

den norske *Mor & barn undersøkelsen*

Questionnaire 6 – Your child at 36 months

In this questionnaire we will ask you some questions which you may recognise from previous questionnaires. We do this because we want to continue following your and your child's development. You are welcome to consult your child's Health card so that you can use the information contained in it.

If you feel that a question is too upsetting or difficult to answer you can skip this question and go on to the next one.

The questionnaire will be processed by a computer. It is therefore important that you follow these instructions when completing it:

- Use a blue or black ballpoint pen.
- Put a cross in the box that is most relevant like this:
- If you put a cross in the wrong box, correct it by filling in the box completely like this:
- Write numbers in the large boxes. **It is important that you only write in the white area of each box like this:**

Number:

1	2	3	4	5	6	7	8	9	0
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- Numbered boxes have two or more squares. When you enter a single-digit number, use the square on the right.

Example: 5 is entered as follows

	5
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- Specific information concerning, for example, medication should be written on the lines provided. Write clearly in CAPITAL LETTERS.
- Remember to fill in the date on which you completed the questionnaire

As soon as you have completed this questionnaire, return it to us in the stamped addressed envelope provided.

Specify the day, month and year when the questionnaire was completed

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Day

--	--

Month

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Year

(write the year in full, e.g. 2005)

Your child's development, health and history of illness

1. What is your child's height and weight (without clothes) at 3 years? If you know your child's height and weight at 2 years and 15-18 months, enter these measurements too. (If you don't know them, go on to the next question.) Give the date when the measurements were taken and enter a cross to indicate whether they were taken by you.

	Date of measurement			Height	Weight	Own measurement																
Approx. 3 years	<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> cm						<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> kg						<input type="checkbox"/>
Approx. 2 years	<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> cm						<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> kg						<input type="checkbox"/>
Approx. 15-18 months	<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> cm						<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> kg						<input type="checkbox"/>
	Day	Month	Year																			

2. How many months old was your child when he/she took his/her first steps unaided?

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month

Still not walking
unaided.

The following questions concern any illnesses or health problems your child has had. We will first ask you about longer-term problems and then about illnesses and problems of a more acute nature.

3. Has your child suffered any long-term illness or health problems since the age of 18 months?

Health problem	No	Yes, has now	Yes, had previously	If so, has child been referred to a specialist	
				No	Yes
1. Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Delayed motor development (e.g. sits/walks late) .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Gained too little weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Gained too much weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Testicles not descended into scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Allergy affecting eyes or nose, e.g. hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Atopic eczema (childhood eczema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Other type of eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Frequent diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Frequent stomach pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Food allergy/intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Other gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Late or abnormal speech development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Trouble relating to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Autistic traits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Other behavioural problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Other long-term illness/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify _____

4. If your child has been to see a specialist or to the hospital, what did the investigation show?

- Everything was fine
- Still some doubts/further investigations needed
- Has not been for any investigation yet
- Received diagnosis I: _____
- _____
- Received diagnosis II: _____
- _____
- Received diagnosis III: _____
- _____

5. If your child has a serious or long-term illness, describe it, if possible, in more detail:

6. Has your child ever been exposed to or involved in a serious incident?

- No Yes

7. If yes, give a description:

8. Do you think that this has affected your child's behaviour or development?

- No Yes

9. Has your child suffered any acute illness/health problem since the age of 18 months?

(Specify how many times and whether your child has been admitted to or examined at a hospital for this health problem.)

	No	Yes	Number of times	If yes, has child been admitted to or examined in hospital?	
				No	Yes
1. Common cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Throat infection with a confirmed streptococci	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Other type of throat infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pseudocroup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Gastric flu/diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Encephalitis/meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Febrile convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other convulsions (without any fever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Injury or accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If your child has been examined in or admitted to hospital, give the name of the hospital:

Hospital name: _____
 Hospital name: _____
 Hospital name: _____

11. Has your child been referred to the following services since the age of 18 months?

	No	Yes
Habilitation service	<input type="checkbox"/>	<input type="checkbox"/>
Educational psychology service	<input type="checkbox"/>	<input type="checkbox"/>
Child psychiatric clinic/department	<input type="checkbox"/>	<input type="checkbox"/>

12. Has your child taken any medication during the last 12 months? *(This means any type of medication, including fever-reducing medicines, alternative medicines and herbal remedies)*

No Yes

13. If yes, give the name of the medicines and indicate how long your child took these medicines for altogether and whether he/she is still taking them now.

