

Health Survey Cover Sheet

Home ID:	Place Sticker Here	
Surveyor Name:		
Date 1 / Date 2:		
Start Time 1 / Time 2:		
End Time 1 / Time 2:		

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SURVEY SCRIPT:

The first thing we will complete is the health survey. This survey will ask questions about your home and your family and in particular your children. We will ask you about many different kinds of things in your home. Lots of things you may not have in your home and that is ok. Don't worry about your answers to the questions!

As we go through the questions, please feel free to stop me if you need more clarification, explanation or if you need to step away for a second. If at any time you do not feel comfortable and prefer not to answer please let me know.

Section A: Primary Care Provider

I. Inhabitants:

First, I just need to learn a little about your family, so I will understand your answers.

1. How many people live in this house?

2. How many children or teens aged <18 years live here?

3. How many children <6 years live here?

Family is defined as husband/wife/partner, dependents/children)

4. Is there more than one family living here?
 YES → If YES, Go to 5
 NO → *SKIP to Part II: Environmental*

5. How many people live in this house that are part of your immediate family or for whom you are responsible?

6. How many children under the age of 18 live in this house that are part of your immediate family or for whom you are responsible?

II. Environmental

This is the part of the interview in which we will ask you questions about the place where you live.

7. For how long have you been living in this home? _____ Yrs _____ Mo

8. Was your home built before 1978?
 Yes → Remember to do Lead testing
 No → Consider Lead Swab Check
 Don't Know → Remember to do Lead testing
 Refused → Remember to do Lead testing

NOTE: Unless they **definitely know** that their house was built after 1977, lead testing should be performed. If answer is Yes, Don't Know, or Refused, do lead testing. If they say No but it looks older to you, do a lead swab check on window sills or troughs. If positive, do regular lead testing.

9. What is your primary source of drinking water?

- Bottled Water
- City Water
- Personal Well Water
- Purchased Well Water
- Other: _____
- Don't Know
- Refused

If they use more than one, which one is the source of MOST of the water that they drink.

10. Do you currently use any type of water treatment device in you home?

- Yes → *If Yes, Go to 10a*
- No
- Don't Know
- Refused

10a. Which of the following do you now use in your home? (Check all that apply)

- Central water filter system
- Tap water filter
- Refrigerator water filter
- Pitcher water filter
- Other water filter: _____
- Don't Know
- Refused

11. What is the main heating source in your house?

- Forced air (central heating)
- Radiators (steam or hot water)
- Electric space heater
- Electric base board
- Open stove →→→→→→→→→→→→→→→
- Wood burning stove/fireplace →→→→→→→→→→→
- Kerosene (liquid fuel) space heater →→→→→
- Natural Gas Fireplace →→→→→→→→→→→
- Other: _____ →→→→→
- Don't Know
- Refused

11a. Is it vented to the outside?			
Yes	No	DK	R

12. Do you use any other sources of heat in your home?

- Yes → *If Yes, Go to 12a*
- No
- Don't Know
- Refused

12a Which ones?

- Forced air (central heating)
- Radiators (steam or hot water)
- Electric space heater
- Electric base board
- Open stove → → → → → → → →
- Wood burning stove/fireplace → →
- Kerosene space heater → → →
- Natural Gas Fireplace → → → → →
- Other: _____ →
- Don't Know
- Refused

12b. Is it vented to the outside?

Yes	No	DK	R

13. In the past 12 months, did you burn any solid combustible fuel like coal or wood for heating inside your home?

- Yes
- No
- Don't Know
- Refused

14. Is there a working central cooling or air conditioning system in the home?

- Yes → *If Yes, Go to 14a*
- No → *If NO, Go to 17*
- Don't Know
- Refused

14a. Which type?

- Air conditioning (compressor or cooling coil)
- Swamp (Evaporative) Cooler
- Other: _____
- Don't Know
- Refused

15. Do any individual rooms have a working unit cooling system?

- Yes → *If Yes, Go to 15a*
- No
- Don't Know
- Refused

15a. Which rooms have a working unit cooling system?

- Children's Bedrooms
- Other Bedrooms
- Living/Family/Play Room
- Kitchen
- Laundry Room
- Other: _____
- Don't Know
- Refused

15b. What type?
Swamp Air Conditioner

Swamp	Air Conditioner

16. In the last 12 months, have there been any damp patches on the walls or ceilings?

- Yes → *If Yes, Go to 16a*
- No
- Don't Know
- Refused

16a. Which rooms?

- Children's Bedrooms
- Other Bedrooms
- Living/Family/Play Room
- Kitchen
- Laundry Room
- Other: _____
- Don't Know
- Refused

Children's Bedroom is any room where the children sleep for either part of the night 5-7 nights a week or all night at least 3 nights a week. Parents' bedroom could be a children's bedroom with this definition. Also, the child may have more than one room that qualifies as their bedroom.

17. In the last 12 months, has there been mold on any surface in the home?

- Yes → *Go to 17a*
- No
- Don't Know
- Refused

17a. Which rooms?

- Children's Bedrooms
- Other Bedrooms
- Living/Family/Play Room
- Kitchen
- Laundry Room
- Other: _____
- Don't Know
- Refused

III. Cleaning Practices

Now we are going to ask you some questions on how you usually clean your house. We just need to have an idea of how you control things like dust in your home.

18. How do you usually clean the floors in your home? (Check all that apply)

- Vacuum → *Go to 18a*
- Wet mop
- Sweep
- Other: _____
- Don't clean

18a. Does the vacuum have a special filter, such as a HEPA filter, to keep dust in the vacuum? (Prompt as necessary)

- Yes
- No
- Don't Know
- Refused

IV. Pets, Pests & Pesticides

Next we would like to ask you some questions about pets, cockroaches and mice or rats and pesticides.

19. Do you keep any pets?

- Yes → *Go to 19 a & b*
- No
- Don't Know
- Refused

19a. Which ones?

19b. Do they come or stay inside?

	#				
<input type="checkbox"/> Dogs		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/> Cats		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/> Birds		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/> Other furry animals (ferrets, rabbits, guinea pigs)		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/> Other (Describe):		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

20. In the last 12 months, have you seen any types of pests inside your home, such as insects or rodents? Note: Exclude flies, spiders, and mosquitoes. Refers to the CURRENT home only, even if they have lived there less than 12 months.

- Yes → *Go to 20a*
- No
- Don't Know
- Refused

20a. Which ones?

