

Born In Bradford 24 Months Questionnaire

General Instructions:

1. Questions to be read to respondents in **bold**
2. Instructions to interviewers marked: **Interviewer**
3. Instructions meant to be read to respondents are in *italics*
4. For multiple choice questions: CROSS boxes
5. For single response questions: enter value in drop down box

Hello my name is from the Born in Bradford project. Thank you for agreeing for us to visit you again. We are very interested to know how things have been going since we last saw you. Children grow so quickly, and change so much.

We are interested to know about what your child is eating and how mealtimes are going. We also want to know if there have been any changes in your household and how your are feeling.

I will ask most of the questions but there are some sections of the questionnaire that I will ask you to complete yourself. I will be here to help you if you have any queries.

All the answers you give are confidential. Your name and address will not appear anywhere on the questionnaire.

We apologise if any questions in this section cause offence – we are asking everyone the same questions but we realize some religions do not permit certain things.

We would be grateful if you would help us by answering as many of these questions as possible but if there are any questions you do not want to answer that is fine. There are no right or wrong answers.

Thank you for agreeing to answer these questions.

Study ID -

Interviewer ID

This child is: Singleton/First twin/Triplet Second Twin/Triplet Third triplet

Child's date of birth - -

Date of completion - -

Completed by: Mother Father Carer

What language was used for administering the questionnaire?

English Mirpuri Urdu Other

Mother's date of birth - -

MOTHER'S Weight . Not able to take

CHILD'S

Weight . Not able to take

Height . Not able to take

SKINFOLDS

Triceps . Not able to take

Sub scapular	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>	Not able to take	<input type="checkbox"/>
Thigh	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>	Not able to take	<input type="checkbox"/>

SECTION A

GENERAL HEALTH

This first section asks about you and your child's general health

1. I would now like to ask you about your health. How would you describe your own health generally. Would you say it is

Excellent

Very Good

Good

Fair

Poor

2. I would now like to ask you about your child's health. How would you describe his/her general health? Would you say it is

Excellent

Very Good

Good

Fair

Poor

SECTION B **WHO YOU LIVE WITH**

Can I just check, has your marital status changed since we last saw you?

1. Are you: (CROSS one box only)

- Married
- Re-married
- Single (never married)
- Separated (but still legally married)
- Divorced
- Widowed

2. Are you:

- Living with baby's father
- Living with another partner
- Not living with a partner but in a relationship (e.g. partner living abroad or in another property)
- Not living with a partner and not in a relationship

SECTION C

CHILDHOOD ILLNESSES

We would like to know about any health problems (child's name) has been taken to the GP surgery for. How many separate health problems, if any, has (child's name) had, not counting any accidents or injuries?

1. Has your son/daughter seen a doctor/nurse in the last six months because he/she had a problem you were worried about? (Cross ONE box only)

Yes No Don't know Refused

Interviewer: If NO, DON'T KNOW or REFUSED go to Q4

2. How many times? (Cross ONE box only)

Once Twice 3-4 5 - 10
11 or more Don't know Refused

3. What was the reason for the visit? (Cross ALL that apply)

	Yes and saw A doctor	Yes but did not did not see a doctor
Tummy upset/wind/colic	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Crying	<input type="checkbox"/>	<input type="checkbox"/>
High temperature	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/fits	<input type="checkbox"/>	<input type="checkbox"/>
Snuffles/cold	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>
Not gaining enough weight	<input type="checkbox"/>	<input type="checkbox"/>
Gaining too much weight	<input type="checkbox"/>	<input type="checkbox"/>
Accident	<input type="checkbox"/>	<input type="checkbox"/>
Other Please describe	<input type="checkbox"/>	<input type="checkbox"/>

4. Has (child's name) been given any medical diagnosis?

Yes No

Please list a. _____
b. _____
c. _____
d. _____

5. Has (child's name) been admitted to hospital in the last six months ? (Cross ONE box only)

Yes No Don't know Refused

5a. If YES how many times?

Interviewer: If NO, DON'T KNOW or REFUSED go to question 6

6. Has (child's name) been to a hospital outpatient clinic in the last six months? (Cross ONE box only)

Yes No Don't know Refused

6a. If YES how many times?

Interviewer: If NO, DON'T KNOW or REFUSED go to question 7

7. Has your son/daughter been hurt, injured or had an accident and needed medical attention from a doctor or hospital in the last six months? (Cross ONE box only)

Yes None Don't know Refused

7a. If YES, how many times?

Interviewer: If NO, DON'T KNOW or REFUSED go to section

We are also interested to know if you and/or your husband/partner are working nowadays.