Name of medicine: (CAPITALS)	Duration of use					Still being taken now?	
	0-2 weeks	3-4 weeks	1-2 mth	3-6 mth	7-12 mth	No	Yes
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Has your child been given any vaccinations since you completed the previous questionnaire (at around 18 months or 6 months)? No Yes

15. If yes, specify which vaccinations and when your child received them.

Type of vaccination:

Date given:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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Day Month Year

16. Is your child taking at the moment any cod liver oil, vitamins or other dietary supplements?

	Yes, daily	Sometimes	No
1. Cod liver oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Fluoride tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Vitamin preparations, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Iron supplement, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Other dietary supplements, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your child's development and ability to cope

In this section you will find some questions repeated in a different form. We do this so that we can compare your child's development with other similar studies and try out the best way to ask the question. The questions will relate to children who have reached different stages of development. Answer all the questions as well as you can, even if everything does not necessarily apply to your child.

17. About your child's motor development. (Enter a cross in a box for each item.)

	Yes	A few times	Not yet
1. Can your child kick a ball by swinging his/her leg forward without holding onto anything for support?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can your child catch a large ball with both hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When drawing, does your child hold a pencil, crayon or pen between his/her fingers and thumb like an adult does?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can your child undo one or more buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. About your child's language skills. (Enter a cross for the option which best describes the way your child talks.)

- Not yet talking
- He/she is talking, but you can't understand him/her
- Talking in one-word utterances, such as "milk" or "down"
- Talking in 2- to 3-word phrases, such as "me got ball" or "give doll"
- Talking in fairly complete sentences, such as "I got a doll" or "can I go outside?"
- Talking in long and complicated sentences, such as "when I went to the park, I went on the swings" or "I saw a man standing on the corner"

19. Your child's body language. (Enter a cross in the box of the answer that fits your child best for each statement.)

	Yes, usually	Very seldom	Not yet
1. When you enthusiastically say: "Where is the ball (or other toy)?", will your child point towards the toy, even if it is more than 1 metre away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When you look at a distant object and, surprised and excited, say: "Waaa...what's that?", - does he/she turn his/her head in the same direction as you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child use sounds or words together with gestures? (for example, uses sounds when pointing or reaching towards toys or objects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child show you toys by looking at you and holding the toy up towards you? (from a distance just so you can look at it)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. About your child's social skills.

(Enter a cross in a box for each statement to indicate whether you agree or disagree.)

	Disagree	Partially agree	Totally agree
1. Your child shares readily with other children (treats, toys, pencils, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your child is helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your child is considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your child is kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Your child often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your child pays careful attention when you try to teach him/her something new	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Understanding what others say and being able to communicate

(Enter a cross in the box of the answer that fits your child best for each statement.)

	Yes	A few times	Not yet
1. Without showing him/her first, does your child point to the correct picture when you say, "Where is the cat" or "Where is the dog"? Your child must only point at the correct picture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When you ask your child to point at his/her eyes, nose, hair, feet, ears, etc., does he/she point correctly at least seven parts of the body? (The child can point at himself/herself, you or a doll.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child use sentences made up of three or four words?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Without giving him/her help by pointing or using gestures, ask your child to "Put the shoe on the table" and "Put the book under the chair". Does your child carry out both of these directions correctly? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture? (For example, "Barking", "Running", "Eating" and "Crying"?) You may ask, "What is the dog (or boy) doing?"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Can your child tell you at least two things about an object he/she is familiar with? If you say, for example, "Tell me about your ball", will your child answer by saying something like "It is round, I can throw it, it is big"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. About body language and other ways of communicating with others. (We are asking you about how your child usually is. If the behaviour is rare, e.g. you have only seen it once or twice, enter a cross in the 'No' box. Enter a cross in a box for each question.)