- Cockroaches
- Rats
- Mice
- Ants
- Bed Bugs
- Fleas
- Other: _____
- Don't Know
- Refused

21. Have you used chemicals/sprays inside your home [this house] to control or treat pests?
- Yes
 - No
 - Don't Know
 - Refused
22. While doing farm work or just helping around the house or yard, do your children ever have to use/mix chemicals for plants, crops, or animals?
- Yes
 - No
 - Don't Know
 - Refused
23. While doing farm work or just helping around the house or yard, are your children ever present while people spray chemicals? TM: within 15 – 20 ft close enough to observe
- Yes
 - No
 - Don't Know
 - Refused

V. Tobacco

Now we will be asking a few questions about tobacco.

24. Does anyone smoke inside your home, whether or not the person lives here?
- Yes → *Go to 24 a & b*
 - No
 - Don't Know
 - Refused

24a How many people smoke inside your home?

24b On average, how many cigarettes, cigars, or pipes are smoked inside the house per day?

25. Does anyone living in your home smoke at all, whether inside or outside your home?

- Yes
- No
- Don't Know
- Refused

VI. Lead Exposure

The next set of questions helps us learn about the presence of lead in your home.

26. Are any children living in this house being followed or treated for lead poisoning? TM followed=monitored at clinic – treated=Chelation treatment usually for blood levels >20, elevated levels = 10

- Yes
- No
- Don't Know
- Refused

27. Do you know if anyone that plays with your children is being treated for lead poisoning?

- Yes
- No
- Don't Know
- Refused

28. Do any adults in your home have a job or hobby that involves exposure to lead? Examples include ceramics, carpentry, construction, home remodeling, plumbing, furniture refinishing, and stained glass work.

- Yes → 28a. What is the hobby or occupation? _____
- No
- Don't Know
- Refused

29. Does your family regularly use tableware made of glazed ceramics? Examples include water containers, plates, and pitchers.

- Yes
- No
- Don't Know
- Refused

VII. Supervision

The next few questions ask your opinion about a few topics.

PROMPT: For each question, **if** parent says, “it depends on the child”, say “please think about the typical or average child when you answer.” **If** the parent states that it should be an older or younger age than they actually allowed for their own child, say “please say the age when you actually did let your child ... [cross the street/bicycle on a busy street/take a bath/swim] without an adult present.”

	Age (Yrs)	Never	DK	R
30. How old would a child have to be for you to let him or her cross a busy street by themselves? (Prompt: without an adult present)				
31. How old would a child have to be for you to let him or her bicycle on a busy street without an adult present?				
32. How old would a child have to be for you to let him or her take a bath without an adult being in the room? (Prompt: Another child could be present, but not an adult)				
33. How old would a child have to be for you to let him or her swim without a lifeguard or adult supervision? (Prompt: Another child could be present, but not an adult.)				

VIII. Home Safety and Injury Risks:

A. Smoke Alarms

34. Do you have an installed smoke alarm in your home?

- Yes → 34a. How Many? _____
- No → Skip to 39
- Don't Know
- Refused

35. How are they powered (even if not currently powered)? Examples include batteries or wiring into the home's electrical system.

- All are hard wired → Skip to 38
- All have batteries
- Some are hard wired and some have batteries
- Don't Know
- Refused

36. What type of batteries do they have?

- All have lithium (10-yr) batteries → *Skip to 38*
- All have 9 volt or other alkaline batteries
- Some have lithium (10-yr) batteries and some have other batteries
- No battery currently present
- Don't Know
- Refused

37. Have you or anyone else ever changed the batteries? Note: If they have more than one alarm, code Yes if they have ever changed any of the batteries.

- Yes → *Go to 37a*
- No
- No, because the alarm is less than 12 months old
- Don't Know
- Refused

37a When did you last change the batteries? (TM: If more than one, ask about most recent.)

- Less than a year ago
- About one year ago
- More than one year ago
- Batteries have been removed
- Don't Know
- Refused

38. Since the alarm(s) was/were installed, have you or anyone else ever tested any of the alarm(s) to check that it is (they are) working? TM: Same as 37. above

- Yes → *Go to 38a*
- No
- Don't Know
- Refused

38a How often do you or someone else test the alarm(s)?

- At least once per month
- At least several times per year
- At least once a year
- Less than once a year
- Don't Know
- Refused

B. Carbon Monoxide Alarms

Another type of alarm tests for carbon monoxide. Many people do not have these types of alarms but we just want to check if you do.

39. Do you have an installed carbon monoxide alarm?

- Yes → 39a. How Many? _____
- No → *Skip to 43*
- Don't Know
- Refused

40. Is it/are they plugged into electrical outlets or powered by batteries?

- It is/All are plug-in → *Skip to 42*
- It has/All have batteries
- Some are plug-ins and some have batteries
- Don't Know
- Refused

41. Have you or anyone else ever changed the batteries? Note: If they have more than one alarm, code Yes if they have ever changed any of the batteries.

- Yes → *Go to 41a*
- No
- No, because the alarm is less than 12 months old
- Don't Know
- Refused

41a. When did you last change the batteries? (TM: If more than one, ask about most recent.)

- Less than a year ago
- About one year ago
- More than one year ago
- Batteries have been removed
- Don't Know
- Refused

42. Since the alarm(s) was/were installed, have you or anyone else ever tested [any of] the alarm(s) to check that it is (they are) working? TM: Same as 41. above

- Yes → *Go to 42a*
- No
- Don't Know
- Refused

42a How often do you or someone else test the alarm(s)?

- At least once per month
- At least several times per year
- At least once a year
- Less than once a year
- Don't Know
- Refused

C. Other

43. Do you have a fire extinguisher in the house?

- Yes
- No
- Don't Know
- Refused

44. Do you have a fire blanket in the house?

- Yes
- No
- Don't Know
- Refused

45. Do you light candles in your home (other than during a power outage)?

- Yes
- No
- Don't Know
- Refused

46. Does your family have a fire escape plan for how to get out of the house in case of a fire?

- Yes → *Go to 46 a - d*
- No
- Don't Know
- Refused

46a. How many exits out of each room have you identified?

46b. Where have you arranged for family members to meet outside of the home?

- Nowhere - have not arranged
- Location (specify): _____
- Don't know
- Refused

46c. Have you ever practiced your home fire escape plan?

- Yes → 46d. How often? _____
- No
- Don't Know
- Refused

Section B. Child Condition Survey

This next set of questions is for all children in your home who are part of your immediate family or for whom you are responsible.

I. Children

47. Can you give us the first name of each child under age 18 who is part of your family and lives in this home – your children or other children for whom you are primarily responsible?