SECTION D EMPLOYMENT STATUS

1. Have there been any changes to your employment status since our last visit?

Yes No Don't know Refused

If Yes go to Q2

If Don't know go to Q2

If No or refused go to Q8

2. Can I just check, have you returned to work since (child's name) was born, or are you still on leave

- Yes, has returned to work
- No, still on leave

3. I'd like to ask you some questions about how (child's name) is looked after, but first can you tell me which of the things on this card best describes what you are currently doing?

Interviewer: (Cross ONE box only)

If respondent is on annual leave/sick leave from their employer, code as working

- In a job and currently working for an employer
- On maternity leave from an employer
- Self employed
- Full time student
- Looking after the home and family
- Doing something else

Other

Interviewer: Write in 'doing something else' answer (description of activity).

Interviewer: If answers:

'In a job and currently working for an employer' OR 'on maternity leave from an employer'

-ask questions in **Employment Status** section for mother (from Q4)

If mother does not work and living with a husband/partner

-go to **Employment Status** section and ask from Q8

Now we have some questions about any paid work you or your husband/partner may have undertaken since your baby was born.

About yourself

Employed or self-employed

4. Do you work as an employee or are you self employed? (Cross ONE box only)

- Employee
- Self employed with employees
- Self employed/freelance without employees (go to Q6)
- Student/in training

Number of employees

5. For employees: 'How many people work for your employer at the place where you work?'

For self employed: 'How many people do you employ?'

Interviewer: Go to Q6 when you have completed this question.)

- 1-24 25 or more

Supervisory status

6. Do you supervise any other employees (A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis).

(Cross ONE box only)

- Yes No

Occupation

7. What best describes the sort of work you did/do?

(Cross ONE box only)

- Modern professional occupations
- Clerical and intermediate occupations
- Senior managers or administrators
- Technical and craft occupations
- Semi routine manual and service occupations
- Routine manual and service occupations
- Middle or junior managers

Traditional professional occupations

Interviewer: If mother has a partner/husband living with her, please ask the following:

8. Have there been any changes to the employment status of your partner/husband since our last visit?

Yes No Don't know Not applicable

If Yes go to Q9

If Don't know go to Q9

If NO, go to Section D - CHILDCARE

About your partner/husband

9. Has your partner/husband ever been employed? (Cross ONE box only)

Yes No Never been in employment

Employed or self-employed

10. Does/did he work as an employee or is/was he self-employed? (Cross ONE box only)

Employee

Self employed with employees

Self employed/freelance without employees (go to Q11)

Student/in training

Number of employees

11. For employees: 'How many people work/ed for his employer at the place where he work/ed?'

For self employed: 'How many people do/did you employ?'

Interviewer: (Go to Q12 when you have completed this question.)

1-24 25 or more

Supervisory status

12. Does/did he supervise any other employees (A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis).

(Cross ONE box only)

Yes No

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13. What best describes the sort of work he does/did?(Cross ONE box only)

- Modern professional occupations
- Clerical and intermediate occupations
- Senior managers or administrators
- Technical and craft occupations
- Semi routine manual and service occupations
- Routine manual and service occupations
- Middle or junior managers
- Traditional professional occupations
- Does not work – long term unemployed/ill health (one year or over)
- Don't know

SECTION E

CHILDCARE

This next section asks about any childcare arrangements you may have for (child's name)

1. Have there been any changes to your childcare arrangements since our last visit?

Yes No Don't know Refused

Interviewer:

If Yes, go to Q2

If Don't know go to Q2

If NO, go to Section E – HOW ARE YOU FEELING

2. Have you ever made any *regular* arrangement for your child to be looked after, either while you are at work or for any other reasons? (By regular we mean an arrangement that normally runs for at least five hours a week and has lasted for at least one month).

Yes No

1. a) If YES, who looks after (child's name)? This question is about *current* arrangements. (Please complete ALL that apply)

	How many hours per week on average?	In your home		Does the carer feed your child?		How many other children does the carer usually look after at the same time as your baby?
		Yes	No	Yes	No	
Husband/Wife/Partner	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Baby's non-resident father/mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Baby's non-resident father's/mother's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Baby's non-resident father's/mother's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other relative	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Friends/Neighbours	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

	How many hours per week on average?	In your home		Does the carer feed your child?		How many other children does the carer usually look after at the same time as your baby?
		Yes	No	Yes	No	
Live-in nanny/au pair	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other nanny/au pair	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Registered childminder	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Unregistered childminder	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Workplace/college nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Local authority day nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Private day nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other specify	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

SECTION F

FEEDING YOUR CHILD

This next section asks questions about how you have been feeding your child.

