

den norske *Mor & barn undersøkelsen*

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Questionnaire 5 – Your child at 18 months

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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 progress. It will help if you have child's Health card to hand 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 following 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
- Write numbers in the large green 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
---	---	---	---	---	---	---	---	---	---

Please do not use this questionnaire. Contact us at morbarn@fhi.no or phone + 47 53 20 40 40 if you need a questionnaire.

- 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

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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

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Month

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Year

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

ABOUT YOUR CHILD

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Food and drink

1. What type of milk has your baby been given since he/she was 6 months old?

(You can enter more than one cross.)

Milk type	Child's age in months			
	6 - 8	9 - 11	12 - 14	15 - 18
1. Breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Formula in the case of milk intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Whole milk (sweet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Low-fat milk normal (sweet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Extra low-fat milk (sweet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Skimmed milk (sweet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Yogurt with active Lactobacillus, all types	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Other yogurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other types of sour milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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5. Do you give your child a home-made dinner or readymade (processed) baby food in a jar?

- Only home-made
- Mostly home-made
- About half and half of each
- Mostly ready-made
- Only ready-made

6. How often do you give your child organic food/drink?

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

	Never	Sometimes	Often	Almost always
Sweet milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttermilk/yogurt . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables/fruit . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Porridge/flour/bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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7. Does your child have a reaction to certain foods?

- No
- Yes
- Don't know

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8. If yes, what type of food does your child have a reaction to? (You can enter a cross in more than one box.)

- | | | |
|---|---|--|
| 1. <input type="checkbox"/> Whole milk | 8. <input type="checkbox"/> Boiled or fried egg | 14. <input type="checkbox"/> Fruit, berries |
| 2. <input type="checkbox"/> Skimmed milk/low-fat milk | 9. <input type="checkbox"/> Fish/fish products | 15. <input type="checkbox"/> Vegetables/potatoes |
| 3. <input type="checkbox"/> Cream | 10. <input type="checkbox"/> Additives | 16. <input type="checkbox"/> Chocolate |
| 4. <input type="checkbox"/> Yogurt/buttermilk | 11. <input type="checkbox"/> Wheat | 17. <input type="checkbox"/> Other sweets |
| 5. <input type="checkbox"/> Ice cream | 12. <input type="checkbox"/> Nuts | 18. <input type="checkbox"/> Sugar |
| 6. <input type="checkbox"/> Cheese | 13. <input type="checkbox"/> Soya | 19. <input type="checkbox"/> Other: _____ |
| 7. <input type="checkbox"/> Raw egg (e.g. egg flip) | | |

9. Are there any foods which you specifically avoid giving your child?

- No
- Yes

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10. If yes, which foods do you try to avoid and how strict are you with your child's diet?

	Some reduced use compared to normal diet	Not used unmixed but allowed a little bit in different dishes	Use completely avoided (also "hidden" in dishes)
1. Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fish/fish products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Meat/meat products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Wheat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you give your child cold liver oil, vitamins, iron or any other dietary supplement?

- No
- Yes

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12. If yes, specify which product(s) and how often you give them to your child. How old was your child when you first started giving him/her the product?

+	How often do you give it to your child?		How old was your child when you first gave him the product?	
	Every day	sometimes	Number of months	
1. Cod liver oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
2. Biovit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
3. Sanasol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
4. Nycoplus Multi-Vitamin mixture for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
5. Fluoride tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
6. Iron supplement, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
7. Other dietary supplement, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Growth, health and illness

Consult your child's health card and use the information contained in it to complete the following questions.

13. How many times have you been to the mother and child health centre since his/her birth?

- 0 - 4
 5 -10
 11 -15
 16 or more

14. Do you want your child to be given the vaccinations that are recommended for children in Norway?

- Yes, all the recommended vaccinations
 Yes, some vaccinations
 No, no vaccinations

15. Indicate whether your child has had any vaccinations. If yes, how many times, and indicate if there have been any sideeffects requiring a doctor or hospital to be contacted. (Enter a cross in a box for each item.)

