

Census Tract (For Office Use Only)

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COMMUNITY ISSUES

1. Communities can struggle with different issues. Let us know what issues you feel that your community struggles with by rating the following on a scale of “Not a Problem” to “Big Problem.”

Issue	Not a Problem	Small Problem	Medium Problem	Big Problem
Domestic Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Juvenile Delinquency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Underage Drinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teenage Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unemployment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homelessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hunger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Childhood Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adult Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Think about the following community services. Tell us how important you feel that it is for your community to provide each service on a scale of “Not Important” to “Very Important.”

Issue	Not Important	Somewhat Important	Important	Very Important
Health Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care of the Elderly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services for People with Disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol/Substance Abuse Programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Youth Programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Income Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Upkeep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Do you feel that your community is a safe place to grow up or to raise children?

Very Unsafe Unsafe Somewhat Safe Safe Very Safe

4. Finally, provide your opinion on each of the following community needs. Tell us whether each is “Not a Problem” to a “Big Problem.”

Issue	Not a Problem	Small Problem	Medium Problem	Big Problem
Affordable Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Public Transportation (Daytime)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Public Transportation (Evening/Weekend)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial Literacy Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Senior Nutrition Programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Computer Skills Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PERSONAL HEALTH AND WELLNESS

1. How would you rate your general health?

Poor	Fair	Good	Very Good	Excellent
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. How many times per week do you take part in physical activities or exercise, such as running, calisthenics, golf, gardening, or walking?

I do not exercise.	1 Time/Week	3 Times/Week	5 Times/Week	Daily
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. How much time do you usually spend each time you take part in physical activities/exercise?

Less than 30 minutes	30-60 minutes	60 minutes or more
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. What is your height without shoes? Enter number of feet and inches. For instance, if you are 5 feet 6 inches tall, bubble 5 in the first column and 6 in the second column.

	Feet	Inches
0	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>
10	<input type="radio"/>	<input type="radio"/>
11	<input type="radio"/>	<input type="radio"/>

5. What is your weight without shoes? Estimate your weight in pounds. For instance, if you weigh 160 pounds, you would bubble "1" in the first column, "6" in the second column, and "0" in the third column.

	Estimated Weight (in pounds)		
	Hundreds	Tens	Ones
0	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Did you do any of the following to lose weight or keep from gaining weight over the past 6 months? Bubble all that apply.

- | | |
|--|---|
| <input type="radio"/> Eat less food
<input type="radio"/> Fewer calories
<input type="radio"/> Low fat foods
<input type="radio"/> Exercise
<input type="radio"/> Go without eating for 24 hours | <input type="radio"/> Take diet pills, powders, or liquids without doctor's advice
<input type="radio"/> Vomit
<input type="radio"/> Take laxatives
<input type="radio"/> Smoke Cigarettes |
|--|---|

QUALITY OF LIFE/CAREGIVING NEEDS

1. In the past 30 days, have you needed help meeting your general daily needs such as food, clothing, shelter, or paying utility bills?

- Yes
 No

If yes, do any of the following limit your abilities to meet your daily needs?

	Yes	No
Physical Conditions	<input type="radio"/>	<input type="radio"/>
Psychological Conditions	<input type="radio"/>	<input type="radio"/>

2. During the past 12 months, have you experienced confusion or memory loss?

- Yes
 No

If yes, please rate the following.

Severity	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>
Frequency	Seldom (1-2 Times) <input type="radio"/>	Occasionally (monthly) <input type="radio"/>	Often (weekly or more) <input type="radio"/>
Is it?	Getting Worse <input type="radio"/>	Staying the Same <input type="radio"/>	Getting Better <input type="radio"/>

3. During the past month, did you provide regular care or assistance to someone who has a health (including long-term disability) problem?

- Yes
- No

If yes, what was the age of the person?