1. Was (child's name) ever breast fed? (Cross ONE box only)

Interviewer: Include colostrum in first few days and expressed breast milk

Yes No Don't know

2. Is (child's name) still being breastfed? (Cross ONE box only)

Yes No Don't know

3. How old was (child's name) when he/she completely stopped being breastfed?

Interviewer: Include expressed breast milk (Cross ONE box only)

Still having breast milk

Days

Weeks

Months

Don't know

4. How old was (child's name) when he/she was first given baby milk formula to

drink? Interviewer: SMA, Cow & Gate. Formula Soya milk, Follow-on formula milk etc
(Cross ONE box only)

Still not had formula milk

Days

Weeks

Months

Don't know

24 MONTH CHILD'S DIET

How would you describe your toddler's eating and drinking? (please tick one box only)				
Very easy	Easy	All right	Difficult	Very difficult

During the WEEKDAYS how often does your toddler usually eat and drink; with who and where? (please tick all that apply)					
	Yes/no	With a parent/sibling/ family member	With childminder / at nursery	On his/her own	In front of the TV
Early morning/breakfast time					
During the morning					
Midday/ lunchtime					
During the afternoon					
Early evening/teatime					
During the evening					
Late evening/dinner or supper					
Before bed					
In bed/during the night					
Doesn't really have set meal times but eats when he/she is convenient or if hungry?					

During the <u>WEEKENDS</u> how often does your toddler usually eat and drink; with who and where? (please tick all that apply)					
	Yes/no	With a parent/sibling/ family member	With childminder / at nursery	On his/her own	In front of the TV
Early morning/breakfast time					
During the morning					
Midday/ lunchtime					
During the afternoon					
Early evening/teatime					
During the evening					
Late evening/dinner or supper					
Before bed					
In bed/during the night					
Doesn't really have set meal times but eats when he/she is convenient or if hungry?					

SECTION G

SLEEP

We are also interested in how many hours (child's name) is sleeping throughout the day and night

1. How many hours on average does (child's name) sleep in 24 hours? Please enter number of hours in boxes provided – (this includes any naps in a baby chair/buggy etc) (Cross ONE box only)

1a Day time - 6am to 6pm

1b Night time - 6pm until 6am

SECTION H

LIFESTYLE

SMOKING

1. Have you ever regularly smoked cigarettes; that is at least one cigarette a day?
(Cross ONE BOX ONLY)

Yes for more than 1 year Yes less than 1 year No

If NO, go to question 4

2. Do you smoke cigarettes nowadays? (Cross ONE box only.)

Yes No

2a. If no, when did you stop smoking?

Age Years old Don't remember

3. If yes, how many cigarettes do/did you smoke in the last year? (Cross ONE box only)

None	1-5 a day	6-10 a day	11-20 a day	Over 20 a day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Are you exposed to other peoples' smoke at work or at home and if YES, for how many hours per day approx

Yes No Less than one hour per day/occasionally

4a. If yes – Hours

5. Is (child's name) exposed to other peoples' smoke and if YES, how many hours per day approx?

Yes Less than one hour per day/occasionally No

If yes – Hours

ALCOHOL

6. Have you drunk alcohol in the last year? (Cross ONE box only)

Yes, once a week or more Yes, occasionally No Don't remember

7. If once per week or more, what is the weekly average and maximum number of units in a week?

	Average number of units per week	Maximum units at one time
Beer/Lager	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Wine	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Spirits	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Don't remember	<input type="checkbox"/>	<input type="checkbox"/>

8. In the last year how often did you consume 5 or more units of alcohol one occasion? (Cross ONE box only)

Every day	<input type="checkbox"/>	1-3 times per month	<input type="checkbox"/>
Nearly every day	<input type="checkbox"/>	Rarely	<input type="checkbox"/>
1-4 times per week	<input type="checkbox"/>	Never	<input type="checkbox"/>

SECTION I

SCREEN TIME

1. How many hours per day on average is your television on at home (you don't have to be watching it)?

Weekdays

Weekends

Please write number of hours

2. TV or DVD viewing of mother

Hours of TV or DVD watching per day	On average over the last month					
	None	Less than 1 hour a day	1 to 2 hours a day	2-3 hours a day	3-4 hours a day	More than 4 hours a day
On a week day before 6pm						
On a week day after 6pm						
On a weekend day before 6pm						
On a weekend day after 6pm						