Vaccinations	No		If yes, how many times?			Side-effect resulting in extra contact with a doctor?		Side-effect resulting in examination/admission to hospital?	
	No	Yes	1	2	3	No	Yes	No	Yes
1. DTP (diphtheria, tetanus, whooping cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2. Hib (Haemophilus influenzae type b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3. Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
4. MMR (measles, mumps, rubella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
5. DT (diphtheria, tetanus - sometimes given instead of DTP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
6. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
7. BCG (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
8. Pneumococcus (Prevenar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
9. Other vaccination: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

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

16. Does your child have or has he/she had any of the following health problems? If yes, has your child been referred for a specialist examination? (Enter a cross in a box for each item.)

Health problem	No		Yes, has now		Yes, had previously		If yes, has child been referred for a specialist examination?	
	No	Yes	No	Yes	No	Yes	No	Yes
1. Dislocated hip (hip problem)	<input type="checkbox"/>	<input type="checkbox"/>						
2. Reduced hearing	<input type="checkbox"/>	<input type="checkbox"/>						
3. Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>						

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(cont.)

Health problem	+				
	No	Yes, has now	Yes, had previously	If yes, has child been referred for specialist examination?	
				No	Yes
4. Delayed motor development (e.g. sits/walks late) . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Too little weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Too much weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Abnormal head circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Testicles not descended into scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Atopic eczema (childhood eczema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Urticaria (hives)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Food allergy/intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Late or abnormal speech development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Sleep problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Behavioural problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Social problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. (Other) malformations: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. If a specialist referral was made, what did this examination show?

Everything was fine

Still some doubts/further examinations needed

Has not been for any examination yet

Diagnosis I: _____

Diagnose II: _____

Diagnose III: _____

18. Has your child been treated with a “cushion” for a hip problem?

No

Yes How long? months

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19. Has your child had any of the following illnesses/health problems between 6 and 11 months and/or 12 and 18 months? Specify how many times and whether your child has been admitted to hospital for this health problem. (Enter a cross in a box for each item.)

Illness/health problem	At 6 –11 months		Number of times	At 12 -18 months		Number of times	Was admitted to hospital for this?	
	No	Yes		No	Yes		No	Yes
1.Common cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Throat infection with confirmed streptococcal infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Other type of sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pseudocroup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Bronchitis/RS virus/pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Gastric flu/diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>

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Illness/health problem	+		At 6 –11 months		Number of times	At 12 -18 months		Number of times	Was admitted to hospital for this?	
	No	Yes	No	Yes		No	Yes			
	10. Febrile convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
11. Other convulsions (without any fever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<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="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<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="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Has your child been to see the doctor or to the hospital between 6 and 11 months and/or 12 and 18 months?

If yes, specify how many times. (Enter a cross in a box for each item.)

	At 6 – 11 months			At 12-18 months		
	No	Yes	Number of times	No	Yes	Number of times
GP (excluding mother and baby health centre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Casualty doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Private specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hospital outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Admitted to hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

21. Has your child been referred to any of the following services?

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

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

Hospital name: _____

Hospital name: _____

Hospital name: _____

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23. Has your child had any of the following symptoms since the age of 6 months? If yes, at what age? (Enter a cross in a box for each item.)

	Had symptoms?		If yes, at what age?			
	No	Yes	6-8 mth	9-11 mth	12-14 mth	15 mth or more
1. Wheezing/whistling in the chest	<input type="checkbox"/>					
2. Tightness in the chest	<input type="checkbox"/>					
3. Coughing at night	<input type="checkbox"/>					
4. Runny nose without a cold	<input type="checkbox"/>					
5. Constipation	<input type="checkbox"/>					
6. Diarrhoea	<input type="checkbox"/>					
7. Itchy rash that comes and goes	<input type="checkbox"/>					

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24. Has your child ever been tested for allergies?

