

QM:

Fam ID: U X Resp: Father Mother 2nd Male Parent 2nd Female Parent

Date / / Wave: 7 Int ID:

INSTRUCTIONS: These questions are about different services and support your son or daughter may have received while he/she was growing up. Please answer to the best of your knowledge.

Has your son/daughter received:

1. Special Education for learning? No Yes *(If no, skip to #2)*

A. If yes, at what ages? Please mark all that apply:

10 yrs or younger	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs or older
<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"/>

B. Over what period of time?

0 to Six months	Six months to a year	More than a year to two years	More than two years to four years	Four to seven years	More than seven years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Special Education for behavioral or emotional support? No Yes *(If no, skip to #3)*

A. If yes, at what ages? Please mark all that apply:

10 yrs or younger	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs or older
<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"/>

B. Over what period of time?

0 to Six months	Six months to a year	More than a year to two years	More than two years to four years	Four to seven years	More than seven years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Mental health or counseling services? No Yes *(If no, skip to #4)*

A. If yes, at what ages? Please mark all that apply:

10 yrs or younger	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs or older
<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"/>

B. Over what period of time?

0 to Six months	Six months to a year	More than a year to two years	More than two years to four years	Four to seven years	More than seven years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C. What was the total number of times he/she received these services?

Once	2 to 5 times	6 to 10 times	11 to 20 times	21 to 50 times	More than 50 times
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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D. What was the problem and/or diagnosis? _____

E. Was he/she put on any medications? No Yes

If yes, what medication(s)? _____

Has your son/daughter received:

4. Drug treatment that was not in-patient? No Yes (If no, skip to #5)

A. If yes, at what ages? Please mark all that apply:

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10 yrs or
younger | 11 yrs | 12 yrs | 13 yrs | 14 yrs | 15 yrs | 16 yrs | 17 yrs | 18 yrs or older |
| <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"/> |

B. Over what period of time?

- | | | | | | |
|-----------------------|-------------------------|-------------------------------------|---|------------------------|--------------------------|
| 0 to Six
months | Six months
to a year | More than
a year to
two years | More than
two years to
four years | Four to
seven years | More than
seven years |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

C. What was the total number of times he/she received these services?

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Once | 2 to 5
times | 6 to 10
times | 11 to 20
times | 21 to 50
times | More than
50 times |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

5. In-patient drug treatment? No Yes (If no, skip to #6)

A. If yes, at what ages? Please mark all that apply:

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10 yrs or
younger | 11 yrs | 12 yrs | 13 yrs | 14 yrs | 15 yrs | 16 yrs | 17 yrs | 18 yrs or older |
| <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"/> |

B. Over what period of time?

- | | | | | | |
|-----------------------|-------------------------|-------------------------------------|---|------------------------|--------------------------|
| 0 to Six
months | Six months
to a year | More than
a year to
two years | More than
two years to
four years | Four to
seven years | More than
seven years |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

C. What was the total number of times he/she received these services?

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Once | 2 to 5
times | 6 to 10
times | 11 to 20
times | 21 to 50
times | More than
50 times |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



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Has your son/daughter received:

6. Therapeutic foster care? No Yes *(If no, skip to #7)*

A. If yes, at what ages? Please mark all that apply:

- 10 yrs or younger
- 11 yrs
- 12 yrs
- 13 yrs
- 14 yrs
- 15 yrs
- 16 yrs
- 17 yrs
- 18 yrs or older

B. Over what period of time?

- 0 to Six months
- Six months to a year
- More than a year to two years
- More than two years to four years
- Four to seven years
- More than seven years

C. What was the total number of times he/she received these services?

- Once
- 2 to 5 times
- 6 to 10 times
- 11 to 20 times
- 21 to 50 times
- More than 50 times

7. Day treatment for mental health or behavior problems? No Yes *(If no, skip to #8)*

A. If yes, at what ages? Please mark all that apply:

- 10 yrs or younger
- 11 yrs
- 12 yrs
- 13 yrs
- 14 yrs
- 15 yrs
- 16 yrs
- 17 yrs
- 18 yrs or older

B. Over what period of time?

- 0 to Six months
- Six months to a year
- More than a year to two years
- More than two years to four years
- Four to seven years
- More than seven years

C. What was the total number of times he/she received these services?

- Once
- 2 to 5 times
- 6 to 10 times
- 11 to 20 times
- 21 to 50 times
- More than 50 times

D. What was the problem and/or diagnosis? _____

E. Was he/she put on any medications? No Yes

If yes, what medication(s)? _____



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Has your son/daughter received:

8. Residential treatment for mental health or behavior problems? No Yes (If no, skip to #9)

A. If yes, at what ages? Please mark all that apply:

- 10 yrs or younger
- 11 yrs
- 12 yrs
- 13 yrs
- 14 yrs
- 15 yrs
- 16 yrs
- 17 yrs
- 18 yrs or older

B. Over what period of time?

- 0 to Six months
- Six months to a year
- More than a year to two years
- More than two years to four years
- Four to seven years
- More than seven years

C. What was the total number of times he/she received these services?

- Once
- 2 to 5 times
- 6 to 10 times
- 11 to 20 times
- 21 to 50 times
- More than 50 times

D. What was the problem and/or diagnosis? _____

E. Was he/she put on any medications? No Yes

If yes, what medication(s)? _____

9. Hospitalization because of mental health problems? No Yes (If no, skip this question)

A. If yes, at what ages? Please mark all that apply:

- 10 yrs or younger
- 11 yrs
- 12 yrs
- 13 yrs
- 14 yrs
- 15 yrs
- 16 yrs
- 17 yrs
- 18 yrs or older

B. Over what period of time?

- 0 to Six months
- Six months to a year
- More than a year to two years
- More than two years to four years
- Four to seven years
- More than seven years

C. What was the total number of times he/she received these services?

- Once
- 2 to 5 times
- 6 to 10 times
- 11 to 20 times
- 21 to 50 times
- More than 50 times

D. What was the problem and/or diagnosis? _____

E. Was he/she put on any medications? No Yes

If yes, what medication(s)? _____