3. TV or DVD viewing of your child

Hours of TV or DVD watching per day	On average over the last month					
	None	Less than 1 hour a day	1 to 2 hours a day	2-3 hours a day	3-4 hours a day	More than 4 hours a day
On a week day before 6pm						
On a week day after 6pm						
On a weekend day before 6pm						
On a weekend day after 6pm						

SECTION J

CHILD GROWTH AND GROWTH PERCEPTION

We would like to know how you feel your child has been growing in the past six months

(Cross ONE box only)

1. At this moment in time, how do you see the body weight of your child?

Much too low A little too low Just right A little too high Much too high

2. At this moment in time how would you classify your child's weight?

Very underweight Underweight Average Overweight Very overweight

3. Compared with other children his/her age, what is your child's weight?

Much thinner A little bit thinner About the same A little heavier Much heavier

4. Compared with other children his/her age, how quickly has your child gained weight?

Much slower A little slower About the same A little quicker Much more quickly

5. I am worried my child will become overweight

Disagree a lot Disagree a little Neither agree Nor disagree Agree a little Agree a lot

6. I would be concerned if my baby was under-eating and not gaining weight

Disagree a lot Disagree a little Neither agree Nor disagree Agree a little Agree a lot

7. At this moment in time how would you describe yourself?

Very Overweight Moderately overweight Slightly overweight Just right Slightly underweight Moderately underweight Very underweight

Interviewer: For question 8 please show card with male and female pictures and note the figure chosen in the table.

8. Here are a number of pictures. We want you to select the picture that most looks like you and your husband/partner NOW. If you do not know please put 'don't know' in the column instead of the picture letter.

	Please insert the letter from the picture that looks most like you and the picture that looks most like your husband/partner
You	
Your husband/partner	

SECTION K

PARENT'S PHYSICAL ACTIVITY

Interviewer: *I am going to ask you about the time you spent being physically active in the last 7 days. Please answer each question even if you do not consider yourself to be an active person. Think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.*

Think about all the vigorous activities which take hard physical effort that you did in the last 7 days. Vigorous activities make you breathe much harder than normal and may include heavy lifting, digging, aerobics, or fast bicycling.

Think only about those physical activities that you did for at least 10 minutes at a time.

1a During the last 7 days, on how many days did you do vigorous physical activities?

_____ Days per week

Don't know N/A Refused

[Interviewer note: If respondent answers not applicable , refuses or does not know, skip to Question 2a]

1b How much time did you usually spend doing vigorous physical activities on one of those days?

__ __ Hours per day
__ __ __ Minutes per day

Interviewer: *Now think about activities which take moderate physical effort that you did in the last 7 days. Moderate physical activities make you breathe somewhat harder than normal and may include carrying light loads, bicycling at a regular pace, or doubles tennis. Do not include walking. Again, think about only those physical activities that you did for at least 10 minutes at a time.*

2a. During the last 7 days, on how many days did you do moderate physical activities?

_____ Days per week

Don't know N/A Refused

[Interviewer Note: If respondent answers zero, refuses or does not know, skip to Question 3a]

2b. **How much time did you usually spend doing moderate physical activities on one of those days?**

__ __ Hours per day
 __ __ __ Minutes per day

Interviewer: *Now think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.*

3a. **During the last 7 days, on how many days did you walk for at least 10 minutes at a time?**

_____ Days per week

Don't know N/A Refused

3b. **How much time did you usually spend walking on one of those days?**

__ __ Hours per day N/A
 __ __ __ Minutes per day N/A

Interviewer: *Now think about the time that you spend sitting.*

4. In a typical week, how many hours do you spend, on average, SITTING EACH DAY in the following situations (please write your answer)

	On a WEEK Day		On a WEEKEND Day	
	Hours	Minutes	Hours	Minutes
While travelling to and from places				
While at work				
While watching television				
While using a computer at home				
In your leisure time, NOT including television (e.g., visiting friends, movies, dining out, etc.)				

SECTION L

CHILDREN'S PHYSICAL ACTIVITY

Interviewer: *These questions are about the types of activities that your child does in a typical week. Please think about the sorts of activities that your child has been doing in the past month.*

- 1. In the last month, how many days each week and for how long each day would you say your child has spent doing the following activities at home?**

	Less than once a week	How often	For how long each day			
	Yes/ No	Number of days each week. If never, put zero	Up to 15 mins/day	16-30 mins/day	31-60 mins/day	More than one hour/day, please estimate time
Colouring/drawing/craft		...../7				Hrs... Mins...
Sitting playing with toys (e.g. dolls/puzzles educational play)		...../7				Hrs... Mins...
Watching TV/DVDs		...../7				Hrs... Mins...
Playing on the computer (not physically active games such as Nintendo Wii)		...../7				Hrs... Mins...