	Yes	No
1. Does your child respond to his/her name one of the first two times you call?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child ever bring objects over to you to show you something?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child imitate you (e.g. you make a face - will your child imitate it)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child ever use his/her index finger to point, to indicate interest in something?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child take an interest in other children?	<input type="checkbox"/>	<input type="checkbox"/>
6. If you point at a toy across the room, does your child look at it?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is it easy to make eye contact with your child?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child react when spoken to, for instance, by looking, listening, smiling, speaking or babbling?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child ever seem oversensitive to noise (e.g. plugging ears)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child only choose a very small number of particular toys or objects, even if you try to make him/her interested in more things?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child wave to people to greet or say goodbye to them?	<input type="checkbox"/>	<input type="checkbox"/>
12. Can your child hurt himself/herself a lot without seeming to be bothered (has a high pain threshold)?	<input type="checkbox"/>	<input type="checkbox"/>

23. About talking with others. (Enter a cross in a box for each question to indicate whether you think it applies to your child or not.)

	Yes	No
1. Does your child talk using short phrases or sentences?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a to-and-fro "conversation" with your child that involves taking turns or building on what you have said?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child ever use odd phrases or say the same thing over and over again in almost exactly the same way? (either phrases that the child hears other people use or ones that he/she makes up)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child ever use socially inappropriate questions or statements? For example, does your child ever regularly ask personal questions or make personal comments at awkward times?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child ever get his/her pronouns mixed up (i.e. saying "you" or "he/she" instead of "I")?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child ever use words that he/she seems to have invented or made up himself/herself, put things in odd, indirect ways or use metaphorical ways of saying things? (e.g. saying "hot rain" for "steam") ..	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child ever say the same thing over and over in exactly the same way or insist that you say the same thing over and over again?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child ever have things that he/she seems to have to do in a very particular way or order, or rituals that the child insists that you go through?	<input type="checkbox"/>	<input type="checkbox"/>

24. About behaviour and specific things that children can think of doing. (Enter a cross in a box for each question to indicate whether you think it applies to your child or not.)

	Yes	No
9. Does your child's facial expression usually seem appropriate to the particular situation, as far as you can tell? ..	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child ever use your hand like a tool or as if it were part of his/her own body (e.g. pointing with your finger or putting your hand on a doorknob to get you to open the door)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child ever have any interests that preoccupy him/her and might seem odd to other people (e.g. traffic lights, drainpipes or timetables)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child ever seem to be more interested in parts of a toy or an object, rather than in using the object as it was intended (e.g. spinning the wheels of a car)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child ever have any special interests that are unusual in their intensity, but otherwise appropriate for his/her age and peer group (e.g. trains or dinosaurs)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your child ever seem to be unusually interested in the sight, feel, sound, taste or smell of things or people?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does your child ever have any mannerisms or odd ways of moving his/her hands or fingers, such as flapping or moving his/her fingers in front of his/her eyes?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child ever have any complicated movements of his/her whole body, such as spinning or repeatedly bouncing up and down?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does your child ever injure himself/herself deliberately, such as by biting his/her arm or banging his/her head? ..	<input type="checkbox"/>	<input type="checkbox"/>
18. Does your child ever have any objects that he/she has to carry around (other than a soft toy or comfort blanket)? ..	<input type="checkbox"/>	<input type="checkbox"/>

25. About your child's social development and interest in others. (Enter a cross in a box for each question to indicate whether you think it applies to your child or not.)