Birth to 21 <input type="radio"/>	22-64 <input type="radio"/>	65 or older <input type="radio"/>
--------------------------------------	--------------------------------	--------------------------------------

What condition(s) required the person to need care and/or assistance? Bubble all that apply

- | | |
|--|--|
| <input type="radio"/> Arthritis/Rheumatism | <input type="radio"/> Multiple Sclerosis (MS) |
| <input type="radio"/> Asthma | <input type="radio"/> Spinal Cord Injury |
| <input type="radio"/> Cancer | <input type="radio"/> Traumatic Brain Injury |
| <input type="radio"/> Diabetes | <input type="radio"/> Alzheimer's Disease or Other Dementia |
| <input type="radio"/> Heart Disease | <input type="radio"/> Attention Deficit/Hyperactivity Disorder |
| <input type="radio"/> Hypertension/High Blood Pressure | <input type="radio"/> Learning Disabilities |
| <input type="radio"/> Lung Disease/Emphysema | <input type="radio"/> Cerebral Palsy |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Down's Syndrome |
| <input type="radio"/> Parkinson's Disease | <input type="radio"/> Other Developmental Disability |
| <input type="radio"/> Stroke | <input type="radio"/> Anxiety |
| <input type="radio"/> Eye/Vision Problems | <input type="radio"/> Depression |
| <input type="radio"/> Hearing Problems | <input type="radio"/> Other Mental Illness |

4. Within the past 12 months, have any of your family members needed long-term placement, nursing home or rehabilitation care, or home health care services?

- Yes
- No

2. Where do you usually go if you are sick or need advice about your health? Bubble the one that you use the most often.

- Doctor's Office
- Hospital Emergency Room
- Urgent Care Center
- Hospital Outpatient Clinic
- Internet/Web
- Call-a-Nurse Service
- Other

3. What might prevent you from seeing a doctor if you were sick, injured, or needed some type of health care? Bubble all that apply.

- Cost
- Cannot get time off work
- Hours not convenient
- Difficult to get appointment
- No transportation or difficult to find transportation
- Frightened of the procedure or doctor

4. About how long has it been since you visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- | | | | | |
|-------------------------|------------------------------|-------------------------------|-----------------------|-----------------------|
| Within the past
year | Within the past
two years | Within the past
five years | Five or more
years | Never |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

5. In the past 12 months, have you gone outside of Logan County for health care?

- Yes
- No

If so, why? Bubble all that apply.

- My provider of choice is in another area.
- No providers are available for services I need
- My insurance only covers doctors in another area.
- No appropriate doctors accept Medicaid.
- My primary physician referred me.
- I have concerns about care provided by area physicians.
- I have concerns about care provided by area hospital

What type of services did you receive outside of Logan County? Bubble all that apply.

- | | |
|--|---|
| <input type="radio"/> Lab Work | <input type="radio"/> Immunizations |
| <input type="radio"/> Mammography or Breast Care | <input type="radio"/> General Practitioner Care |
| <input type="radio"/> General Surgery | <input type="radio"/> Mental Health Services |
| <input type="radio"/> Urology Care | <input type="radio"/> Eye Care |
| <input type="radio"/> Ear, Nose, or Throat Care | <input type="radio"/> Orthopedic/Bone Care |
| <input type="radio"/> Podiatry Care | <input type="radio"/> Cardiac/Heart Care |
| <input type="radio"/> X-Ray or MRI | <input type="radio"/> General Dental Care |
| <input type="radio"/> Hearing Services | <input type="radio"/> Orthodontia |
| <input type="radio"/> Family Planning | <input type="radio"/> Obstetrics/Gynecology |
| <input type="radio"/> Emergency Room Service | <input type="radio"/> CPR Training |

6. In the past 12 months, did you get a prescription from your doctor which you did NOT get filled?

- Yes
No

If yes, why? Bubble all that apply.

- | | |
|--|---|
| <input type="radio"/> Did not have money to purchase | <input type="radio"/> Did not have transportation to pharmacy |
| <input type="radio"/> Chose not to take it | <input type="radio"/> Other |

HEALTH CARE COVERAGE

1. What type of health care coverage do you have? Bubble all that apply.

- | | |
|---|---|
| <input type="radio"/> I currently don't have coverage | <input type="radio"/> Medicare |
| <input type="radio"/> Employer Plan (self) | <input type="radio"/> Medicaid |
| <input type="radio"/> Employer Plan (other) | <input type="radio"/> Military Coverage |
| <input type="radio"/> Individual (Self-Pay) Plan | <input type="radio"/> Other |

2. What does your coverage include?

	Yes	No	Don't Know
Routine Medical Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription Coverage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skilled Nursing Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Who does your coverage include?

Myself

Myself and Spouse

Myself, Spouse, and Children

4. If you are without coverage, what is the main reason?

- Lost Job/Changed Employers
- Spouse or Parent Lost Job/Changed Employers
- Became Divorced/Separated
- Spouse/Parent Died
- Became Ineligible (age or left school)
- Employer Doesn't Offer Coverage
- Became Part-Time or Temporary Employee
- Benefits from Former Employer (e.g., Cobra) Ran Out
- Couldn't Afford Premiums
- Insurance Company Refused Coverage
- Lost Medicaid Eligibility
- Other

ORAL HEALTH

1. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialist, such as orthodontists.