	Name	Age	US Born? (Yes/No)	Random Selection
1.				
2.				
3.				
4.				
5.				
6.				

II. Asthma

TM: If family refuses an answer, cross out DK and place an R in the DK box. Parent should answer to the best of their knowledge; there are no right or wrong answers.

48. Have any of your children who live here with you ever had wheezing or whistling in the chest at any time in the past?

- Yes → 48a How many children? _____ → Go to 49
- No → Skip to 54
- Don't Know
- Refused

49. Which children?

50. In the last 12 months, has (Child's name) had wheezing or whistling in the chest?

	Y	N	DK									
IF YES for any child(ren), complete 51-53 for that child/those children only. Otherwise, SKIP to 54 (Next Page)												
51. How many attacks of wheezing has (Child's name) had <u>in the last 12 months</u> ? (total # of attacks) TM: If more than once a month, put >12.												

Go to Next Page →

49.	Which children?												
52.	<u>In the last 12 months</u> , how often, on average, has (Child's name)'s sleep been disturbed due to wheezing? 0=Never; 1=less than one night per week; 2=at least one night per week	0	1	2	0	1	2	0	1	2	0	1	2
53.	<u>In the last 12 months</u> , has wheezing been severe enough to limit (Child's name)'s speech to only 1 or 2 words at a time between breaths?	Y	N	DK									

54. Have any of your children who live here with you ever had asthma?

(Prompt **only** if required: "Just answer what you believe is true.")

- Yes → 54a. How many children? _____ → Go to 55
- No → Skip to 56
- Don't Know
- Refused

55. Which children?

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56. In the last 12 months, have any of your children who live here with you had a chest that sounded wheezy during or after exercise?

- Yes → 56a. How many children? _____ → Go to 57
- No → Skip to 58
- Don't Know
- Refused

57. Which children?

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58. In the last 12 months, have any of your children who live here with you had a dry cough at night, apart from a cough associated with a cold or chest infection?

- Yes → 58a. How many children? _____ → Go to 59
- No → Skip to III. Allergic Rhinitis/Hay Fever
- Don't Know
- Refused

59. Which children?

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II. Allergic Rhinitis/Hay Fever

TM: If family refuses an answer, cross out DK and place an R in the DK box. Parent should answer to the best of their knowledge; there are no right or wrong answers.

60. Have any of your children who live here with you ever had a problem with sneezing, or a runny, or a blocked nose when he/she DID NOT have a cold or the flu?

- Yes → 60a. How many children? _____ → Go to 61
- No → Skip to 66
- Don't Know
- Refused

61. Which children?												
62. <u>In the past 12 months</u> , has (Child's name) had a problem with sneezing, or a runny, or a blocked nose when he/she DID NOT have a cold or the flu?	Y	N	DK									
IF YES for any child(ren), complete 63-65 for that child/those children only. Otherwise, SKIP to 66												
63. <u>In the past 12 months</u> , has this nose problem been accompanied by itchy-watery eyes?	Y	N	DK									
64. In which of the <u>past 12 months</u> did this nose problem occur? (Circle which months)	Ja	Fe	Mr									
	Ap	Ma	Jn									
	Jl	Au	Se									
	Oc	No	De									
65. <u>In the past 12 months</u> , how much did this nose problem interfere with your child's daily activities? 0 = not at all, 1 = a little, 2 = a moderate amount, 3 = a lot (TM: Daily activities = play, eating, sleep, school, etc.)	0	1	2	3	0	1	2	3	0	1	2	3

66. Have any of your children who live here with you ever had hay fever?

(Prompt **only** if required: “Just answer what you believe is true.”)

- Yes → 66a. How many children? _____ → Go to 67
- No → Skip to **IV. Eczema**
- Don't Know
- Refused

67. Which children?

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IV. Eczema

TM: If family refuses an answer, cross out DK and place an R in the DK box. Parent should answer to the best of their knowledge; there are no right or wrong answers.

68. Have any of your children who live here with you ever had an itchy rash which was coming and going for at least 6 months?

- Yes → 68a How many children? _____ → Go to 69
- No → Skip to 75
- Don't Know
- Refused

69. Which children?

70. In the past 12 months, has (Child's name) had this itchy rash at any time?

IF YES, complete 71-74 for that child/those children only. Otherwise, SKIP to 75.

71. Has this itchy rash at any time affected any of the following places: folds of the elbows, behind the knees, in front of ankles, under the buttocks, or around the neck, ears or eyes?

72. At what age did this itchy rash first appear? (Specify age in years)

	Y	N	DK									

69.	Which children?												
73.	Has this rash cleared completely at any time during the last 12 months?	Y	N	DK									
74.	In the last 12 months, how often, on average, has (Child's name) been kept awake at night by this itchy rash? 0=Never; 1=less than one night per week; 2=at least one night per week	0	1	2	0	1	2	0	1	2	0	1	2

75. Have any of your children who live here with you ever had eczema?
 (Prompt **only** if required: "Just answer what you believe is true.")
- Yes → 75a. How many children? _____ → Go to 76
 - No → Skip to **V. Injuries**
 - Don't Know
 - Refused

76. Which children?

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V. Injuries

Now we are going to ask you a few questions about any injuries that have happened to your children within the past three months. We will ask about poisonings separately, so don't count those as injuries.

77. During the past 3 months, that is (*Calculate and state date that is 91 days before today's date*), were any of your children injured seriously enough that he or she got medical advice or treatment, missed school, or remained in bed for at least a half a day because of an injury?
 TM: Define medical advice- any professional to whom they go to receive care for which they have to pay. Includes curanderos (folk medicine)

- Yes → 77a. How Many? _____ → Go to 78
- No → Skip to **VI. Poisonings**
- Don't Know
- Refused

78.	Which children?			
-----	-----------------	--	--	--

79. For each injured child, think about the most recent injury that they had in the past 3 months. In what type of activity was (Child's Name) taking part (or what was (Child's Name) doing) when the injury happened?