Sitting listening/singing to music		...../7				Hrs... Mins...
Reading/being read to		...../7				Hrs... Mins...
Playing actively inside the house (dancing, crawling, running, sit and ride toys, push toys, physically active computer games such as Nintendo Wii)		...../7				Hrs... Mins...
Playing actively in the garden/yard		...../7				Hrs... Mins...
Engaging in physical activity/active play that makes them sweat or breathe harder		...../7				Hrs... Mins...

2. Please can you tell me any organised/structured physical activity programmes that your child is involved in (e.g. swimming class, dancing club, gymnastics club, tumble tots). How many hours and minutes a week do they attend each programme for?

Programme Time/week in hours and minutes

..... Hrs.....Mins.....

..... Hrs.....Mins.....

..... Hrs.....Mins.....

3. In the last month, how many days each week and for how long each day would you say your child has spent playing in a physically active way with:

	Less than once a week	How often	For how long each day			
	Yes/ No	Number of days each week. If never put a zero	Up to 15 mins/day	16-30 mins/day	31-60 mins/day	More than an hour/day, please estimate time
Siblings or cousins		<i>17</i>				Hrs... Mins...
Friends		<i>17</i>				Hrs... Mins...
Mother		<i>17</i>				Hrs... Mins...
Father or mothers partner		<i>17</i>				Hrs... Mins...
Grandparent		<i>17</i>				Hrs...

						Mins...
Other adult family member		<i>17</i>				Hrs... Mins...
Carer		<i>17</i>				Hrs... Mins...

4. In the last month, to get from place to place (e.g to the shops, school/groups, park, visiting friends/relatives), on how many days each week and for how long each day would you say your child has spent:

	Less than once a week	How often	For how long each day			
	Yes/ No	Number of days each week. If never put a zero	Up to 15 mins/day	16-30 mins/day	31-60 mins/day	More than an hour/day. Please estimate time
In their buggy/pushchair		<i>17</i>				Hrs... Mins...
Walking		<i>17</i>				Hrs... Mins...

Being carried		<i>17</i>				Hrs... Mins...
In the car		<i>17</i>				Hrs... Mins...
On public transport		<i>17</i>				Hrs... Mins...

SECTION M

CAREGIVER’S FEEDING STYLES QUESTIONNAIRE

These questions deal with YOUR interactions with your preschool child during the dinner meal. Circle the best answer that describes how often these things happen. If you are not certain, make your best guess.

How often during the dinner meal do YOU....

		Never	Rarely	Some- times	Most of the time	Always
1.	Physically struggle with the child to get him or her to eat (for example, physically putting the child in the chair so he or she will eat).	1	2	3	4	5
2.	Promise the child something other than food if he or she eats (for example, “If you eat your beans, we can play ball after dinner”).	1	2	3	4	5
3.	Encourage the child to eat by arranging the food to make it more interesting (for example, making smiley faces on the pancakes).	1	2	3	4	5
4.	Ask the child questions about the food during dinner.	1	2	3	4	5
5.	Tell the child to eat at least a little bit of food on his or her plate.	1	2	3	4	5
6.	Reason with the child to get him or her to eat (for example, “Milk is good for your health because it will make you strong”).	1	2	3	4	5
7.	Say something to show your disapproval of the child for not eating dinner.	1	2	3	4	5
8.	Allow the child to choose the foods he or she wants to eat for dinner from foods already prepared.	1	2	3	4	5
9.	Compliment the child for eating food (for example, “What a good boy! You’re eating your beans”).	1	2	3	4	5
10.	Suggest to the child that he or she eats dinner, for example by saying, “Your dinner is getting cold”.	1	2	3	4	5
11.	Say to the child “Hurry up and eat your food”.	1	2	3	4	5
12.	Warn the child that you will take away something other than food if he or she doesn’t eat (for example, “If you don’t	1	2	3	4	5

	finish your meat, there will be no play time after dinner”).					
13.	Tell the child to eat something on the plate (for example, “Eat your beans”).	1	2	3	4	5
14.	Warn the child that you will take a food away if the child doesn’t eat (for example, “If you don’t finish your vegetables, you won’t get fruit”).					
15.	Say something positive about the food the child is eating during dinner.	1	2	3	4	5
16.	Spoon-feed the child to get him or her to eat dinner.	1	2	3	4	5
17.	Help the child to eat dinner (for example, cutting the food into smaller pieces).	1	2	3	4	5
18.	Encourage the child to eat something by using food as a reward (for example, “If you finish your vegetables, you will get some fruit”).	1	2	3	4	5
19.	Beg the child to eat dinner.	1	2	3	4	5

SECTION M CONTINUED:

Short Form Food Frequency Questionnaire

The following questions ask about some foods & drinks your child might have during a 'typical' week, over the past month or so. Do not be concerned if some things your child eats or drinks are not mentioned.

