ Community rain water collection

☐ Home rain water collection

☐ Household tap

☐ Private tap in yard

☐ Public – shared standpipe

☐ Refilling station

☐ Other *(please describe)* _____

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FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

MEDICAL

1. How many TOTAL hours does your child usually sleep in a 24-hour period (at night + naps)? (*Please choose one*, ☑; h= hours)

5h	5.5h	6h	6.5h	7h	7.5h	8h	8.5h	9h	9.5h	10h	10.5h	11h	11.5h
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

12h	12.5h	13h	>13h
☐	☐	☐	☐

2. Does your child have any current medical conditions diagnosed by a doctor?

☐ Yes ☐ No

If yes, please specify: _____

_____

3. Has a doctor or nurse ever told you that the child has asthma?

☐ Yes ☐ No ☐ Don't Know/Not Sure

4. How often does your child brush his/her teeth?

☐ More than once per day ☐ Once per day ☐ Once per week ☐ Once per year ☐ Never

☐ Don't know ☐ No response

5. During the past 12 months, did your child see a dentist for any routine preventive dental care, including check-ups, screenings, and sealants?

☐ Yes ☐ No ☐ Don't know ☐ No response

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ MM DD YEAR **Checked by:** _____

MEDICAL CONTINUED

6. Does your child have any problems that keep him/her from being physically active?

☐ Yes ☐ No

If Yes, what type of problem: _____

7. If yes, has your child had any problems with her / his

☐ heart	☐ nerves	☐ liver
☐ blood pressure	☐ thyroid	☐ kidney
☐ bones or joints	☐ cancer	☐ diabetes

8. Does your child take any medications?

☐ Yes ☐ No

9. If yes, does he or she take

_____ Antidepressants

_____ Lithium

_____ Appetite suppressants

_____ Any medication that affects appetite or metabolism

10. If you answered YES to any of these medications, does your child take <u>them regularly?</u>

☐ Yes ☐ No

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-02 Time 3	**CHL Center** **Information About Your Child**	**For Office Use Only** **Child's ID:** __ __ __ __ __ __ __ **Date:** ____/__ __/__ __ __ MM DD YEAR **Checked by:** _____

RELIGION

1. Do you engage in religious activities or events?

☐ Yes ☐ No

2. How often do <u>you</u> engage in religious activities or events?

_____ per Week _____ per Month ☐ Do not attend ☐ No Response

Approved by UH IRB for Time 3 – 06/15/2018

FORM 23-03 – Time 3	Children's Healthy Living Center of Excellence Culture	For Office Use Only Child's ID: ___ ___ ___ ___ ___ ___ ___ Date: ____/___/____ MM DD YEAR Checked by: _____

Below are questions about your attitude and beliefs on **your group's** culture and lifestyle. Please read each question carefully and circle the response that best describes you.

Your Group's Heritage and Lifestyle

1) How knowledgeable are you of **your group's** traditional culture and lifestyle?	Very Knowledgeable	Somewhat knowledgeable	Neutral or no response	Somewhat not knowledgeable	Not at all knowledgeable
2) How involved are you in **your group's** traditional culture and lifestyle?	Very involved	Somewhat involved	Neutral or no response	Somewhat not involved	Not at all involved
3) How do you feel toward **your group's** traditional culture and lifestyle?	Very positive	Somewhat positive	Neutral or no response	Somewhat negative	Very Negative
4) How often do you associate with people of **your group's** traditional culture and lifestyle?	Most of the time	Somewhat often	Neutral or no response	Very little of the time	Not at all

Below are questions about your attitude and beliefs on **U.S. Mainland / Lower 48** culture and lifestyle. Please read each question carefully and circle the response that best describes you.

U.S. Mainland / Lower 48 Heritage and Lifestyle

1) How knowledgeable are you of **U.S. Mainland / Lower 48** culture and lifestyle?	Very Knowledgeable	Somewhat knowledgeable	Neutral or no response	Somewhat not knowledgeable	Not at all knowledgeable
2) How involved are you in **U.S. Mainland / Lower 48** culture and lifestyle?	Very involved	Somewhat involved	Neutral or no response	Somewhat not involved	Not at all involved
3) How do you feel toward the **U.S. Mainland / Lower 48** culture and lifestyle?	Very positive	Somewhat positive	Neutral or no response	Somewhat negative	Very Negative
4) How often do you associate with people of **U.S. Mainland / Lower 48** culture and lifestyle?	Most of the time	Somewhat often	Neutral or no response	Very little of the time	Not at all

FORM 23-04 – Time 3	Children's Healthy Living Center of Excellence Lifestyle Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ____/__ __/20__ MM DD YEAR Checked by: _____

Please complete the following questions about your child.

