FAMILY WELLNESS SURVEY

Making sure your child is well cared for and develops healthy is our top priority. In addition to providing quality services, we believe that the next best thing we can do for your child is to support you as a parent.

We are giving this questionnaire to learn about you and your family. The first part asks about 10 stressful experiences that can happen during childhood. We want to know if any happened to you during your childhood and how your family has been doing recently. Your answers will help us to make sure you and your children have the support and resources to cope with any potential stressors. We are asking, not to judge you, but to help us better respond to the needs of your family.

Skip any question you do not feel comfortable answering, but please provide honest answers.

Parental Consent

Your service provider, _____, requests your permission to share information about your child's development and family wellness with the Consortium for Resilient Young Children and affiliated organizations. **All personal information shared with your child care provider, such as names and birth dates, will remain confidential and will NOT be shared. An identification number will be used so that you and your child's identity will be protected and not available to anyone outside of the center or program staff.**

This information will help us to better understand the challenges that families are experiencing and measure the effectiveness of supports to families in reducing stress. Information collected through the following assessments will be shared:

- Family Wellness Survey
- Ages and Stages Questionnaire or Devereux Early Childhood Assessment (DECA)

I understand that signing of this consent is voluntary and refusal to participate does not have any impact on the services provided to me and my child. By signing and dating this consent, I am giving approval to include my child's and family information as described above.

_____ _____

Parent's Signature Parent's Name – Printed Date

_____ _____

Witness Signature Witness Name – Printed Date

Thank you for your willingness to help us show how our services are making a difference!

JOINING FORCES FOR CHILDREN

The Consortium for Resilient Young Children

FAMILY WELLNESS SURVEY

Today's date: _____ **Your ZIP Code:**_____

Are you the child's: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Other relative
☐ Other: _____

Your race: ☐ African American ☐ Caucasian ☐ Multi-racial ☐ Other

Your ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

TELL US ABOUT YOUR CHILDHOOD EXPERIENCES

If you have completed this box in the past or prefer not to, then you can skip it & check here: ☐

During YOUR CHILDHOOD (prior to 18 years of age)…	**If Yes check the box**
a. Were your parents or guardians ever separated or divorced?	☐
b. Did you live with a household member who served time in jail or prison?	☐
c. Did you live with a household member who was depressed, mentally ill, or attempted suicide?	☐
d. Did you live with someone who had a problem with drinking or using drugs?	☐
e. Did you often see or hear household members hurt/threaten to hurt each other?	☐
f. Did you often feel unsupported, unloved, and/or unprotected?	☐
g. Did you often go without food, clothing, a place to live, or had no one to protect you?	☐
h. Did a household member often swear at, insult, put you down, or humiliate you OR act in a way that made you afraid that you might be physically hurt?	☐
i. Did a household member often push, grab, slap, or throw something at you OR ever hit you so hard that you had marks or were injured?	☐
j. Did someone touch your private parts or ask you to touch their private parts in a sexual way?	☐

TELL US ABOUT HOW YOU ARE DOING

How true have the following statements been for you recently:	**NOT AT ALL**	**RARELY**	**SOME TIMES**	**OFTEN**	**NEARLY ALL THE TIME**
1. I have a positive attitude about myself.					
2. I have people and places where I feel like I belong.					
3. I have others I can rely on for support.					
4. I am able to be flexible when things don't go as expected.					
5. I have the strength within myself to solve problems that happen in my life.					
6. I ask for help when I need it.					
7. I feel stressed with my home/family life.					
8. I feel little interest or pleasure in doing things.					
9. I feel down, depressed or hopeless.					

10. Has anything bad, sad, or scary happened to you OR your child recently? **NO** ☐ **YES** ☐

Would you like to tell us more? _____

11.12.2021 **ID:** _____

TELL US ABOUT YOUR SATISFACTION WITH LIFE

Over the LAST MONTH, how satisfied are you with the different aspects of your life? Indicate your satisfaction by placing an X along on the arrow from Not at All Satisfied to Very Satisfied:

NOT AT ALL SATISFIED

11. Your finances — VERY SATISFIED
12. Your job/education/career — VERY SATISFIED
13. Your basic needs (e.g. food, housing, transportation) — VERY SATISFIED
14. Your safety — VERY SATISFIED
15. Your family, friends and relationships — VERY SATISFIED
16. Your health and well-being — VERY SATISFIED
17. Your parenting — VERY SATISFIED
18. Your hopes for the future — VERY SATISFIED

What kind of help or support would you like in any of these areas?

_____

TELL US ABOUT YOUR RELATIONSHIP WITH YOUR CHILD

Over the LAST MONTH, how often have you…	NEVER	RARELY	SOMETIMES	MOST OF THE TIME	ALWAYS
19. Praised your child for trying something new or completing a difficult task?					
20. Labeled or encouraged your child to name his/her feelings?					
21. Helped your child practice ways to solve problems or get their needs met?					
22. Spent time with your child doing what he/she likes to do?					
23. Soothed your child when he/she was upset?					

24. Felt good about your relationship with your child?					

What kind of help or support, if any, would you like related to parenting and child development (e.g. toilet training, sleeping routines, nutrition, behavior concerns, emotional concerns)?

_____