Please cross how often your child eats at least ONE portion of the following foods & drinks: (a portion includes: a handful of grapes, an orange, a serving of carrots, a side salad, a slice of bread, a glass of pop).

(Please only put one CROSS, but answer **EVERY** line)

	Rarely or never	Less than 1 a Week	Once a Week	2-3 times a Week	4-6 times a Week	1-2 times a Day	3-4 times a Day	5+ a Day
Fruit (tinned / fresh)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salad (not garnish added to sandwiches or accompaniment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables (tinned / frozen / fresh but not potatoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled, mashed or jacket potatoes baked in the oven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried or roasted potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oven-cooked chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried rice/biryani	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chapattis/parathas/puris/nan with butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chapattis/nan without butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Snacks	Rarely or never	Less than 1 a Week	Once a Week	2-3 times a Week	4-6 times a Week	1-2 times a Day	3-4 times a Day	5+ a Day
Biscuits (chocolate, plain, savoury)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes/ pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisps and other savoury snacks (Doritos, cheese puffs etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sweets or chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chevda, Bombay mix etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indian sweets e.g. burfi, jelabi, gulab jaman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Samosas, pakoras, spring rolls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sausage rolls, pork pies, pasties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other snacks (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drinks	Rarely or never	Less than 1 a Week	Once a Week	2-3 times a Week	4-6 times a Week	1-2 times a Day	3-4 times a Day	5+ a Day
Natural Fruit Juice e.g. orange, pineapple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mango juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit drinks or squash – sugar free (with sweetener)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit drinks or squash - containing sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coke/Pepsi/Fanta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet coke/diet Pepsi/diet Fanta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drinks	Rarely or never	Less than 1 a Week	Once a Week	2-3 times a Week	4-6 times a Week	1-2 times a Day	3-4 times a Day	5+ a Day
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ready meals (take-away, chip shop, supermarket chilled meals etc)	Rarely or never	Less than 1 a Week	Once a Week	2-3 times a Week	4-6 times a Week	7+ times a week
Meat pies/pasties, vegetarian pies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pizza, quiche, flan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal from chip-shop, e.g. chips, fish & chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beef burgers/veggie burgers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kentucky-fried chicken or similar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indian food take-away e.g. curry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Donner kebab (meat, chicken etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese food take-away e.g. chow mein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ready meals/take-away meals (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On average, how many portions of FRUIT does your child eat a day?

(examples include a handful of grapes, an orange, a glass of fruit juice, a handful of dried fruits). _

No of portions =

On average, how many portions of VEGETABLES does your child eat a day? (examples include: 3 heaped tablespoons of carrots, a side salad, 2 spears of broccoli).

No of portions =

What milk does your child usually use or drink, such as in hot & cold drinks or on cereal? (including tea, coffee, hot milk, milk shakes, or on cereal)

Whole / full-fat milk	<input type="checkbox"/>	Condensed milk	<input type="checkbox"/>
Semi - skimmed milk	<input type="checkbox"/>	Rarely/never use milk	<input type="checkbox"/>
Skimmed milk	<input type="checkbox"/>		
Other (please write its name, exclude formula milk)			

SECTION N

CHILDREN'S PHYSICAL ACTIVITY

These questions are about different activities that your child might do in a typical week. As you answer the questions please think about the sorts of activities that your child has been doing in the last month.

1. Compared with children of the same age and sex, do you think your child is: *(please tick one box)*

Generally less active

Similarly active

Generally more active

2. Do you agree or disagree with the following statements about your child's activity? *(please tick one box for each statement)*

		Disagree	Neither agree nor disagree	Agree
a.	I think my child enjoys being physically active			
b.	I think it's important that my child doesn't watch too much TV			
c.	I think it is important that my child is physically active			

3. In the last month, how often have you or your partner *(please tick one box for each statement)*

		Never	1-3 times this month	Once a week	2-4 times a week	5-6 times a week	Everyday
a.	Encouraged your child to play physically active games?						
b.	Done a physical activity or played in a physically active way with your child?						
c.	Taken your child to places where he/she can be physical active?						