Within the past
year

Within the past
two years

Within the past
five years

Five or more
years

Never

If it has been more than a 12 months, what is the main reason?

- Don't Have Dentist
- Cost
- No Transportation
- No Appointment Available
- Dentist Doesn't Accept Insurance

PREVENTATIVE MEDICINE AND HEALTH SCREENINGS

1. Have you ever been told by a doctor, nurse, or other health professional that you had diabetes?

- Yes
- No

If yes:

	Yes	No
Have you taken a class on how to manage your diabetes yourself?	<input type="radio"/>	<input type="radio"/>
Was the diagnosis only during pregnancy	<input type="radio"/>	<input type="radio"/>

2. Have you ever been told by a doctor, nurse, or other health care professional that you have hypertension, or high blood pressure?

Yes
 No

If yes:

	Yes	No
Are you currently taking medication?	<input type="radio"/>	<input type="radio"/>
Is your blood pressure currently controlled with medication?	<input type="radio"/>	<input type="radio"/>
Is your blood pressure currently controlled with diet and/or exercise?	<input type="radio"/>	<input type="radio"/>

3. Have you ever been told by a doctor, nurse, or other health care professional that you have high blood cholesterol?

Yes
 No

If yes:

	Yes	No
Are you currently taking medication?	<input type="radio"/>	<input type="radio"/>
Is your cholesterol currently controlled with medication?	<input type="radio"/>	<input type="radio"/>
Is your cholesterol currently controlled with natural supplements?	<input type="radio"/>	<input type="radio"/>
Is your cholesterol currently controlled with diet and/or exercise?	<input type="radio"/>	<input type="radio"/>

4. Have you ever been told by a doctor, nurse, or other health care professional that you had cancer?

Yes
 No

If yes, what type? Bubble all that apply.

- | | |
|--|--|
| <input type="radio"/> Breast Cancer | <input type="radio"/> Stomach Cancer |
| <input type="radio"/> Cervical Cancer | <input type="radio"/> Hodgkin's Lymphoma |
| <input type="radio"/> Endometrial Cancer | <input type="radio"/> Non-Hodgkin's Lymphoma |
| <input type="radio"/> Ovarian Cancer | <input type="radio"/> Leukemia |
| <input type="radio"/> Head or Neck Cancer | <input type="radio"/> Prostate Cancer |
| <input type="radio"/> Oral Cancer | <input type="radio"/> Testicular Cancer |
| <input type="radio"/> Pharyngeal (Throat) Cancer | <input type="radio"/> Melanoma |
| <input type="radio"/> Thyroid Cancer | <input type="radio"/> Other Skin Cancer |
| <input type="radio"/> Colon Cancer | <input type="radio"/> Heart Cancer |
| <input type="radio"/> Esophageal Cancer | <input type="radio"/> Lung Cancer |
| <input type="radio"/> Liver Cancer | <input type="radio"/> Bladder Cancer |
| <input type="radio"/> Pancreatic Cancer | <input type="radio"/> Renal Cancer |
| <input type="radio"/> Rectal Cancer | <input type="radio"/> Other |

5. Have you ever been told by a doctor, nurse, or other health care professional that you have any of the following other conditions? Bubble all that apply.

- | | |
|--|--|
| <input type="radio"/> Heart Attack | <input type="radio"/> Depression |
| <input type="radio"/> Coronary Heart Disease | <input type="radio"/> Anxiety |
| <input type="radio"/> Stroke | <input type="radio"/> Other Mental Illness |
| <input type="radio"/> Asthma | <input type="radio"/> Sexually Transmitted Disease |
| <input type="radio"/> COPD | <input type="radio"/> Alzheimer's Disease |
| <input type="radio"/> Emphysema | <input type="radio"/> Other Form of Dementia |
| <input type="radio"/> Arthritis | |

6. Have you received a tetanus shot in the past 10 years?

- Yes
 No

7. Have you received a pertussis or whooping cough vaccine in the past 10 years?

- Yes
 No

8. During the past 12 months, have you received a flu vaccine?

- | | | |
|-----------------------|-----------------------|-----------------------|
| No | Yes – Flu Shot | Yes – Nasal Mist |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

9. Have you received preventative information from a health care provider about any of the following topics? .

	Yes	No	Didn't Need
Diet or Eating Habits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Activity or Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injury Prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug Use/Drug Addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quitting Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Immunizations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. During the past 30 days, for about how many days did you get less than 6 hours of sleep in a 24-hour period?