A	Formal, organized sports or athletics (e.g., team sports, ski or tennis lessons)			
B	Riding a bicycle			
C	Other informal, specific recreational activity (e.g., snowboarding, pick-up basketball, skateboarding) (TM: Not organized)			
	Specify			
D	Just playing (not organized or specific)			
E	Walking (e.g., to or from school, between rooms at home or elsewhere)			
F	Other			
	Specify			
G	Don't Know			
H	Refused			

80. How did the injury happen?

A	Ran into or was struck by an object (like a ball or wall)				
B	Another person accidentally struck or ran into him/her				
C	Fell from playground equipment				
D	Fell for other reasons (e.g., tripping, stumbling, fall from height)				
E	Overexertion, for example from excessive force, lifting or pulling (causes sprains, strains, twisted ankles)				
F	Bite or sting from animal or insect (not human)				
G	Cut or puncture from a sharp object (e.g., knife, pin, nail, scissors)				
H	Bicycle crash (collision, loss of control, etc.)				
I	Other				
	Specify:				
J	Don't Know				
K	Refused				

81. Where did this injury happen?

Read only if necessary

A	Your home (includes inside the home as well as yard/driveway)				
B	Other home (includes inside the home as well as yard/driveway)				
C	School or child care center (includes inside or on the school grounds)				
D	Public street or highway				
E	Indoor or outdoor recreation area (not a school)				
F	Retail, commercial or public building (malls, stores, shops, movie theatres)				
G	Other				
	Specify				
H	Don't Know				
I	Refused				

82. In what way was [child's name] hurt?

Read only if necessary					
A	Broken bone or fracture				
B	Sprain, strain, or twist				
C	Cut				
D	Scrape or bruise				
E	Burn				
F	Animal bite				
G	Other				
	Specify				
H	Don't Know				
I	Refused				

83. As a result of the injury, which one of the following occurred?

Child's Name					
Please Read:					
A	Child missed school or stayed in bed for at least half a day, but did not seek medical advice or treatment				
B	Child went to a physician or clinic				
C	Child went to another health provider, such as a curandero				
D	Child went to an emergency room, but was not admitted to the hospital				
E	Child stayed in hospital at least overnight				
F	Other				
	Specify				
G	Don't Know				
H	Refused				

VI. Poisonings

The next questions are about poisoning, that is, swallowing or breathing in a harmful substance such as bleach, carbon monoxide, plants, or too many pills or drugs. Do not include food poisoning, poison ivy, or sun poisoning.

84. During the past three months, that is since {91 days before today's date}, was any of your children poisoned seriously enough that (he/she) got medical advice or treatment, missed school, or remained in bed for at least half a day because of the poisoning

- Yes → 84a How Many? _____ → Go to 85
- No → Go to Section C.
- Don't Know
- Refused

85. Which Children?

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86. For each child, think about the most recent poisoning that they had in the past 3 months. What kind of poison was it?

Read only if necessary

A	Medicines (pills or liquid)			
B	Cleaning products (for example, bleach, detergent)			
C	Pesticides/bug spray			
D	Paint, solvents, glue (for example, stain, varnish, thinner, stripper)			
E	Auto product (E.g. degreaser, antifreeze)			
F	Carbon monoxide			
G	Other			
	Specify			
H	Don't Know			
I	Refused			

87. Where did this poisoning happen?

Read only if necessary

A	Your home (includes inside the home as well as yard/driveway)				
B	Other home (includes inside the home as well as yard/driveway)				
C	School or child care center (includes inside or on the school grounds)				
D	Public street or highway				
E	Indoor or outdoor recreation area (not a school)				
F	Retail, commercial or public building (malls, stores, shops, movie theatres)				
G	Other				
	Specify				
H	Don't Know				
I	Refused				

88. As a result of the poisoning, which one of the following occurred?

Please Read:

Child's Name					
A	Child missed school or stayed in bed for at least half a day, but did not seek medical advice or treatment				
B	Child went to a physician or clinic				
C	Child went to another health provider, such as a curandero				
D	Child went to an emergency room, but was not admitted to the hospital				
E	Child stayed in hospital at least overnight				
F	Other				
	Specify				
G	Don't Know				
H	Refused				

Section C. Randomly Selected Child Survey

All of the following questions will only be about your child named _____. We picked the name of this child randomly, by throwing the dice. Not all the questions may apply to the child whose name we picked.

I. Transportation Safety

89. During the past 30 days, how often did (child's name) use a child safety seat, booster seat or seat belt when riding in a car, van, sports utility vehicle, or truck?

Would you say:

Please Read:

- Always
- Nearly always
- Sometimes
- Seldom
- Never

Do NOT Read:

- Does not ride in car
- Don't Know
- Refused

90. What is the primary mode of restraint used by (child's name) when riding in a car, van, sports utility vehicle, or truck?

Please read:

- Lap belt only
- Shoulder and lap belt only
- Car seat – Forward facing
- Car seat – Rear facing
- Booster seat used with car's lap or shoulder belt
- Something else (specify)

Do NOT Read:

- Does not ride in car
- Don't Know / Not sure
- Refused

91. In a typical week, how much time does (child's name) spend riding a bicycle? (age 3 or older)

_____ Minutes

_____ Hours

Do NOT Read:

- Doesn't have a bicycle → **Skip to 93**
- Don't Know / Not sure
- Refused

Go to Next Page →

Child under 3 → **Skip to 93**

92. How often does (child's name) wear a helmet when riding (his/her) bicycle? (If age under 3 or does not have a bicycle, SKIP to 93)

Would you say:

Please Read:

- Always
- Nearly always
- Sometimes
- Seldom
- Never

Do NOT Read:

- Don't Know / Not sure
- Refused

II. Nutrition

93. How often does (child's name) drink soda pop, Kool-Aid or sports drinks?

- _____ Servings Per day
- _____ Servings Per week
- _____ Servings Per month
- _____ Servings Per year

Do NOT Read:

- Never
- Don't Know / Not sure
- Refused

94. How often does (child's name) eat fast food? Note: Include taquerias

- _____ Per day
- _____ Per week
- _____ Per month
- _____ Per year

Do NOT Read:

- Never
- Don't Know / Not sure
- Refused

95. How many times does your household eat a meal together in a typical week?

- _____ Number of times per week

Do NOT Read:

- None
- Don't Know / Not sure
- Refused

III. Physical Activity

96. On a typical day, how many hours does (child's name) spend watching TV, DVDs or videos? (TM: Round up)

- _____ Number of hours

Do NOT Read:

- None
- Don't Know / Not sure
- Refused

97. On a typical day, how many hours does (child's name) spend playing video games, computer games or using the Internet? TM: Round up (Age 1 and older only)
- ____ Number of hours
- Do NOT Read:
- None
 - Don't Know / Not sure
 - Refused
 - Child Under 1
98. IN a typical week, how many hours does (child's name) spend playing sports or doing some other physical activity like dance, roller-skating, or bicycling? (Age 1 and older only)
- ____ Number of hours
- Do NOT Read:
- None
 - Don't Know / Not sure
 - Refused
 - Child Under 1
99. In a typical week, how many days does(child's name) bicycle to or from school? (Ages 5 and older only)
- ____ Number of days
- Do NOT Read:
- None
 - Don't Know / Not sure
 - Refused
 - Child Under 5
100. In a typical week, how many days does(child's name) walk to or from school? (Ages 5 and older only)
- ____ Number of days
- Do NOT Read:
- None
 - Don't Know / Not sure
 - Refused
 - Child Under 5

IV. Health Care Coverage

101. Does (child's name) have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicaid?
Prompt: Exclude discount health plans

Please Read:

- Yes
 No

Do NOT Read:

- Don't Know / Not sure
 Refused

102. During the past 12 months, was there any time when (he/she) was not covered by ANY health insurance?

Please Read:

- Yes
 No

Do NOT Read:

- Don't Know / Not sure
 Refused

103. Does (child's name) have any kind of discounted health care plan other than a health insurance, prepaid, or government plan?