4. In the last month, how often has your child...

(please tick on box for each statement)

		Never	1-3 times this month	Once a week	2-4 times a week	5-6 times a week	Everyday
a.	Watched TV at meal times						
b.	Gone to bed at a regular time						
c.	Played ball games in the house						
d.	Eaten snacks while watching TV						
e.	Ran or ridden a tricycle in the house						

5. In the last month, how often have you or your partner limited the time your child spends doing the following activities? (please tick one box for each statement)

		Never	1-3 times this month	Once a week	2-4 times a week	5-6 times a week	Everyday
a.	Watching TV/DVDs						
b.	Playing on the computer						
	N/A						
c.	Playing outside						

6. In the past month how often has your child been limited from doing a physical activity because: (please tick one box for each statement)

		Never	1-3 times this month	Once a week	2-4 times a week	5-6 times a week	Everyday
a.	Of the cost of clubs or facilities (e.g. swimming pools/activity centres)						
b.	It is difficult to travel to places where my child can be physical activity						
c.	Of the weather						
d.	I am too busy						
e.	I am scared that my child will get hurt						
f.	There are no other children to play with						
g.	There is no adult to supervise the child whilst playing						
h.	I can't take them on my own						

7. Which of the following types of toys does your child have at home to play with?

(please circle)

a) Cuddly toys/dolls	Yes	No
b) Light, sound and music toys	Yes	No
c) Swing	Yes	No
d) Slide/climbing frame/tunnels	Yes	No
e) Trampoline	Yes	No
f) Toy vehicles (cars) and construction toys (building blocks)	Yes	No
g) Jigsaw puzzles/Shape sorter/ stacking toys	Yes	No
h) Books	Yes	No
i) Balls	Yes	No
j) Push toys (e.g. pram or trolley)	Yes	No
k) Tricycle/scooter/sit and ride toys	Yes	No
l) Role play equipment (e.g. kitchen toys)	Yes	No
m) Ball/sand pit or paddling pools	Yes	No
n) Educational toys (alphabet, numbers, games)	Yes	No
o) Musical Instruments	Yes	No
p) Arts and craft equipment (crayons/paints)	Yes	No
q) Computer games (not including physically active games, e.g Nintendo Wii)	Yes	No
r) Physically active computer games (e.g. Nintendo Wii)	Yes	No

8. Is there space for your child to play active games (tag/playing with a ball, sit and ride toys or push toys) inside the home? *(please circle)*

Yes No

9. Do you have a garden/yard where your child can play outside at home? *(please circle)*

Yes No

If yes, in the last month how often has your child played outside in your garden/yard?

(please tick one box)

- Never
- 1-3 times this month
- Once a week
- 2-3 times a week
- 5-6 times a week
- Everyday

10. In the last month has the time your child has spent doing the following activities been different between week days and weekend days?

(please tick one box for each statement)

	My child has spent more time doing this on week days	My child has spent more time doing this on weekend days	There's been no difference between week days and weekend days
Playing actively (dancing, running, playing with active toys)			

Sitting playing with toys (dolls, puzzles)			
Watching TV/DVDs and playing on the computer			

11. Is there free space for your child to play outside in the surrounding neighbourhood e.g. parks and playgrounds? (Please circle) Yes No

12. In the last month, how often has your child played at the park/playground? (any playground)
(please tick one box)

- Never
- 1-3 times this month
- Once a week
- 2-3 times a week
- 5-6 times a week
- Everyday

13. In the last month, how long has your child spent at the park or playground when they have been? (please tick one box)

- N/A, they haven't been
- Up to 15 minutes
- 16 – 30 minutes
- 31 – 60 minutes
- More than 60 minutes

14. Do you feel that your neighbourhood is an unsafe place for your child to play in terms of criminal activity/anti-social behaviour? (please circle)

Yes No

15. Are there any indoor facilities for your child to play inside in the surrounding neighbourhood? e.g. Playgroups and activity centres (not nursery or pre-school)?