- | | | |
|-----------------------|-----------------------|-----------------------|
| 0-5 Days | 10-15 Days | 16 Days or More |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

11. Have you ever been tested for HIV?

- | | | |
|-----------------------|-----------------------|---------------------------------|
| No | Yes (out of concern) | Yes (part of routine screening) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

ALCOHOL AND TOBACCO USE

1. During the past 30 days, how many days did you have at least one drink of any alcoholic beverage?

- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Never | 1-2 Days | 3-5 Days | 5-10 days | 10 Days or More |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

2. One drink is equivalent to a 12-ounce beer, a small glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average? Note: A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

- | | | |
|-----------------------|-----------------------|-----------------------|
| 1-2 | 3-4 | More than 4 |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

3. During the past 30 days how many times have you driven when you've had perhaps too much to drink?

- | | | |
|-----------------------|-----------------------|-----------------------|
| Never | 1-2 Times | More than 2 Times |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. At that age do you think it is ok for youth and young adults to drink on special occasions with their families?

Under 11	11-12	13-14	15-16	17-18	19-20	Never
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. At what age do you think it is ok for youth to drink socially with their friends?

Under 11	11-12	13-14	15-16	17-18	19-20	Never
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Please rate your agreement with the following statements related to your attitude towards underage drinking.

	Strongly Disagree	Disagree	Agree	Strongly Agree
It is ok for youth under the age of 21 to drink if they don't drive afterward.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol retailers are careful when it comes to preventing the sale of alcohol to underage persons in our community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parents should be able to buy alcohol for their children under the age of 21.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is ok for adults to supply youth under the age of 21 with alcohol.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. How difficult would it be for youth under the age of 21 in your community to buy alcohol at a store?

Very Difficult	Somewhat Difficult	Easy	Very Easy
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. How long has it been since you smoked cigarettes regularly?

- Within the past month
- Within the past 3 months
- Within the past 6 months
- Within the past year
- Within the past 5 years
- Within the past 10 years
- 10 years or more
- Never smoked regularly

WOMEN'S HEALTH

1. A mammogram is an x-ray of each breast to look for breast cancer. How long has it been since you have had a mammogram?

- | | | | | | |
|-----------------------|-----------------------|----------------------------|----------------------------|----------------------------|-------------------------|
| Never | More than 5
Years | Within the
Past 5 Years | Within the
Past 3 Years | Within the
Past 2 Years | Within the
Past Year |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

2. A pap test is a test for cancer of the cervix. It usually involves taking a swab of vaginal fluid. How long has it been since you had your last Pap test?

- | | | | | | |
|-----------------------|-----------------------|----------------------------|----------------------------|----------------------------|-------------------------|
| Never | More than 5
Years | Within the
Past 5 Years | Within the
Past 3 Years | Within the
Past 2 Years | Within the
Past Year |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

3. A colonoscopy is a test for cancer of the colon. How long has it been since you had a colonoscopy?

- | | | | | | |
|-----------------------|-----------------------|----------------------------|----------------------------|----------------------------|-------------------------|
| Never | More than 5
Years | Within the
Past 5 Years | Within the
Past 3 Years | Within the
Past 2 Years | Within the
Past Year |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. A vaccine to prevent the human papilloma virus or HPV infection is available and is called the cervical cancer or genital warts vaccine, HPV shot (sometimes called Gardasil). Have you received any HPV shots?

- Yes
- No

5. During your last pregnancy, did you do any of the following? Bubble all that apply.

- | | |
|--|---|
| <input type="radio"/> Received Prenatal Care (1 st Trimester) | <input type="radio"/> Took a Prenatal Vitamin |
| <input type="radio"/> Smoked Cigarettes | <input type="radio"/> Lived with a Smoker |
| <input type="radio"/> Drank Alcohol | <input type="radio"/> Used Illegal Drugs |
| <input type="radio"/> Used Other Drugs (Not Prescribed) | <input type="radio"/> Experienced Domestic Violence |

6. Within the past 12 months, have you or any family members received help with prenatal care (financial or otherwise) from a public or private agency in the community?