Please Read:

- Yes
 No

Do NOT Read:

- Don't Know / Not sure
 Refused

104. A personal doctor or nurse is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have one or more persons you think of as (child's name)'s personal doctor or nurse? Interviewer note: Do not include: acupuncture, chiropractor, homeopath, naturopath, etc.

Please Read:

- Yes
 No

Do NOT Read:

- Don't Know / Not sure
 Refused

105. During the past 12 months, did (child's name) receive all the medical care (he/she) needed?

Please Read:

- Yes → Go to 107
 No → Go to 106

Do NOT Read:

- Don't Know / Not sure
 Refused

106. Why did (child's name) not get all the medical care that he/she needed? (Mark all that apply. After each response, ask if there are any other reasons.)

Please Read only if Necessary:

- Cost too much
- No insurance
- Health plan problem
- Can't find doctor who accepts child's insurance
- Not available in area/transportation problems
- No convenient times/could not get appointment
- Other: _____

Do NOT Read:

- Don't Know / Not sure
- Refused

Section D: Community and Home

The next set of questions will help us understand more about the community where you live and how that might contribute to your safety and well-being.

Please answer the following questions thinking about your street. How much of each of these is present in your street? TM: What ever the respondent defines as their street. Use SHOW CARDS for answers.		None At All	A Little	Some	A Great Deal	All
107.	Burnt out/boarded-up properties					
108.	Vandalism/graffiti on houses					
109.	Vandalism/graffiti on public property (for example, street signs, light posts, mailboxes, telephone poles, or public buildings if any)					
110.	Disused/abandoned cars					
111.	Well looked after properties					
112.	Derelict land					
113.	Stray dogs roaming or tied up in front yards					
114.	Illegally parked cars					
115.	Obviously vacant properties					
116.	Dog litter					
117.	General litter					
118.	Poor sidewalk condition					
119.	Cars parked on both sides of the street					
120.	Cars parked mainly off the street (on driveways or in parking lots)					
121.	Busy traffic					
122.	Difficult to cross the street (e.g. because of traffic)					
123.	People passing/chatting on the street					
Please answer the following questions thinking about your neighborhood . How much of each of these is present in your neighborhood ? TM: What ever the respondent defines as their neighborhood.		None At All	A Little	Some	A Great Deal	All
124.	Neighborhood watch signs					
125.	Recreational space					

Section E: Demographics

We would like to be sure we have information about all the different types of immigrant families who live in Commerce City. The following questions will help us find out if we have achieved this. We will use this only for statistical purposes.

126. Age:
- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 18-19 | 20-24 | 24-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
| <input type="checkbox"/> |

127. Gender



128. In what country were you born?

- Mexico
- Guatemala
- El Salvador
- United States
- Other: _____

129. What educational level have you completed?

- Elementary or Middle School
- High School
- Vocational/ Technical School
- Some university/college courses
- Bachelor's Degree
- Graduate Degree
- Other:

130. What type of job outside of the home, if any, does the children's father work in?

131. What type of job outside of the home, if any does the children's mother work in?

132. Do you own or rent this home?

- Rent
- Own

The next question is about the income from all sources for this household. We can ask it for yearly, monthly or weekly income. Which do you prefer? (NOTE: write answer into blank space for question #133 and ask ranges for that column below)

133. Is the _____ income from all sources for this household...?

If the respondent refuses at ANY income level, code '99 Refused'

	Yearly	Monthly	Weekly
<input type="checkbox"/>	Less than \$10,000	Less than \$833	Less than \$192
<input type="checkbox"/>	10,000 to less than 15,000	833 to less than 1250	192 to less than 288
<input type="checkbox"/>	15,000 to less than 20,000	1250 to less than 1666	288 to less than 384
<input type="checkbox"/>	20,000 to less than 25,000	1666 to less than 2083	384 to less than 480
<input type="checkbox"/>	25,000 to less than 35,000	2083 to less than 2917	480 to less than 673
<input type="checkbox"/>	35,000 to less than 50,000	2917 to less than 4167	673 to less than 961
<input type="checkbox"/>	50,000 to less than 75,000	4167 to less than 6250	961 to less than 1442
<input type="checkbox"/>	75,000 or more	6250 or more	1442 or more

We're all done with the health survey. If you want, we can take a 5 minute break, then move on to the home inspection. (NOTE: If they don't want a break, continue with inspection.)

Inspection Survey Cover Sheet

Home ID:	Place Sticker Here	
Surveyor Name:		
Date 1 / Date 2:		
Start Time 1 / Time 2:		
End Time 1 / Time 2:		

Inspection Script:

Before we start looking at your home and doing testing, we just need to ask a few questions that will help guide us when we are looking at your home to make sure your home is safe for you and your children.

NOTE: The answers to these questions should be marked here, and then the responses should be transferred to the boxes on the inspection form before beginning the inspection.

134 Can you please tell us, what are all the rooms or places in the house or elsewhere on your property where you keep flammable liquids like gasoline, kerosene, and turpentine? (Check all that apply)

- a Kitchen
- b Bathroom
- c Bedroom
- d Closet
- e laundry room
- f garage or shed
- g other: _____
- h Not Applicable/ Does not have

135 What are all the rooms or places in the house or elsewhere on your property where you keep chemicals that you use in the yard or for the car (like weed killer, fertilizer, wasp spray, brake fluid, antifreeze)? (Check all that apply)

- a Kitchen
- b Bathroom
- c Bedroom
- d Closet
- e laundry room
- f garage or shed
- g other: _____
- h Not Applicable/ Does not have

If no children aged under 5 years: Now we will begin looking at your house. (SKIP TO Page 5. I. External Environment)

If children under 5 present, go to next section.