- No
 Yes +

25. If yes, what allergens were tested for and what was the result?
(You can enter a cross in more than one box.)

Test:	Was the test positive?		
	No	Yes	Don't know
1. <input type="checkbox"/> Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <input type="checkbox"/> Egg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="checkbox"/> Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <input type="checkbox"/> Mould	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <input type="checkbox"/> Mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <input type="checkbox"/> Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <input type="checkbox"/> Pollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Have you ever tried any kind of so-called alternative medicine on your child since he/she was 6 months old?

- No
 Yes times

27. If yes, what kind of alternative medicine?

28. Has your child received any medication since the age of 6 months? *(This means any type of medication, including natural medicines and herbal remedies)*

- No
 Yes +

29. If yes, give the name of the medication and what age your child was when he took it. *(Include all types of medication, as well as natural medicines)*

Name of medicine <i>(WRITE IN CAPITALS, e.g. APOCILLIN, PARACET)</i>	How old was your child when he/she took this medication?			
	6-8 mth	9-11 mth	12-14 mth	15-18 mth
_____	<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"/>

30. What were your child's length, weight and head circumference when he/she was around 8 months, 1 year and the last time they were measured (15-18 months)?
(Refer to your child's health card)

	Date of measurement			Length	Head circumference	Weight
	Day	Month	Year			
Around 8 mth	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/> cm	<input type="text" value=""/> cm	<input type="text" value=""/> g
Around 1 year	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/> cm	<input type="text" value=""/> cm	<input type="text" value=""/> g
15 - 18 mth	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/> cm	<input type="text" value=""/>	<input type="text" value=""/> g

Development and behaviour

In this section you will find some questions repeated in a different form. However, please answer all the questions as well as you can.

31. Can your child walk unaided? No Yes

If yes, how old was your child when he/she could first walk unaided? Number: months.

32. The questions that follow are about your child's development at around the age of 18 months. (Enter a cross in a box for each item.) ⁺

	Yes	Sometimes	Not yet
1. When you ask him/her, does your child go into another room to find a familiar toy or object? (When you ask, for instance: "Where's your ball?", "Go and get your coat" or "Go and get your blanket")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child say eight or more words, in addition to "mamma" and "dadda"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Without showing him/her first, does your child point to the correct picture when you say "Show me the cat" or "Where is the dog"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child move around by walking, rather than by crawling on his/her hands and knees?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Can your child walk well and seldom fall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child walk down stairs if you hold onto one of his/her hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child throw a small ball or toy with a forward arm motion? (If he/she simply drops the ball, enter a cross under "Not yet")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child stack a small block or toy on top of another? (For example, small boxes or toys about 3 cm in size)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child turn the pages in a book by himself/herself? (He/she may turn over more than one page at a time.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child hug dolls or cuddly toys when playing with them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child try to get your attention show you something by pulling your hand or clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child come to you when he/she needs help, such as with opening a box?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child copy the activities you do, such as wiping up a spill, sweeping, shaving or combing hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. More about your child's development (Enter a cross in a box for each item.)

	Yes, usually	Very seldom	Not yet
1. Does your child use sounds or words together with gestures (e.g. uses sounds when pointing or reaching towards toys or objects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When you look at a distant object and, surprised and excited, say: "Wao...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. 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"/>
4. Does your child show you a toy by looking at you and holding the toy up towards your face (from a distance just so you can look at it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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34. How typical is the following behaviour of your child? (Enter a cross in a box for each item.)

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

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35. About your child's behaviour We are asking you about how your child usually is. If something happens seldom (for instance, if you have only seen it one or twice), enter a cross under "No". (Enter a cross in a box for each item.)