- | | | | |
|-----------------------|-----------------------|-----------------------------|-----------------------|
| No | Yes - Medicaid | Yes – Food Stamps or
WIC | Yes - Other |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

MEN'S HEALTH

1. A Prostate-Specific Antigen test, also called a PSA test is a blood test used to check men for prostate cancer. When was your last PSA test?

Never	More than 5 Years	Within the Past 5 Years	Within the Past 3 Years	Within the Past 2 Years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. A digital rectal exam is when a health professional places a gloved finger inside the rectum in order to feel the prostate gland. When was your last digital rectal exam?

Never	More than 5 Years	Within the Past 5 Years	Within the Past 3 Years	Within the Past 2 Years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. A colonoscopy is a test for cancer of the colon. How long has it been since you had a colonoscopy?

Never	More than 5 Years	Within the Past 5 Years	Within the Past 3 Years	Within the Past 2 Years
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SEXUAL BEHAVIOR

1. In the past 12 months, how many people have you had sexual intercourse with?

None	1	2-5	6-10	More than 10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. If you are currently sexually active, what are you or your partner doing now to keep from getting pregnant?

- | | |
|--|--|
| <input type="radio"/> Not Using Birth Control | <input type="radio"/> Contraceptive Ring (e.g., Nuvaring) |
| <input type="radio"/> Tubes Tied | <input type="radio"/> Contraceptive Patch (e.g., Ortho-Evra) |
| <input type="radio"/> Vasectomy | <input type="radio"/> Diaphragm |
| <input type="radio"/> Birth Control Pills | <input type="radio"/> Cervical Cap or Sponge |
| <input type="radio"/> Male Condom | <input type="radio"/> Foam, Jelly, or Cream |
| <input type="radio"/> Female Condom | <input type="radio"/> IUD (e.g., Mirena) |
| <input type="radio"/> Contraceptive Implant (e.g., Implanon) | <input type="radio"/> Rhythm Method |
| <input type="radio"/> Shots (e.g., Depo-Provera) | <input type="radio"/> Withdrawal (or pulling out) |
| <input type="radio"/> Emergency Contraceptive (e.g., morning after pill) | |

3. If you are not currently using birth control, what is your main reason for not doing anything now to keep from getting pregnant?

- Trying to Get Pregnant
- Didn't Plan to Have Sex
- Don't Like Birth Control
- Side Effects of Birth Control
- Can't Pay for Birth Control
- Religious Reasons
- Self or Partner had Tubes Tied/Vasectomy
- Past Menopause
- Can't Get Pregnant for Other Medical Reasons
- Breastfeeding or Postpartum
- Currently Pregnant
- Same-Sex Partner

4. Have you ever been forced to have sexual activity when you didn't want to?

- Yes
- No

MENTAL HEALTH

1. Over the past 12 months, have you had 2 or weeks in which you felt sad, blue or depressed or lost interest or pleasure in things you usually care about or enjoy?

- Yes
- No

2. In the past 30 days, how many days would you say your mental health has prevented you from performing your usual daily activities?

- | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|
| None | 1-2 Days | 3-10 Days | More than 10 Days |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

3. During the past 12 months, did you ever seriously consider attempting suicide?

- Yes
- No

If yes, how many times did you actually attempt suicide?

- | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|
| NA – Didn't Attempt | Once | 2-3 Times | More than 3 Times |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. On a typical day, how would you rate your stress level?

- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Very Low | Low | Moderate | High | Very High |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

5. When you feel stressed, how do you deal with it? Bubble all that apply.

- | | |
|---|--|
| <input type="radio"/> Talking to Someone | <input type="radio"/> Sleeping |
| <input type="radio"/> Exercising | <input type="radio"/> TV or Video Games |
| <input type="radio"/> Drinking Alcohol | <input type="radio"/> Drugs |
| <input type="radio"/> Prescription Medication | <input type="radio"/> Working |
| <input type="radio"/> Yelling and Screaming | <input type="radio"/> Shopping |
| <input type="radio"/> Eating | <input type="radio"/> Working on a Hobby |
| <input type="radio"/> Listening to Music | <input type="radio"/> Meditation |
| <input type="radio"/> Smoking | |

6. Have you or has anyone in your family been diagnosed with a mental illness?

- Yes
 No

If yes:

- | | Yes | No |
|--|-----------------------|-----------------------|
| Was the diagnosis completed locally? | <input type="radio"/> | <input type="radio"/> |
| Was the mental assessment difficult to obtain? | <input type="radio"/> | <input type="radio"/> |
| Was adequate treatment found in the community? | <input type="radio"/> | <input type="radio"/> |
| Does the person have a mental health caseworker? | <input type="radio"/> | <input type="radio"/> |

7. Have you or has anyone in your family been diagnosed with a mental disability?

- Yes
 No

If yes:

- | | Yes | No |
|---|-----------------------|-----------------------|
| Are there adequate educational programs in the community? | <input type="radio"/> | <input type="radio"/> |
| Are there adequate social activities in the community? | <input type="radio"/> | <input type="radio"/> |
| Are there adequate occupational therapies in the community? | <input type="radio"/> | <input type="radio"/> |
| Is proper placement available in the community? | <input type="radio"/> | <input type="radio"/> |

PARENTING

1. What are the ages of any children living in your household? Bubble all that apply.
(If no children are living in your household, skip to the next section)

- | | |
|-------------------------------|--------------------------|
| <input type="radio"/> Under 1 | <input type="radio"/> 9 |
| <input type="radio"/> 1 | <input type="radio"/> 10 |
| <input type="radio"/> 2 | <input type="radio"/> 11 |
| <input type="radio"/> 3 | <input type="radio"/> 12 |
| <input type="radio"/> 4 | <input type="radio"/> 13 |
| <input type="radio"/> 5 | <input type="radio"/> 14 |
| <input type="radio"/> 6 | <input type="radio"/> 15 |
| <input type="radio"/> 7 | <input type="radio"/> 16 |
| <input type="radio"/> 8 | <input type="radio"/> 17 |

2. How many of your children are male vs. female?

	0	1	2	3	4	5 or More
Male	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Female	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. During the past 12 months, was there any time that any of your children did not have health insurance coverage?

- | | | |
|-----------------------|-------------------------|----------------------------------|
| No | Yes (have coverage now) | Yes (currently without coverage) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. How are you related to the children in your household?

- | | |
|---|--------------------------------------|
| <input type="radio"/> Parent | <input type="radio"/> Sibling |
| <input type="radio"/> Grandparent | <input type="radio"/> Other Relative |
| <input type="radio"/> Foster Parent or Guardian | <input type="radio"/> Not Related |

5. Have any of the children in your household ever been diagnosed with asthma?

- Yes
 No

If yes, does the child still have asthma?

- Yes
 No

6. During the past 12 months, how many of the children in your household have received the seasonal flu vaccine?

None

Some

All

7. Have any of the girls in your household received an HPV shot?

Yes, all of them

Yes, some of them

No

NA – no girls

8. Have you used any of the following programs for infant to four-year olds? Bubble all that apply.

WIC

Help Me Grow

Newborn Home Visits

Head Start

Early Head Start

Subsidized Child Care

9. Did you discuss any of the following with your 12 to 17-year old in the past 12 months? Bubble all that apply.

Abstinence/How to Refuse Sex

Dating and Relationships

Time on Electronics

Alcohol

Tobacco/Smoking

NA – No children 12-17

Birth Control

STD Prevention

Eating Habits

Body Image

Other Drugs

10. In an average week, how many times do all of the people in your household eat a meal together? (include eating out if the entire family is eating together)

0

1

2

3

4

5 or More

11. Within the past 12 months, have you or a household member adopted a child?

Yes

No

If yes, who handled the adoption?

Public Agency

Private Agency

Was financial assistance provided?

- Yes
- No

12. Within the past 12 months, have you or a household member relinquished rights to a child for adoption?

- Yes
- No

If yes:

	Yes	No
Was relinquishing of rights completed by a private agency?	<input type="radio"/>	<input type="radio"/>
Was the private agency found in the community?	<input type="radio"/>	<input type="radio"/>

13. Are you familiar with the Putative Father Registry? Note: The Putative Father Registry is a State of Ohio registry to help protect the rights of fathers

- Yes
- No

ENVIRONMENT/SAFETY

1. How often do you use seatbelts when you drive or ride in a car?

Never	Seldom	Sometimes	Almost Always	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. When was the last time you or someone else deliberately tested all the smoke detectors in your home?

Never	Over a Year Ago	Within the Past 12 Months	Within the Past 6 Months
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. How well prepared do you feel your household is to handle a large-scale disaster or emergency?