(please circle)

Yes No

16. In the last month how often has your child played at indoor play facilities (playgroups and soft play centres, not nursery or pre-school)? (please tick one box)

- Never
- 1-3 times this month
- Once a week
- 2-3 times a week
- 5-6 times a week
- Everyday

17. In the last month, how long has your child spent at indoor play facilities when they have been? (please tick one box)

- N/A, they haven't been
- Up to 15 minutes
- 16 – 30 minutes
- 31 – 60 minutes
- More than 60 minutes

18. In the last month, how much time has your child spend at nursery/pre-school each week?

(please tick one box)

- Full time 30 hours or more per week
- Part time, how many Hours and Minutes
.....
- They don't go

19. Does the nursery/pre-school your child attends have an indoor movement area where your child can be physically active? (by this we mean a dedicated indoor open area. *(please circle)*)

Yes No Don't know

20. Does the nursery/pre-school your child attends have an outdoor play area where your child can be physically active? *(please circle)*

Yes

No

Don't know

21. In the last month when your child has been travelling short distances that an adult could walk on foot in about 10 minutes (for example, to go to the local shop/school/park), how has your child normally travelled? (please tick one box)

In their buggy/pushchair

Walked

Carried

In the car

On public transport

Other, Please specify:

22. In the last month has the time your child has spent sitting down travelling (e.g in the car/buggy/public transport) been different between week days and weekend days? (please tick one box)

My child has spent more time in seated travel on weekdays

My child has spent more time in seated travel on weekend days

There has been no difference between week days and weekend days

SECTION O

PARENTING PRACTICES

Now there are some questions about being a parent. These are for you to fill out yourself. Don't spend too long thinking about the answers because often your first thoughts are the best.

Cross ONE box for each question.

1. Overall as a parent, do you feel that you are: *(Cross ONE box only)*

- Not very good at being a parent
- A person who has some trouble being a parent
- An average parent
- A better than average parent
- A very good parent

Please CROSS ONE BOX for how much this describes the way you generally feel or behave with this child

	Not at all how I feel					Exactly how I feel				
	1	2	3	4	5	6	7	8	9	10
2. I feel I am very good at keeping this child amused										
3. I feel that I am very good at calming this child when he/she is upset										
4. I feel I am very good at keeping this child busy while I am doing housework										
5. I feel that I am very good at routine tasks of caring for this child (feeding him/her, changing his or her nappies and giving him/her a bath)										

We are just asking about parents' views on child rearing.

	Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always
6. How often do you express affection by hugging, kissing and holding this child?					
7. How often do you hug or hold this child for no particular reason?					
8. How often do you tell this child how happy he/she makes you?					
9. How often do you have warm, close times together with this child?					
10. How often do you enjoy doing things with this child?					
11. How often do you feel close to this child both when he/she is happy and he/she is upset?					

Now thinking about the last 4 weeks, how much do these statements describe how you have been feeling or behaving with this child?

	Not at All									All the time
	1	2	3	4	5	6	7	8	9	10
12. I have been angry with this child										
13. I have raised my voice with or shouted at this child										
14. When this child cries, he/she gets on my nerves										
15. I have lost my temper with this child.										
16. I have left this child alone in his/her bedroom when he/she was particularly upset										

To what extent do you agree or disagree with the following statements? If you have never left this baby with a babysitter, please answer about how you *would* feel if you left this baby with someone else.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
17. I always check on my child immediately when he/she is crying.					
18. Child is happier with me than with babysitters.					
19. When away from child, I worry about whether or not the babysitter/carer is able to soothe and comfort the child if he/she is lonely or upset.					
20. Only a mother just naturally knows how to comfort her distressed child.					
21. I worry when someone else cares for child.					
22. I am naturally better at keeping child safe than any other person.					
23. A child is likely to get upset when he/she is left with a babysitter or carer.					

SECTION P HOW YOU HAVE FELT OVER THE LAST 30 DAYS

The next few questions are about how you have felt over the last 30 days.

1. During the past 30 days, about how often did you feel so depressed that nothing could cheer you up? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

2. During the last 30 days about how often did you feel hopeless? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

3. During the last 30 days about how often did you feel restless or fidgety? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

4. During the last 30 days, about how often did you feel that everything was an effort? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

5. During the last 30 days, about how often did you feel worthless? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

6. During the last 30 days, about how often did you feel nervous? (CROSS one box only)

All of the time Most of the time Some of the time A little of the time None of the time

SECTION Q

These last few questions ask about how being in Born in Bradford may have effected you and what your main health concerns are for your child.

1. Has being part of the Born in Bradford project made you more aware of the health of you and your child?

Yes No

2. Has being part of Born in Bradford encouraged you to adopt a healthier life style?

Yes No

3. What would your priorities be for future health research for Born in Bradford?

Diabetes	<input type="checkbox"/>	Childhood infections	<input type="checkbox"/>
Autism	<input type="checkbox"/>	Behavioural disorders	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Childhood obesity	<input type="checkbox"/>
Childhood Accidents	<input type="checkbox"/>	Dental health for children	<input type="checkbox"/>
Eczema	<input type="checkbox"/>		

Other _____