	Yes	No	+
1. Is your child interested in different sorts of toys or objects and not for instance mainly in cars or buttons?	<input type="checkbox"/>	<input type="checkbox"/>	
2. When your child expresses his/her feelings, for instance by crying or smiling, do you usually understand <u>why</u> your child is laughing or crying?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does your child react in a normal way to sensory stimulation, such as coldness, warmth, light, pain or tickling?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Can you easily tell from the face of your child how he/she feels?	<input type="checkbox"/>	<input type="checkbox"/>	
5. When your child has been left alone for some time, does he/she try to attract your attention, for instance, by crying or calling?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is your child's behaviour without stereotyped repetitive movements, e.g. banging his/her head against the wall or rocking his/her body back and forth?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does your child like to be cuddled?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does your child ever laugh directly at you or at other people?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does your child react when spoken to, for instance, by looking, listening, smiling, speaking or babbling?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Does your child ever try to comfort you if you are sad or hurt?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Has your child ever had things that he/she seemed to have to do in a very particular way or order, or rituals that he/she has to have you do?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does your child ever do things to get you to laugh?	<input type="checkbox"/>	<input type="checkbox"/>	

+

36. More about your child's play and behaviour. We are asking you again about how your child usually is. If something seldom happens (for instance, if you have only seen it one or twice), enter a cross under "No". (Enter a cross in a box for each item.)

	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child take an interest in other children?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child like climbing on things, such as up stairs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child ever use his/her index finger to point, to ask for something?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child ever use his/her index finger to point, to indicate interest in something?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling or dropping them?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child ever bring objects over to you to show you something?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child look you in the eye for more than a second or two?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child ever seem oversensitive to noise (e.g. plugging ears)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child smile in response to your face or your smile?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child imitate you (e.g. you make a face - will your child imitate it)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your child respond when you call his/her name?	<input type="checkbox"/>	<input type="checkbox"/>
15. If you point at a toy across the room, does your child look at it?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child look at things you are looking at?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does your child make unusual finger movements near his/her face?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does your child try to attract your attention to his/her own activity?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you every wondered if your child is deaf?	<input type="checkbox"/>	<input type="checkbox"/>
20. Does your child understand what people say?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child sometimes stare at nothing or wander with no purpose?	<input type="checkbox"/>	<input type="checkbox"/>
22. Does your child look at your face to check your reaction when faced with something unfamiliar? ..	<input type="checkbox"/>	<input type="checkbox"/>

CBCL

37. 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. Can't concentrate, can't pay attention for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Quickly shifts from one activity to another	<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. Gets into everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

(cont.)

+	Not true	Somewhat or sometimes true	Very true or often true
5. Is mostly happy and content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Clings to adults or too dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Gets too upset when separated from parents	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Gets into many fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Hits others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is defiant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Doesn't seem to feel guilty after misbehaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Punishment doesn't change his/her behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Doesn't eat well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Likes almost every kind of food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Resists going to bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Doesn't want to sleep alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Afraid to try new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Disturbed by any change in routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Too fearful or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. How often does your child usually wake during the night?

3 or more times every night

Once or twice every night

A few times a week

Seldom or never

+

39. How many hours in total does your child sleep in 24hrs?

10 hours or less

11 - 12 hours

13 -14 hours

15 hours or more

40. About your worries (Enter a cross in a box for each item.)

	No	Yes	Don't know
1. Are you worried about your child's physical development?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you worried about your child's behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you worried because your child is demanding and difficult to cope with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you worried because your child is so uninterested in other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you any other worries with regard to your child's health	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____

(Use the last page if you need more space to write)

Your child's daily routine

41. Where has your child been cared for during the day? Enter a cross for the various age groups. (Enter a cross in a box for each item.)

	At home with his/her mother his/her father	At home with unqualified childminder	At a childminder's	In a day nursery
1. 0-6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 7-9 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 10-12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 13-15 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. 16-18 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. How many hours a week is your child looked after in the current childcare scheme (other than by his/her mother and father)?

hours

+

43. How many children in total are looked after in this childcare scheme (if day-care centre, how many in the department)?

children

44. Do you and your child live with your child's father?

Yes

No

+

45. If your child does not live with his/her father, how much time does your child spend with him?

- At least half the time
 At least once a week +
 At least once a month
 Less often than once a month
 Never

46. How many times have you moved house since your child was born?

times

47. Roughly how many square metres is the living area where you currently live?

m²

48. Are the rooms where your child is heated by electrical underfloor heating?

- No Yes

49. If yes, which rooms? Enter a cross in more than one box, if appropriate)

- Living room Hall
 Kitchen Bathroom
 Child's room Other rooms
 Bedroom

50. Has there been any damage caused by damp, any visible fungal/mould growth or mouldy smell in your home during the last year (You can enter a cross in more than one box.)