Not at All Prepared	Somewhat Prepared	Well Prepared
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. What would be your main method of getting information from authorities in a large-scale disaster or emergency?

- Television
- Newspaper
- Radio
- Telephone
- Internet
- Walking (i.e., neighbors)

5. In your opinion, have any of the following threatened you or your family's health in the past 12 months? Bubble all that apply.

- Rodents (mice or rats)
- Insects
- Unsafe Water Supply
- Plumbing Problems
- Sewage Problems
- Heating/AC Problems
- Structural Housing Issues
- Lead Paint
- Chemicals in Household Products
- Mold
- Asbestos

6. For which of the following reasons might you not report illegal activity in your community? Bubble all that apply.

- Lack of Trust in Police
- Lack of Trust in Judicial System
- Fear of Getting Hurt
- Lack of Evidence

7. During the past 12 months, do you feel that you have been abused (physically, sexually, or verbally) by another person?

- Yes
- No

If yes, what is your relationship to that person?

- Spouse
- Sibling
- Boyfriend/Girlfriend
- Parent
- Other Family Member
- Unrelated Person not in Household
- Unrelated Person in Household

SOCIAL CONTEXT

1. In your opinion, do any of the following apply to your house or apartment?

- It is too crowded.
- It is too expensive.
- It is too far from everything.
- It is "run down."
- I am too close to neighbors.
- It is in an unsafe neighborhood.

2. How often in the past 12 months would you say you were worried or stressed about having enough money for the following?

Issue	Never	Rarely	Some	Usually	Never
Having Money for Rent/Mortgage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having Money for Utilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buying Nutritious Food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Would you have any problems getting the following if you needed them today?

	Yes	No
Someone to loan me \$50	<input type="radio"/>	<input type="radio"/>
Someone to talk to about problems	<input type="radio"/>	<input type="radio"/>
Someone to help if I were sick and in bed	<input type="radio"/>	<input type="radio"/>
Someone to take me to the doctor's office	<input type="radio"/>	<input type="radio"/>

4. Have you used any type of utility, housing, meal, education, or rental assistance from a Logan County agency or organization in the past 12 months?

- Yes
- No

If yes, what type of assistance/organization? Bubble all that apply.

- WIC
- Food Stamps
- Medicare or Medicaid
- Child Care Subsidy
- Housing/Rent Subsidy
- Cash Assistance
- Other Food/Meal Subsidy
- Other Medical Subsidy/Assistance
- Education Subsidy
- Other

5. In the community, what is the one place you go most often for recreation?

- Parks
- Live Theater or Concerts
- Social Clubs
- Outside Areas (e.g., river,
- Sports Fields
- Swimming Pools
- Health/Fitness Clubs
- Dance Halls
- YMCA
- Church
- Senior Center
- Library

6. Please tell us about how you feel about your community by rating the following statements.

Issue	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I am given lots of chances to help make my town or city a better place in which to live.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In my town/city, I feel like I matter to people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In my neighborhood, there are a lot of people who care about me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. During an average week, how often do you do the following?

	Never	1-2 Times	3-4 Times	5-6 Times	Daily
Going to programs, groups, or shows	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Going to church services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Volunteering (helping other people without getting paid)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

DEMOGRAPHICS

1. What is your age?

	Age	
	Tens	Ones
0	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>

2. What is your gender?

- Male
- Female

3. What is your race/ethnicity?

- American Indian/Alaskan
- Black or African American (not Hispanic)
- White/Caucasian (not Hispanic)
- Asian
- Native Hawaiian/Other Pacific Islander
- Hispanic
- Mixed or Biracial
- Other

4. What is your marital status?

- Single
- Married
- Live with Partner
- Divorced or Separated
- Widowed

5. What is your highest level of education?

- Elementary School
- Some Middle or High School
- High School Graduate/GED
- Some College
- College Graduate

6. Have you ever served on active duty in the Armed Forces, either in the regular military or a National Guard or military reserve unit?

- Yes – currently active
- Yes – active more than a year ago
- No – never served in the military
- Yes – active within the past 12 months
- No –reserve/national guard training only

7. Are you currently employed for wages?

- Employed Full Time
- Employed Part Time
- Self Employed
- Homemaker
- Unable to Work
- Student
- Retired
- Unemployed (more than a year)
- Unemployed (less than a year)

8. What is your best estimate of your 2010 household income before taxes?

- Less than \$15,000
- \$15,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 - \$99,000
- \$100,000 or higher