Monday to Friday

1. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend watching television and/or videos/DVD? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend playing **INACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.)? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. On usual weekdays (**Monday to Friday**), how long on average a day does your child spend playing **ACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.) that incorporate movement or exercise? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Saturday to Sunday

4. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend watching television and/or videos/DVD? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend playing **INACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.)? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. On a usual weekend day (**Saturday to Sunday**), how long on average a day does your child spend playing **ACTIVE** video games (DS, Play station, XBOX, Wii, computer games, etc.) that incorporate movement or exercise? (Please choose one ☑; h = hours)

0h	0.5h	1h	1.5h	2h	2.5h	3h	3.5h	4h	4.5h	5h	5.5h	6h	6.5h	7h+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reference: Buckworth, J. & Nigg, C., (2004). Physical activity, exercise, and sedentary behavior in college students. *Journal of American College Health, 53,* 28-34.

Approved by UH IRB for Time 3 - 06/15/2018

FORM 23-05 – Time 3	Children's Healthy Living Center of Excellence Sleep Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ___/___/20__ MM DD YEAR Checked by: _____

Please complete the questions below in regard to your child's sleep behavior.

1.	**How long after going to bed does your child usually fall asleep?**
☐	0 to less than 15 minutes
☐	15 to less than 30 minutes
☐	30 to less than 45 minutes
☐	45 to less than 60 minutes
☐	More than 60 minutes
2.	**Your child goes to bed reluctantly, (hesitant, slowly, involuntary)…**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
3.	**The child has difficulty getting to sleep at night (and may require a parent to be present)**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
4.	**The child does not fall asleep in his or her own bed**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

FORM 23-05 – Time 3	Children's Healthy Living Center of Excellence Sleep Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ___/___/20__ MM DD YEAR Checked by: _____

5.	**The child wakes up two or more times in the night**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
6.	**After waking up in the night the child has difficulty falling asleep again by himself or herself**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
7.	**The child sleeps in the parent's bed at some time during the night**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night
8.	**If the child wakes, he or she uses a comforter (e.g. pacifier, binky or blanket) and requires a parent to replace it**
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

FORM 23-05 – Time 3	Children's Healthy Living Center of Excellence Sleep Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ___/___/20__ MM DD YEAR Checked by: _____

9. The child wants a drink during the night (including breast or bottle-feed)	
☐	The sleep behavior never occurs
☐	The behavior occurs once or twice a month
☐	Occurs one or two times a week
☐	Occurs between three and five nights a week
☐	The sleep behavior happens every night

10. Do you think your child has sleeping difficulties?

☐ Yes ☐ No

Please explain:

Questions above were modified from the Tayside Children's Sleep Questionnaire (McGreavy, Donnan, Pagliari, & Sullivan (2005).*Child: Care, Health & Development* 31(5); 539–544).

FORM 59-01 – Time 3	**Children's Healthy Living Center of Excellence Anthropometric Measurements**	**For Office Use Only**
		Child's ID: __ __ __ __ __ __ __
		Date: ____/____/____ MM DD YEAR
		Measured by: _____
		Checked by: _____

Instructions:
Record all measurements using a black/blue pen.
Each measurement must be taken 3 times for each child.
Two of the 3 measures must be within 0.2 units. If two of the three measures are not within 0.2 units or the measurement team is uncertain about any of the three measurements, take an additional measure and write the result in the comments section below the initial three measures.
Continue to take additional measures until there are two within 0.2 units and the measurement team is satisfied with the quality of the measures.