	Yes	No
19. Does your child have any particular friends or a best friend?	<input type="checkbox"/>	<input type="checkbox"/>
20. Does your child ever talk with you just to be friendly (rather than to get something)?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child ever spontaneously copy you (or other people) or what you are doing (such as vacuuming, gardening or mending things)?	<input type="checkbox"/>	<input type="checkbox"/>
22. Does your child ever spontaneously point at things around him/her just to show you things (not because he/she wants them)?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does your child ever use gestures, other than pointing or pulling your hand, to let you know what he/she wants?	<input type="checkbox"/>	<input type="checkbox"/>
24. Does your child nod his/her head to indicate yes?	<input type="checkbox"/>	<input type="checkbox"/>
25. Does your child shake his/her head to indicate no?	<input type="checkbox"/>	<input type="checkbox"/>
26. Does your child usually look at you directly in the face when doing things with you or talking with you?	<input type="checkbox"/>	<input type="checkbox"/>
27. Does your child smile back if someone smiles at him/her?	<input type="checkbox"/>	<input type="checkbox"/>
28. Does your child ever show you things that interest him/her to engage your attention?	<input type="checkbox"/>	<input type="checkbox"/>

cont. next page

	Yes	No
29. Does your child ever offer to share things other than food with you?	<input type="checkbox"/>	<input type="checkbox"/>
30. Does your child ever seem to want you to join in his/her enjoyment of something?	<input type="checkbox"/>	<input type="checkbox"/>
31. Does your child ever try to comfort you when you are sad or hurt?	<input type="checkbox"/>	<input type="checkbox"/>
32. If your child wants something or wants help, does he/she look at you and use gestures with sounds or words to get your attention?	<input type="checkbox"/>	<input type="checkbox"/>
33. Does your child show a normal range of facial expressions?	<input type="checkbox"/>	<input type="checkbox"/>
34. Does your child ever spontaneously join in and try to copy the actions in social games, such as "The Mulberry Bush" or "London Bridge is Falling Down"?	<input type="checkbox"/>	<input type="checkbox"/>
35. Does your child play any pretend or make-believe games?	<input type="checkbox"/>	<input type="checkbox"/>
36. Does your child seem interested in other children of approximately the same age whom he/she does not know? ..	<input type="checkbox"/>	<input type="checkbox"/>
37. Does your child respond positively when another child approaches him/her?	<input type="checkbox"/>	<input type="checkbox"/>
38. If you come into a room and start talking to your child without calling his/her name, does he/she usually look up and pay attention to you?	<input type="checkbox"/>	<input type="checkbox"/>
39. Does your child ever play imaginative games with another child in such a way that you can tell that each child understands what the other is pretending?	<input type="checkbox"/>	<input type="checkbox"/>
40. Does your child play cooperatively in games that need some form of joining in with a group of other children, such as hide-and-seek or ball games?	<input type="checkbox"/>	<input type="checkbox"/>

26. Loss of skills. (*Is there something your child used to be able to do, but has lost the ability to do?*)

	No	Yes	Not sure
1. Has your child lost any language skills? (For example, used single words or sentences for a time and then stopped using the words)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child lost any social skills? (For example, could wave or say "Hi" to greet someone, then lost this skill)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child turned out to be less sociable? (For example, he/she is more difficult to have eye contact with, is less interested in other people now)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child lost any motor skills? (For example, could run and jump while remaining steady, but falls over much more now)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your child's temperament and behaviour

27. To what extent do the following statements apply to your child's behaviour during the last two months? (*Enter a cross in a box for each item.*)

	Very typical	Quite typical	Neither/nor	Not so typical	Not at all typical
1. Your child cries easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your child is always on the go	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your child prefers playing with others rather than alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your child is off and running as soon as he/she wakes up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Your child is very sociable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your child takes a long time to warm up to strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Your child gets upset or sad easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Your child prefers quiet, inactive games to more active ones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Your child likes to be with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Your child reacts intensely when upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Your child is very friendly with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Your child finds other people more fun than anything else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Your child complains that certain garments are too tight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Your child is distressed by having his/her face or hair washed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. The following list contains statements describing children's behaviour and manner from the age of 2-3. Some of these features are temporary while others continue for a longer period of time. To what extent are the following statements true of your child's behaviour during the last two months? (Enter a cross in a box for each item.)