Homes with children < 5 years old:

Now we just have a few final questions that will help us when we are looking at your home to make sure your home is safe for your young children.

NOTE: The answers to these questions should be marked here, and then the responses should be transferred to the boxes on the inspection form before beginning the inspection.

136. **Can please you tell us, what are all the rooms or places in the house or elsewhere on your property where you keep medicines, including drugs, aspirin, vitamins, etc.? (Check all that apply)**

- a Kitchen
- b Bathroom
- c Bedroom
- f garage or shed
- d Closet
- e other: _____
- f. Not applicable / Does not have

137 **What are all the rooms or places in the house or elsewhere on your property where you keep matches or lighters? (Check all that apply)**

- a Kitchen
- b Bathroom
- c Bedroom
- f garage or shed
- d Closet
- e other: _____
- f Not applicable / Does not have

138 **What are all the rooms or places in the house or on your property where you keep knives, scissors, tools, razors, or other sharp objects? (Check all that apply)**

- a Kitchen
- b Bathroom
- c Bedroom
- f garage or shed
- d Closet
- e other: _____
- f Not applicable / Does not have

139 **What are all the rooms or places in the house or elsewhere on your property where you keep pesticides, insect sprays, rat poison, or other poisons to kill pests? (Check all that apply)**

- a kitchen
- b bathroom
- c bedroom
- f garage or shed
- d closet
- e other: _____
- f Not applicable / Does not have

140 **What are all the rooms or places in the house or elsewhere on your property where you keep chemicals for inside use, such as cleaning spray or powder, bleach, paint, or solvents? (Check all that apply)**

- a kitchen
- b bathroom
- c bedroom
- f garage or shed
- d closet
- e other: _____
- f Not applicable / Does not have

That is all the questions. Now we will begin looking at your house.

I. External Environment

A. HOME EXTERIOR

1. Road category on which the property is situated?

- Major arterial (double yellow line, four lanes)
- Primary or Secondary arterial (double yellow line, 2 lanes)
- Collector Road (single yellow or dashed yellow)
- Local Traffic street or Lesser (dashed white line or nothing)

Housing Type? (TM: Count conversions as what they are converted into)

2. Single Family Detached (designed for one family)
- Duplex or Two Family (designed for two families – e.g., separate entrance, address)
- Row House or Townhouse
- Low Rise Apartment: Multiple units, 4 or fewer stories
- High Rise Apartment: Multiple units, 5 or more stories
- Manufactured Home
- Trailer/ Mobile Home
- Quonset Home
- Other: _____

Exterior Doors	Yes	No	N/A	Description / Comments	AS
3. Front Door: interior key deadbolt present					9
4. Rear Door: interior key deadbolt present					9
5. Other Exterior Door: interior key deadbolt present					9
6. Other Exterior Door: interior key deadbolt present					9
7. Other Exterior Door: interior key deadbolt present					9

NOTE: For multi-family apartment buildings, count main door into enrolled family’s own apartment as Front Door and rear door from their own apartment as Rear Door. A door onto the balcony may be counted as the Rear Door if no other Rear Door exists, otherwise as Other Exterior Door. Doors into the apartment BUILDING should be marked as ADDITIONAL exterior doors (describe in Description/Comments, e.g., building front door). If the home has a barred, screened door that has an interior key deadbolt, count this as “YES” for the exterior door even if the exterior door itself does not.

Internal Environment

A ROOM IS: Any space separated by walls, halls or multiple stairs. Count each room only once, in the order shown. Add comment below if any room has multiple uses.

Summary of ROOMS or Habitable Space

8.	How many of each? Note: Ask at start to aid in deciding which hazards to assess in each room.	Total #
	Bedrooms (all places where people regularly sleep)	
	Kitchen(s)	
	Bathroom(s)	
	Living, family, play, or dining rooms; offices, studies, dens	

Comments:

9. What levels are included in your home/housing unit/living space? (Circle all that apply; note number if above 5th floor)

Level B (-1) G (1) 2 3 4 5 #

10. If **BASEMENT**, is it used as a living, play or sleeping space?

- Yes
- No
- Don't Know
- No Basement

11. If **ATTIC**, is it used as a living, play or sleeping space?

- Yes
- No
- Don't Know
- No Attic

For ALL Rooms – Observable Items

I. Exterior Windows

For each room, hall, and stairway, count number of exterior windows and total number open now. Leave blank if none. Total should reflect all windows in the home that open to exterior air.

Tot

12. Window(s) present

11a. Window(s) open now

II. Exhaust Fans* and Room Air Conditioner/Cooling Units

Place check mark for each exhaust fan, A/C unit or room swamp cooler unit seen and whether it is operating now. Total reflects all exhaust fans, A/C units, and swamp cooler units in home.

Tot

13. Exterior exhaust fan present

13a. Exhaust fan on now

14. Room A/C unit present

14a. Room A/C unit on now

15. Room swamp cooling unit present

15a. Room swamp cooling unit on now

*TM: Include only exhaust fans that vent to the exterior of the house, such as those usually found in the kitchen or bathroom. Do not include any other fans, such as window, area, or ceiling fans.

III. Floor Covering

Place check mark for each room that has the specified covering or no covering. Include bathrooms and kitchens.

Tot

16. Room with wall-to-wall carpet

17. Hall or stairway with wall-to-wall carpet

18. Room with area rug(s) only

19. Hall or stairway with area rug(s) only

20. Room without any carpet or area rug

IV. Upholstered furniture and mattresses

In each room, hall, and stairway, count total number of each item seen. Leave blank if none. Total should reflect all items in home.

Tot

21. Upholstered furniture

22. Mattress

TM: Upholstered furniture includes stuffing, springs, and/or cushion material and covering fabric **as part of** the furniture. Do not include throw pillows, detachable seat cushions (e.g., chair cushions that are tied on), etc., that are added by the family. Do not include furniture upholstered with leather, vinyl, fake leather, plastic, or other similar 'wipe-able' coverings.

FOR ALL ROOMS: For each hazard listed, check **YES** if you see it at least once in any room. Some questions require quantification (see RA Manual). UTD=Unable to determine at this time.