- No
 Yes, damage caused by damp +
 Yes, visible fungal/mould growth
 Yes, mouldy smell

51. What type of drinking water do you have where you live?

- Water from a public or private water company
 Water from your own water supply (e.g. own well)
 Don't know

52. Do you live close to high-voltage lines?

- No
 Yes, closer than 50 metres
 Yes, 50–100 metres away
 Yes, but more than 100 metres away

53. Are there pets where your child lives or at the childminder's?

- No
 Yes, at home +
 Yes, at the childminder's

54. If yes, what kind of pets? (You can enter a cross in more than one box.)

- Dog
 Cat
 Guinea pig, rabbit, mouse, rat, etc.
 Budgie, other type of bird
 Other type of animal: _____

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

- Yes, every day Number of times per day +
 Yes, several times a week
 Yes, sometimes
 Don't know
 No

56. How many months old was your child when he/she got his/her first tooth?

- Number of months
 Don't remember

57. How often are your child's teeth brushed?

- Twice a day or more
 Once a day
 sometimes
 Never

58. Do you use fluoride toothpaste when brushing your child's teeth?

- No
 Sometimes
 Yes, usually

59. How often is your child outside at the moment?

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

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

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

61. Does your child go to or has been to swimming classes for babies?

- No
 Yes +
 If yes, how long has your child been going? months

62. Does your child use a dummy/pacifier now at 18 months?

- Seldom or never
 Only when he/she goes to sleep
 Quite often
 Most of the time

72. Have you experienced pain during the last 12 months in any of the following places? (Enter a cross in a box for each item.)

	Seldom/never	Slight pain	Some pain	Major pain	
1. Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Arms/legs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Neck/shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Pelvis (pelvic girdle pains)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

73. Have you experienced any pain in your back or pelvis during the last 12 months. Enter a cross to indicate how much pain you have felt in different places:

	Some pain	Major pain
1. In the small of the back	<input type="checkbox"/>	<input type="checkbox"/>
2. One of the pelvic/sacroiliac joints at the back	<input type="checkbox"/>	<input type="checkbox"/>
3. Both pelvic/sacroiliac joints at the back	<input type="checkbox"/>	<input type="checkbox"/>
4. Over the coccygeal bone	<input type="checkbox"/>	<input type="checkbox"/>
5. In the buttocks	<input type="checkbox"/>	<input type="checkbox"/>
6. Over the pubic bone	<input type="checkbox"/>	<input type="checkbox"/>
7. Groin	<input type="checkbox"/>	<input type="checkbox"/>
8. Other back pains	<input type="checkbox"/>	<input type="checkbox"/>
9. Other pains	<input type="checkbox"/>	<input type="checkbox"/>

74. Currently, do you wake during the night because of pelvic pain?

- No, never
- Yes, but seldom
- Yes, often +

75. Do you have such problems walking at the moment because of pelvic pains that you have to use a stick or crutches?

- No, never
- Yes, but not every day - the pain varies from day to day
- Yes, must use a stick or crutches every day

76. Did you receive any treatment for pelvic pain after your last birth?

- No
- Yes

77. If yes, what type of treatment did you receive?

(You can enter a cross in more than one box.)

- Physiotherapy
- Chiropractic
- Medication
- Other: _____

78. Do you have any of the following problems at the moment? (Enter a cross in a box for each problem.)

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	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"/>
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"/>
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"/>
4. Problems retaining faeces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Problems retaining flatus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

79. Do you regularly take medication? (This means any type of medication, including natural medicines.)

- No
- Yes

+

+

80. If yes, give the name of the medicines and how often you take them. (Include all types of medication, as well as natural medicines.)