	Not true	Somewhat or sometimes true	Very true or often true
1. Afraid to try new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can't concentrate, can't pay attention for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can't sit still, restless or hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can't stand waiting, wants everything now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Clings to adults or too dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Constipated, doesn't move bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Defiant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Demands must be met immediately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Disturbed by any change in routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Doesn't want to sleep alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Doesn't eat well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Doesn't seem to feel guilty after misbehaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Eats or drinks things that are not food (don't include sweets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Gets in many fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Gets into everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Gets too upset when separated from parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Hits others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Poorly coordinated or clumsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Punishment doesn't change his/her behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Quickly shifts from one activity to another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Resists going to bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Stomach aches or cramps (without medical cause)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Sudden changes in moods or feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Too fearful or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Vomiting, throwing up (without medical cause)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Doesn't seem to be happy eating food (don't include sweets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Some more statements follow about your child's behaviour and manner. We are again asking to what extent you feel the statements are true of your child during the last two months? (Enter a cross in a box for each item.)

	Not true	Somewhat or sometimes true	Very true or often true
1. Becomes distracted or diverted by outside stimuli (sounds or events)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Finds it difficult waiting his/her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has problems keeping focused on tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is excessively talkative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Doesn't differentiate between adults; behaves the same way to all of them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Will wander after other adults, even if they are strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Doesn't seem to listen when he/she is being spoken to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a habit of rolling his/her head around or making humming sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Mood can vary greatly from day to day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is extremely passive, needs help to get going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. "Tests" other children to see whether they get angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Becomes aggressive when he/she is frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. His/her body is affected by twitches or contortions that seem difficult to control (e.g. eyes, mouth, nose or legs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Hits, shoves, kicks and bites other children (not including siblings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Is very anxious about getting dirty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Wants things to be clean and tidy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Places toys or other objects in a certain order/sequence over and over again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Wakes up in the night and needs help to get back to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Gets distressed when you go out and he/she is going to be looked after by family or a babysitter he/she knows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not true	Somewhat or sometimes true	Very true or often true
20. Does things he/she is not allowed to do to attract attention from adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Seems to have less fun than other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is extremely noisy. Shouts and screams a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Is disobedient or defiant (e.g. refuses to do anything you ask)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Comes over to you when something happens that makes him/her afraid or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Runs off when you are outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Seems to have less energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Is very fussy when it comes to food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Seems to be unhappy, sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Wakes up several times during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. About your child's eating habits and appetite and your attitude to it.

	Totally disagree	Slightly disagree	Neither/nor	Slightly agree	Totally agree
1. I have to be sure that my child does not eat too many sweet things (sweets, ice cream, cakes or pastries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have to be sure that my child does not eat too many high-fat foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have to be sure that my child does not eat too much of his/her favourite food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I intentionally keep some foods out of my child's reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I offer sweet things (sweets, ice cream, cakes, pastries) to my child as a reward for good behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I offer my child his/her favourite foods in exchange for good behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. If I did not guide or regulate my child's eating he/she would eat too many junk foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If I did not guide or regulate my child's eating he/she would eat too much of his/her favourite foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My child should always eat all of the food on his/her plate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have to be especially careful to make sure that my child eats enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. If my child says: "I'm not hungry", I try to get him/her to eat anyway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. If I did not guide or regulate my child's eating, he/she would eat much less than he/she should.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. About your concerns.

	No	Yes
1. Are you concerned because your child is demanding and difficult to cope with?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you every wondered if your child's hearing is impaired?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have others (family, nursery, health visitor) expressed concerns about your child's development?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are your concerned because your child is hardly interested at all in playing with other children?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any other concern about your child's health?	<input type="checkbox"/>	<input type="checkbox"/>

If so, specify _____

Your child's everyday life and environment

32. Do you live with your child's father?

No Yes

33. If no, how much time does your child spend with his/her mother and father respectively?

	Mother	Father
More than half the time	<input type="checkbox"/>	<input type="checkbox"/>
Roughly half the time	<input type="checkbox"/>	<input type="checkbox"/>
At least once a week	<input type="checkbox"/>	<input type="checkbox"/>
At least once a month	<input type="checkbox"/>	<input type="checkbox"/>
Less often than once a month	<input type="checkbox"/>	<input type="checkbox"/>
Never	<input type="checkbox"/>	<input type="checkbox"/>