Doors and Windows	Y	N	U T D	N A	Description / Comments			AS			
23. Any security bars on doors and windows without quick-release mechanism								9			
24. Any inhabited room without at least two escape routes (doors/windows)								9			
25. Any inhabited room where either escape route is blocked by furniture or clutter								9			
26. Any bedroom without at least one exterior door or egress window (≥ 5 sq. ft; ≥ 20" wide, ≥ 24" high, and ≤ 44" above the floor)								9			
27. Any L>1 bedroom without fire escape ladder								9			
28. Any unsafe L>1 windows (lack guards OR stops with ≤ 4" opening and emergency release OR ledge ≥5 feet above floor)								9			
29. Any furniture in front of L>1 windows								9			
Entire Room											
30. Any holes in walls, ceilings, floors					Min	Mod	Max	5			
31. Any chipped or peeling paint					Min	Mod	Max	5			
32. Any damp areas or leaky pipes					Min	Mod	Max	3			
33. Any water stains or discolored areas					Min	Mod	Max	3			
34. Any visible dust					Min	Mod	Max	1,2			
35. Any visible mold					Min	Mod	Max	3			
36. Any overloaded electrical outlets, extension cords or power strips								9			
37. Any electrical cords with visible wires or frayed								9			
38. Any carpeting, stuffed toys, or fleecy materials in bedrooms								1,2			
39. Any flammable liquids (e.g., turpentine, kerosene, gasoline) present					K	BA	BR	GR	CL	O	7
40. Any chemicals for outside use present (e.g., fertilizer, weed killer, automotive fluids)					K	BA	BR	GR	CL	O	7,8
41. Any hazardous products stored in containers other than original containers											7
42. Any medicines in unlocked storage					K	BA	BR	GR	CL	O	9
43. Any medications without childproof caps					K	BA	BR	GR	CL	O	9
44. Any matches or lighters in unlocked storage					K	BA	BR	GR	CL	O	9
45. Any knives and other sharp objects in unlocked storage					K	BA	BR	GR	CL	O	9
46. Any pesticides, insect spray in unlocked storage					K	BA	BR	GR	CL	O	8
47. Any other poisons (e.g., cleaning products, automotive products, paint, bleach, solvents) in unlocked storage					K	BA	BR	GR	CL	O	7

*K=kitchen; BA=bathroom; BR=Bedroom; GR=Garage; CL=Closet; O=Other

Floor							
48. Trip/slip hazards present (cords, wires, loose flooring, loose rugs without non-skid backs)							9
Pest / Smoke (Evidence of)							
49. Cigarette butts, ashtrays with ashes				Min	Mod	Max	1,2
50. Cockroaches (eggs, feces, insects, traps)				Min	Mod	Max	1,2
51. Rodents (or mice droppings or traps)				Min	Mod	Max	1,2
52. Other pests. Specify:				Min	Mod	Max	1,2
Odors Present							
53. Tobacco				Min	Mod	Max	1,2
54. Mold / Musty				Min	Mod	Max	3
55. Burning candles or incense				Min	Mod	Max	1,2
56. Other: _____				Min	Mod	Max	1,2
Balcony							
57. Any balcony more than 30" above grade/floor below? If YES:							
57a. Any guard rails <3 feet high							9
57b. Any openings in railings > 4 " wide							9
58. Any chipped or peeling paint on balcony				Min	Mod	Max	5
Stairs							
59. Any steps with 4 or more risers between landings. If yes,							9
59a. Any without secure banister or handrail on at least one side extending length of stairs							9
59b. Any without working lighting							9
59c. Any obstructed by clutter or objects							9
59d. Any without stair gate at top & bottom							9

INSTALLED SMOKE ALARMS (Ch 9)

None

60. #1 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1 (G)	2	-1 (B)	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

61. #2 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

62. #3 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

63. #4 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

64. #5 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

INSTALLED SMOKE ALARMS (Ch 9) CONTINUED

65. #6 Alarm							<input type="checkbox"/> None	
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

66. #7 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

67. #8 Alarm								
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
Smoke alarm correctly installed								
Smoke Test Positive								
IF No: Repeat Smoke Test Positive after replace battery								

INSTALLED CARBON MONOXIDE ALARMS (Ch 4)

68. #1 CO Alarm								<input type="checkbox"/> None
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
CO alarm correctly installed								
Button test positive								
IF No: Repeat Button Test + after replace battery/change outlet								

69. #2 CO Alarm								<input type="checkbox"/> None
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
CO alarm correctly installed								
Button test positive								
IF No: Repeat Button test + after replace battery/change outlet								

70. #3 CO Alarm								<input type="checkbox"/> None
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
CO alarm correctly installed								
Button test positive								
IF No: Repeat Button test + after replace battery/change outlet								

71. #4 CO Alarm								<input type="checkbox"/> None
Room (circle)	Hall	Stairs	Bedroom	Living	Kitchen	Other: _____		
Level (circle)	1	2	-1	3	4	5	6	
					Yes	No	N/A	Comments
CO alarm correctly installed								
Button test positive								
IF No: Repeat Button test + after replace battery/change outlet								

KITCHEN(S)	Y	N	U T D	N A	Description / Comments	AS
72. Any gas stove present						1,4
73. Any stove without an exhaust fan						1,4
74. Any exhaust fan present that vents indoors						1,4
75. Any exhaust fan present that is not working						1,4
76. Any blackened areas around stove						9
77. Any combustibles (dishtowels, bags, curtains, papers) within 3 feet of any range top						9
78. Any electrical outlets within 3 ft of faucets (above counter level) lacking ground fault circuit interrupter (GFCI)*						9
79. Hot water temperature >120 degrees					Actual Temp: _____	9
80. Any stove burners or knobs without guards						9
81. Any cords or kitchen appliances within reach						9

*TM: If house built in last 10 years, the GFCI for these outlets might be located elsewhere in house (e.g., basement, garage), so they look like normal outlets but actually do have GFCI. For new homes, if the outlets look like **normal** outlets (i.e., without the test and reset buttons), need to ask respondent if they are GFCI. If respondent doesn't know, leave blank and note why in comments section.

BATHROOM(S)	Y	N	U T D	N A	Description / Comments	AS
82. Any bathroom without either a window that opens or a working exhaust fan						1,3
IF YES, does this bathroom have visible mold?						3
83. Any tub/shower without slip mat or safety strips/decals or other non-slip surface on tub bottom/shower floor						9
84. Any loose bath rug or mat without non-skid bottom						9
85. Any electrical outlets within 3 ft of faucets without GFCI*						9
86. Any small electrical appliances plugged in						9
87. Any cords or electrical appliances within reach						9

*TM: If house built in last 10 years, the GFCI for these outlets might be located elsewhere in house (e.g., basement, garage), so they look like normal outlets but actually do have GFCI. For new homes, if the outlets look like **normal** outlets (i.e., without the test and reset buttons), need to ask respondent if they are GFCI. If respondent doesn't know, leave blank and note why in comments section.