Name of medicine (e.g. APOCILLIN, PARACET)	How often do you take them?		
	Every day	Every day for certain periods	Sometimes
_____	<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"/>

Finances – lifestyle

81. How much leave did you and the child's father take after the birth? (Specify either the number of months or weeks.)

	Months		Weeks
Yourself	<input type="text"/>	or	<input type="text"/>
Child's father	<input type="text"/>	or	<input type="text"/>

82. Are you in paid employment?

No
 Yes **+**

83. If so, how many hours do you work a week?

hours

84. If you are in paid employment, have you taken any time off sick since you went back to work? If yes, specify how many days you were off sick.

No

Yes, due to own illness. Number of days

Yes, due to your child being ill.

85. Would your current finances allow you to cope with an unexpected bill of NOK 3,000 for a dental visit or a repair, for instance?

No
 Yes
 Don't know

86. Have you found it difficult sometimes during the last six months to cope with running expenses for food, transport, rent, etc.?

No, never
 Yes, but infrequently
 Yes, sometimes **+**
 Yes, often

87. How often are you so physically active (during your spare time or at work) that you get out of breath and sweat?

	Spare time	At work
1. Never	<input type="checkbox"/>	<input type="checkbox"/>
2. Less than once a week	<input type="checkbox"/>	<input type="checkbox"/>
3. Once a week	<input type="checkbox"/>	<input type="checkbox"/>
4. Twice a week	<input type="checkbox"/>	<input type="checkbox"/>
5. 3-4 times a week	<input type="checkbox"/>	<input type="checkbox"/>
6. 5 times or more a week	<input type="checkbox"/>	<input type="checkbox"/>

88. How often do you exercise at present? (Enter a cross in a box for each item.)

Activity	Never	1-3 times a month	Once a week	Twice a week	3 times or more a week
1. Walking	<input type="checkbox"/>				
2. Brisk walking	<input type="checkbox"/>				
3. Running/jogging/orienteering	<input type="checkbox"/>				
4. Cycling	<input type="checkbox"/>				
5. Training studio/weight training	<input type="checkbox"/>				
6. Aerobics/gymnastics/dance without running and jumping	<input type="checkbox"/>				
7. Aerobics/gymnastics/dance with running and jumping	<input type="checkbox"/>				
8. Dancing (swing/rock/folk)	<input type="checkbox"/>				
9. Skiing	<input type="checkbox"/>				
10. Ball sports	<input type="checkbox"/>				
11. Swimming	<input type="checkbox"/>				
12. Riding	<input type="checkbox"/>				
13. other	<input type="checkbox"/>				

89. What are your and your partner's smoking habits at home at the moment?

	Yourself	Your partner/ husband
1. Don't smoke	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke sometimes	<input type="checkbox"/>	<input type="checkbox"/>
3. Smoke every day	<input type="checkbox"/>	<input type="checkbox"/>
4. If every day, number of cigarettes per day	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

90. How often do you consume alcohol at the moment?

- 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 often than once a month
- Never

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

	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 checked="" 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 sherry 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

A little more about yourself and how you are keeping now

92. 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 husband/partner and I have a close relationship	<input type="checkbox"/>					
2. My partner and I have problems in our relationship	<input type="checkbox"/>					
3. I am very happy in my relationship	<input type="checkbox"/>					
4. My partner is usually understanding	<input type="checkbox"/>					
5. I often think about ending our relationship	<input type="checkbox"/>					
6. I am satisfied with my relationship with my partner	<input type="checkbox"/>					
7. We often disagree about important decisions	<input type="checkbox"/>					
8. I have been lucky in my choice of partner	<input type="checkbox"/>					
9. We agree on how children should be raised	<input type="checkbox"/>					
10. I think my partner is satisfied with our relationship	<input type="checkbox"/>					

93. 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

94. 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 often
- 2-8 times a month
- More than twice a week