34. How often does your child have his/her teeth brushed?

- Twice a day or more
 Once a day
 Sometimes
 Never

35. Does your child use fluoride toothpaste?

- No
 Sometimes
 Yes, usually

36. Is your child ever present in a room where someone smokes?

- Yes, every day
 Yes, several times a week
 Yes, sometimes
 Don't know
 No

Number of hours a day:

37. How often is your child outside at present?

- Seldom
 Frequently, but less than 1 hour a day on average
 1-3 hours a day on average
 More than 3 hours a day

38. How many hours on average does your child sit in front of a TV/video every day?

- 4 hours or more
 3 hours
 1-2 hours
 Less than 1 hour
 Seldom/never

39. How is your child cared for during the day at the moment? (You can enter a cross in more than one box.)

- At home with his/her mother
 At home with his/her father
 At home with an unqualified childminder
 At a childminder's
 In a short term outdoor day nursery
 In a day nursery

40. How many hours a week is your child looked after during the day by someone other than his/her mother or father?

Diet

41. How often does your child drink or eat the following at present? (Select the frequency which is most applicable on average.)
 (Enter a cross in a box for each item.)

	Seldom/ less than once a week	1-3 times a week	4-6 times a week	Once in 24 hrs	Twice in 24 hrs	3 times in 24 hrs	4 or more times in 24 hrs
1. Whole milk, sweet/sour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Low-fat, extra low-fat, skimmed milk, sweet/sour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Yogurt, natural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Yogurt / yogurt drink with fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Yogurt with active Lactobacillus, all types	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Cordial / nectar / squash / fizzy drinks, sweetened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cordial / squash / fizzy drinks, with artificial sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Meat filling (liver paste, ham, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Fish filling (mackerel, caviar, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Brown cheese, brown cheese spread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other types of cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Jam, honey, chocolate spread, other sweet spread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Eggs, boiled, fried, scrambled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Other filling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Raisins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Ice lolly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Buns, cakes, waffles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Sweets, jelly babies, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Crisps, potato snacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. How many slices of bread/crispbread does your child eat every day?

How many of these include fibre-rich bread/ crispbread (e.g. rye bread, Fedons bread)

43. How often does your child eat the following at present? (Select the frequency which is most applicable on average.)
(Enter a cross in a box for each item.)

	Once a mth or less often	2-3 times a month	Once a week	Twice a week	3 times a week	4 times a week	5 or more times a week
1. Meat, rissoles, sausages, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Oily fish (salmon, herring, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. White fish (cod, coley, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fish pudding, fish cakes, fish balls, etc. ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Soup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Pancakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Pasta, spaghetti, noodles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Pizza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Cooked vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Raw vegetables, salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions about yourself

44. What is your civil status at present?

- Married Separated/divorced
 Cohabiting Widowed
 Single Other

45. Are you in paid employment at the moment?

- No (go to question 49)
 Yes Usual number of hours per week:

46. What type of working pattern do you have? (You can enter a cross in more than one box.)

- Permanent day work
 Shift work/rota system
 Permanent afternoon/evening work
 Non-permanent (relief cover, relief on-call, supply, etc.)
 Permanent night work

47. How many days altogether were you absent from work last year (excluding holidays and time off in lieu)?

days

48. What was the reason for this? (You can enter a cross in more than one box.)

- Leave
 Own illness, specify _____
 Sick child
 Other

49. Do you often feel lonely?

- Almost never
 Seldom
 Sometimes
 Generally
 Almost always

50. Do you have anyone other than your spouse /boyfriend/partner whom you can seek advice from in a difficult situation?

- No
 Yes, 1 or 2 people
 Yes, more than 2 people

51. How often do you see or talk on the telephone to your family (apart from your household) or close friends?

- Once a month or less
 2-8 times a month
 More than twice a week

52. Have you ever experienced the following, since you became pregnant with this child, for a consecutive period of two weeks or more..... (Enter a cross in a box for each item.)