B. BACK/SIDE YARD

		Yes	No
88.	Is there a back or side yard?	Go on	skip to next section

		Y	N	U T D	NA	Comments	AS
89.	Any porch* or deck more than 30" above grade? If yes:						
	a. Any guard rails < 3 feet high						9
	b. Any openings in railings and open risers > 4"?						9
90.	Any steps with 4 or more risers between landings. If YES,						
	a. Lacks secure banister or handrail on at least one side extending length of stairs						9
	b. No working lighting present.						9
	c. Clutter/objects obstruct stairs						9
	d. Lacks stair gate on stairs (top and bottom).						9
91.	Hard surface (e.g., concrete, hard clay) under outdoor play equipment						9
92.	Grill / fogata within 3 feet of house, play area, or shrubs/bushes						9
93.	Any flammable items (gasoline, lighter fluid) or chemicals (fertilizers, automotive fluids, pesticides) accessible						7,8
94.	Any flammable items stored in container other than original						7,8
95.	Any tools within reach						9
96.	Pool, pond or water barrel present. If Yes,						9
	a. Does not have pool cover, safety net, or other safety cover in place						9
	b. If pool: Lacks >5' tall four-sided pool fencing with self-locking and self-closing gates						9
97.	Any ≥5 gallon buckets/open containers stored right side up and within reach						9
98.	Any visible chipping/ peeling paint on exterior surfaces					Min Mod Max	5
99.	Any exposed soil > 9 sq. feet						

*TM: Porch may be open or enclosed. If it is totally enclosed with walls and windows, and is furnished and used as an interior space (e.g., sleeping or living room), count it as an interior room. Otherwise, count it as part of the exterior.

C. FRONTYARD

	Yes	No
100. Is there a front yard?	Go on	Skip to next section

		Y	N	U T D	N A	Comments	AS
101.	Any porch* or deck more than 30" above grade? If yes:						
	a. Any guard rails < 3 feet high						9
	b. Any openings in railings and open risers > 4"?						9
102.	Any steps with 4 or more risers between landings. If YES,						
	e. Lacks secure banister or handrail on at least one side extending length of stairs						9
	f. No working lighting present.						9
	g. Clutter/objects obstruct stairs						9
	h. Lacks stair gate on stairs (top and bottom).						9
103.	Hard surface (e.g., concrete, hard clay) under outdoor play equipment						9
104.	Grill / fogata within 3 feet of house, play area, or shrubs/bushes						9
105.	Any flammable items (gasoline, lighter fluid) or chemicals (fertilizers, automotive fluids, pesticides) accessible						7,8
106.	Any flammable items stored in container other than original						7,8
107.	Any tools within reach						9
108.	Pool, pond or water barrel present. If Yes,						9
	b. Does not have pool cover, safety net, or other safety cover in place						9
	b. If pool: Lacks >5' tall four-sided pool fencing with self-locking and self-closing gates						9
109.	Any ≥5 gallon buckets/open containers stored right side up and within reach						9
110.	Any visible chipping/ peeling paint on exterior surfaces					Min Mod Max	5
111.	Any exposed soil > 9 sq. feet						

*TM: Porch may be open or enclosed. If it is totally enclosed with walls and windows, and is furnished and used as an interior space (e.g., sleeping or living room), count it as an interior room. Otherwise, count it as part of the exterior.

FOR ALL GARAGES/SHEDS/STORAGE (Add Sheets as Needed)

Type (Circle)	# Cars Used	Attached Garage			Shed/Storage		Detached Garage			
					N/A		N/A			
		1	2	3	4	5	6			
If > 1 – Garage/shed #							Y	N	UTD	N/A
112.	Any unlocked doors or windows INTO shed/storage/garage from house or yard?									
	If YES (that is, NOT Locked)									
	a. Any flammable items (lighter fluid, gasoline) or chemicals (fertilizers, automotive fluids, pesticides) in:									
	i. Unlocked storage									
	ii. Containers other than original labeled containers									
	b. Any tools within reach									
	c. Any ≥five gallon buckets/open containers with any liquid in them									
113.	Any steps with 4 or more risers between landings. If yes,									
	a. Any without secure banister or handrail on at least one side extending length of stairs									
	b. Any without working lighting.									
	c. Any obstructed by clutter or objects									
	d. Any without stair gate at top & bottom									

Type (Circle)	# Cars Used	Attached Garage			Shed/Storage		Detached Garage			
					N/A		N/A			
		1	2	3	4	5	6			
If > 1 – Garage/shed #							Y	N	UTD	N/A
114.	Any unlocked doors or windows INTO shed/storage/garage from house or yard?									
	If YES (that is, NOT Locked)									
	a. Any flammable items (lighter fluid, gasoline) or chemicals (fertilizers, automotive fluids, pesticides) in:									
	ii. Unlocked storage									
	iii. Containers other than original labeled containers									
	b. Any tools within reach (<54" above ground)									
	c. Any ≥five gallon buckets/open containers with any liquid in them									
115.	Any steps with 4 or more risers between landings. If yes,									
	e. Any without secure banister or handrail on at least one side extending length of stairs									
	f. Any without working lighting.									
	g. Any obstructed by clutter or objects									
	h. Any without stair gate at top & bottom									

Subjective Property Observations

A. Maintenance

116. Generally, how well maintained is the property?	CHECK ONE
Very well maintained Maintained to a high level, no work required apart from very minor cosmetic faults.	
Moderately well maintained Do it yourself, cosmetic repairs required (e.g. windows frames need painting) that can be done in a weekend.	
In need of maintenance Prompt attention required, e.g. rotten window frames, broken gutters, leaking pipes. Desperately in need of repair Urgent attention is required with extensive, very visible repairs needed (e.g. sagging roof or floors, bowed walls).	

B. Cleanliness

117. Generally, how clean is the property?	CHECK ONE
Very Clean Property looks like it's cleaned on a daily basis.	
Moderately cleaned Property looks like it's cleaned on a weekly basis.	
In need of cleaning Dust and cobwebs can clearly be seen. Untidy; cluttered.	
Desperately in need of cleaning The property is extremely dirty and untidy.	

Field Notes (Any reflections you want to document including dangers, worries, things promised, items requested or questions asked by family, document areas of the home that could not be accessed, add any sampling comments, note any homes (address) where children go play regularly outside their home. Indicate whether you think they may need a mayor intervention)