95. Do you often feel lonely?

- Almost never
- Seldom
- Sometimes
- Generally
- Almost always

96. How accurate are these statements to you? (Enter a cross in a box for each item.)

	Not accurate	Slightly accurate	Almost accurate	Totally accurate
1. I always manage to solve difficult problems if I try hard enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If anyone opposes me, I find a way to get what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am sure that I can cope with unexpected events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am calm when I encounter difficulties because I trust my ability to cope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When I am in a difficult situation, I usually find a solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Seldom/ never	Fairly seldom	Sometimes	Often	Very often
1. Feel pleased about something	<input type="checkbox"/>				
2. Feel happy	<input type="checkbox"/>				
3. Feel joyful, as though everything is going your way	<input type="checkbox"/>				
4. Feel that you will scream at someone or hit something.	<input type="checkbox"/>				
5. Feel angry, irritated or annoyed	<input type="checkbox"/>				
6. Feel mad at somebody	<input type="checkbox"/>				

+

98. How do you feel about 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 do not have much to be proud of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel that I'm a valuable person, as good as anyone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

99. Have you been bothered by any of the following feelings during the past 2 weeks? (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"/>

100. Have you experienced any of the following situations in the last year (since the previous questionnaire)? If yes, how painful and difficult was this for you? (Enter a cross in a box for each item.)

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

+

+

101. How would you rate your quality of life?

- Very poor
- Poor
- Neither poor nor good
- Good
- Very good

+

102. How satisfied are you with your health?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied

+

103. The following questions ask about how much you have experienced certain things in the last two weeks. (Enter a cross in a box for each item.)

	Not at all	A little	A certain amount	A lot/very	Totally/extremely
1. To what extent do you feel that (physical) pain prevents you from doing what you need to do?	<input type="checkbox"/>				
2. To what extent do you need medical treatment to be able to function in your daily life?	<input type="checkbox"/>				
3. How much do you enjoy life?	<input type="checkbox"/>				
4. To what extent do you feel your life to be meaningful?	<input type="checkbox"/>				
5. How well are you able to concentrate?	<input type="checkbox"/>				
6. How safe do you feel in your daily life?	<input type="checkbox"/>				
7. How healthy is your physical environment?	<input type="checkbox"/>				

104. The following questions ask about how completely you experienced or were able to do certain things in the last two weeks. (Enter a cross in a box for each item.)

	Not at all/None	A little	To a certain extent	Mostly Almost	Always
1. Do you have enough energy for everyday life?	<input type="checkbox"/>				
2. Are you able to accept your bodily appearance?	<input type="checkbox"/>				
3. Have you enough money to meet your needs?	<input type="checkbox"/>				
4. How accessible is the information that you need in your day-to-day life?	<input type="checkbox"/>				
5. To what extent do you have the opportunity for leisure activities?	<input type="checkbox"/>				

+

105. How well are you able to get around?

- Very badly
- Badly
- Neither well nor badly
- Well
- Very well

106. The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks. (Enter a cross in a box for each item.)

	Very dissatisfied	Dis-satisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
1. How satisfied are you with your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How satisfied are you with your ability to perform your daily living activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How satisfied are you with your capacity for work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How satisfied are you with your personal relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How satisfied are you with your sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How satisfied are you with the support you get from your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How satisfied are you with the conditions where you live?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How satisfied are you with your access to health services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How satisfied are you with your transport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

+

107. The following question relates to how often you have experienced or had negative feelings during the last two weeks?

How often do you have negative feelings, such as
blue mood, despair, anxiety, depression? + Never Seldom Quite often Very often Always

COMMENTS:

+

+

CHILD'S MEASUREMENTS AND WEIGHT

108. If any of the measurements in Question 30 are missing from the child's health card, can we contact the well baby clinic for them?

- No
- Yes Name of well baby clinic _____
- Post code or district _____

Have you remembered to fill in on page 1 the date on which you completed the questionnaire?

Thank you very much for your help!

Please return the completed questionnaire in the stamped addressed envelope provided to:

Den norske Mor og Barn undersøkelsen
Nasjonalt folkehelseinstitutt
Avd. for medisinsk fødselsregister
Kalfarveien 31
5018 Bergen

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