	No	Yes, during pregnancy	Yes, during first year after birth	Yes, during the last 2 years
1. Felt depressed, sad, down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Had problems with your appetite or eaten too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Been affected by lethargy or a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Really got down on yourself and felt worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Had problems concentrating or found it difficult to make decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Had at least 3 of the problems mentioned above at the same time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

53. Are you pregnant now?

No Yes

54. Have you had any long-term illness or health problems which have occurred during the last 3 years?**Physical problem:**

No
 Yes, before, describe: _____
 Yes, now, describe: _____

Mental problem:

No
 Yes, before, describe: _____
 Yes, now, describe: _____

55. Have you yourself been examined at the hospital during the last 3 years?

No
 Yes, which hospital? _____

56. Do you have any of the following problems at present; if so, how often and how much at a time? (Enter a cross in a box for each item.)

Problems:	How often do you have problems?					How much at a time?		
	Never	1-4 times a month	1-6 times a week	Once a day	More than once a day	Drops	Small gushes	Large amounts
1. Incontinence when coughing, sneezing or laughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Incontinence during physical activity (running/jumping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Incontinence with a strong need to urinate . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Problems retaining faeces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5. Problems with flatulence								

57. How physically active are you? We are asking you here about the duration of activities where you get out of breath or sweat. How often does this happen? Include activities both at home and at work. (Enter a cross in a box for each item.)

Duration of activity where you get out of breath or sweat	How often					
	Never	Less than once a week	Once a week	Twice a week	3-4 times a week	5 times or more a week
Less than 30 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Between 30 and 60 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 60 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

58. Overall, how would you describe your physical health?

Very good
 Good
 Poor
 Very poor

59. Do you smoke at present?

Don't smoke

Smoke sometimes - no. cigarettes per week:

Smoke every day - no. cigarettes per day:

60. Do you take:

Chewing tobacco/snuff
 Nicotine chewing gum
 Nicotine patches
 Nicotine inhaler

61. How often do you consume alcohol at present?

Roughly 6-7 times a week
 Roughly 4-5 times a week
 Roughly 2-3 times a week
 Roughly once a week
 Roughly 1-3 times a month
 Less than once a month
 Never

62. How many alcohol units do you usually drink when you consume alcohol? (Enter a cross for both weekends and weekdays) (See explanation below about alcohol units.)

	Weekend	Weekdays
10 or more	<input type="checkbox"/>	<input type="checkbox"/>
7-9	<input type="checkbox"/>	<input type="checkbox"/>
5-6	<input type="checkbox"/>	<input type="checkbox"/>
3-4	<input type="checkbox"/>	<input type="checkbox"/>
1-2	<input type="checkbox"/>	<input type="checkbox"/>
Less than 1	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol units

In order to compare different types of alcohol, we ask for the number of alcohol units (= 1.5 cl of pure alcohol). This means the following in practice:

- 1 glass (1/3 litre) of beer = 1 unit
- 1 wine glass of red or white wine = 1 unit
- 1 wine glass of sherry or other fortified wine = 1 unit
- 1 brandy glass of spirits or liqueur = 1 unit
- 1 bottle of alcopop/cider = 1 unit

63. Have you experienced any of the following during the last 3 years:

	No	Yes
Being hit, kicked or attacked physically in any other way?	<input type="checkbox"/>	<input type="checkbox"/>
Being pressured into having sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>

64. Have you during the last 18 months: (Enter a cross in a box for each item.)

	No	Yes
1. Thought yourself that you were too fat? . . .	<input type="checkbox"/>	<input type="checkbox"/>
2. Been really afraid of putting on weight or becoming too fat?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heard others say that you were too thin, while you yourself thought that you were too fat?	<input type="checkbox"/>	<input type="checkbox"/>
4. Thought that it was extremely important for your self-image to maintain a particular weight?	<input type="checkbox"/>	<input type="checkbox"/>

65. Have you at some time during the last 18 months or previously in your life - for a period lasting at least 3 months - experienced any of the following situations, and if so, how frequently was this? (Enter a cross in a box for each item.)