Measurement:	**1st Reading:**	**2nd Reading:**	**3rd Reading:**
Weight Scale # _____	☐☐☐.☐ kg	☐☐☐.☐ kg	☐☐☐.☐ kg
	Comments: _____	_____	_____
	_____	_____	_____
Height Stadiometer # _____	☐☐☐.☐ cm	☐☐☐.☐ cm	☐☐☐.☐ cm
	Comments: _____	_____	_____
	_____	_____	_____
Waist Circumference Tape # _____	☐☐☐.☐ cm	☐☐☐.☐ cm	☐☐☐.☐ cm
	Comments: _____	_____	_____
	_____	_____	_____

Child Refused: ☐ Weight ☐ Height ☐ Waist

FORM 59-02 – Time 3	Children's Healthy Living Center of Excellence Acanthosis Nigricans Screen	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ____/__ __/20__ MM DD YEAR Measured by: _____ Checked by: _____

Instructions: Rate and circle using a black/blue pen the severity of acanthosis nigricans on the back of the neck using the screening scale below.

Neck Severity Rating:	0	1	2	3	4

Comments: _____

_____

Acanthosis Nigricans Screening Scale

(Burke JP, Hale DE, Hazuda HP, Stern MP. 1999. A quantitative scale of acanthosis nigricans. Diabetes Care 22:1655–1659.)

Neck Severity Rating	Neck Severity	Description
0	Absent	Not detectable on close inspection.
1	Present	Clearly present on close visual inspection, not visible to the casual observer, extent not measurable
2	Mild	Limited to the base of the skull, does not extend to the lateral margins of the neck (usually <3 inches in breadth).
3	Moderate	Extending to the lateral margins of the neck (posterior border of the sternocleidomastoid) (usually 3-6 inches), should not be visible when the participant is viewed from the front.
4	Severe	Extending anteriorly (>6 inches), visible when the participant is viewed from the front.

Approved by UH IRB for Time 3 – 06/15/2018

CE FORM – Time 3	Children's Healthy Living Center of Excellence Community Behavior	For Office Use Only
		Child's ID: ___ ___ ___ ___ ___ ___ ___
		Date: ____/____/20___ MM DD YEAR
		Checked by: _____

For each of the following, please tell me if it is very likely, likely, neither likely or unlikely, unlikely, or very unlikely that people in your neighborhood would act in the following manner.
Just omit any question that is not applicable to your neighborhood.

		Very Likely (5)	Likely (4)	Neither Likely or unlikely (3)	Unlikely (2)	Very Unlikely (1)
1	If some children were spray-painting graffiti on a local building, how likely is it that your neighbors would do something?					
2	If there was a fight in front of your house and someone was being beaten up or threatened, how likely is it that your neighbors would break it up?					
3	If a child was showing disrespect to an adult how likely is it that people in neighborhood would scold the child?					
4	Suppose that because of budget cuts, the fire station closest to your home was going to be closed down by the city. How likely is it that neighborhood residents would organize to try to do something to keep the fire station open?					
5	If a group of neighborhood children were skipping school and hanging out on a street corner, how likely is it that your neighbors would do something about it?					
6	If a well-known neighbor was short of cash to start a business in the area, how likely is that he or she would be able to borrow money from people in the neighborhood?					
7	How likely is that you could choose to move from this neighborhood in the next five years?					

For each of these statements, please tell me whether you strongly agree, agree, neither agree or disagree, disagree, or strongly disagree.

		Strongly agree (5)	Agree (4)	Neither agree or disagree (3)	Disagree (2)	Strongly disagree (1)
8	People around here are willing to help their neighbors					
9	This is a close-knit neighborhood					
10	People in this neighborhood can be trusted					

Continued on Back

Reference: Sampson, Science 1997: 227, 918

Approved by UH IRB for Time 3 05/24/2019

CE FORM – Time 3	Children's Healthy Living Center of Excellence Community Behavior	For Office Use Only Child's ID: __ __ __ __ __ __ __ Date: ____/____/20___ MM DD YEAR Checked by: _____

Please answer the following questions about the survey.

1. Was there anything about this survey that was confusing?

Yes ☐ **No** ☐

If yes, please explain what you found to be confusing (please limit to 100 words or less).

2. Do you have any suggestions to improve this survey?

Yes ☐ **No** ☐

If yes, please list your suggestion(s) (please limit to 100 words or less).

Reference: Sampson, Science 1997: 227, 918

Approved by UH IRB for Time 3 05/24/2019