	At least twice a week	1-4 times a month	Seldom/never
1. Felt that you were losing control when eating and couldn't stop before you had eaten far too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Used vomiting to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Used laxatives to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Used fasting to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Used hard physical exercise to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

66. Have you at some time during the last 18 months gone at least three months without a period in connection with a time when you have been having eating problems? (without being pregnant)

- No Yes

67. What is your current weight?

--	--	--	--	--	--	--	--	--	--

kg

How tall are you?

--	--	--	--	--	--	--	--	--	--

cm

68. Feeling of anxiety and restlessness. (Enter a cross in a box for the items that apply to you best during the last 6 months.)

	Never	Seldom	Sometimes	Often	Very often
1. How often do you have problems completing the final aspects of a task when the challenging part is already done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often do you have problems putting things in the right order when you are involved in tasks that require organisation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When you have a task which requires a great deal of careful preparation, how often do you avoid or put off starting it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often do you have problems remembering appointments or engagements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When you have to sit still for a long time, how often do you move your hands and feet in an anxious, restless way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often do you feel hyperactive and obliged to do things, as if you are being driven by an engine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. If you have a husband/boyfriend/partner, to what extent do you agree with the following descriptions? (Enter a cross in a box for each item.)

	Totally agree	Agree	Slightly agree	Slightly disagree	Disagree	Totally disagree
1. My partner and I have problems in our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am very happy in my relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My partner is generally understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am satisfied with the relationship with my partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. We agree on how children should be brought up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. Have you been bothered during the last 2 weeks by any of the following? (Enter a cross in a box for each item.)

	Not bothered	A little bothered	Quite bothered	Very bothered
1. Feeling fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nervousness or shakiness inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeling hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Worrying too much about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling everything is an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling tense or keyed up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Suddenly scared for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

71. Have you experienced during the last 18 months any of the following situations? If yes, how painful and difficult was this for you?

(Enter a cross in a box for each item.)

	No	Yes	Not so bad	Painful/difficult	Very painful/difficult
1. Have you had problems at work or where you study?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had financial problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been divorced, separated or ended your relationship with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had problems or conflict with family, friends or neighbours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been seriously worried that there is something wrong with your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has anyone close to you been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been involved in a serious accident, fire or robbery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you lost someone close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

72. In your daily life, how often do you (Enter a cross in a box for each item.)

	Seldom/never	seldom	A few times	Fairly Often	Very often
1. Feel glad about something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feel happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feel joyful, like everything is going your way, everything is rosy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feel like screaming at somebody or hitting things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feel angry, irritated or annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feel mad at somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73. Indicate with a cross whether you agree or disagree with the following statements (Enter a cross for each statement.)

	Totally disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Totally agree
1. My life is largely what I wanted it to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My life is very good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I'm satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I've achieved so far what's important to me in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If I could start all over, there is very little I would do differently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I really enjoy my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74. What kind of perception do you have of yourself? (Enter a cross in a box for each item.)

	Totally agree	Agree	Disagree	Totally disagree
1. I have a positive attitude towards myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel completely useless at times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel that I don't have much to be proud of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel that I am a valuable person, as good as anyone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

75. Bringing up your child (Enter a cross to indicate whether you agree or disagree with the following statements. Enter a cross in a box for each item.)

	Totally disagree	Partially disagree	Neither/nor	Partially agree	Totally agree
1. What I do has little influence on my child's behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My child is used to getting what he/she wants in any case, so there's no point in even trying to refuse him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cuddles and hugs are an important way of showing my child that I love him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If my child and I have a disagreement it is usually easy to divert him/her ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My life is mainly becoming controlled by my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I think it is very important for my child to learn to deal with the fact he/she cannot get their own way on everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. It is often easier to let my child get his/her own way rather than having to put up with a tantrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sometimes when I'm tired I let my child get to do things that I usually would not have allowed otherwise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. It isn't so important what strategies you use to bring up your children; if you love your children they will develop well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

