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FY 2015 **(Draft)**

Fukushima Health Management Survey
Mental Health and Lifestyle Survey
Questionnaire (For ages 0-3)

〒963-0000
Room 302, Idai Apartment
1, Hikarigaoka, Fukushima city

Mr. Taro Idai

00X0X0X

Enter the required items in the fields below.
Please check ✓ in corresponding boxes□.

Date of entry： MM/DD/2016

Child's name：＿＿＿＿＿＿＿＿＿＿

Sex：1□ M 2□ F

Child's date of birth：MM/DD/YYYY

Who will respond to the survey?

1□Mother 2□Father 3□Grandparents 4□Other
（＿＿＿＿＿＿＿＿＿＿）

Name of guardian：
（Relationship：　　）

(Change of mailing address) Please enter only if mailing address differs from the address mentioned above.

〒 ＿＿＿ - ＿＿＿＿ Prefecture ＿＿＿＿＿＿ City, ward, county ＿＿＿＿＿＿ Ward, town, village ＿＿＿＿＿＿

Name of apartment/room number etc.＿＿＿＿＿＿＿＿

Contact information
Phone number ※The mental health support team may contact you.
Home：（　　） ＿＿＿＿＿＿ － ＿＿＿＿＿＿ （Name＿＿＿＿＿＿ ）
Cell：＿＿＿＿＿＿ － ＿＿＿＿＿＿ － ＿＿＿＿＿＿

Fukushima Prefecture, Fukushima Medical University

Please check ✓ in the corresponding small boxes □ below.

Q1. Describe your child's current health condition.

1□ Very good 2□ Good 3□ Normal 4□ Bad 5□ Very bad

Q2. Please enter your child's current height and weight.

Example : Height 89.9cm weight 12.6kg (enter values right justified)

Height 8 9 . 9 cm Weight 1 2 . 6 kg

Height ___ . ___ cm Weight ___ . ___ kg

Q3. Is your child currently receiving treatment for (a) disease(s), etc.?

1□ No 2□ Yes If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Allergic rhinitis 3□ Atopic dermatitis
4☐ Allergic diseases other than 1-3 5☐ Common Cold
6☐ Influenza
7☐ Tympanitis 8☐ Nasal sinus/empyema
9☐ Odontopathy (Cavities, braces, cleft lip and palate, etc.)
10☐ Epilepsy 11☐ ADHD (attention deficit hyperactivity)
12☐ Other (Specific name of disease) (_____)

Q4. Has your child been hospitalized due to an illness within this year?

1□ No 2□ Yes
If so, please check ✓ the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Pneumonia (acute/bronchial pneumonia) 3☐ Mycoplasma pneumonia
4☐ Respiratory syncytial virus infection (Respiratory syncytial virus pneumonia) 5☐ Common cold 6☐ Bronchitis (Acute bronchitis)
7☐ Influenza 8☐ Gastroenteritis (acute gastroenteritis) 9☐ Rotavirus infection
10☐ Febrile convulsion 11☐ Kawasaki disease 12☐ Inguinal hernia (hernia)
13☐ Other (Specific diseases) (_____)

Q5. Below are questions regarding your child's sleeping habits.

1) When does your child regularly sleep or wake up?

(Enter right justified based on 24-hour clock.
(Ex) 7:10PM→ 1 9 1 0 7:10AM→ 7 1 0)

Bedtime h min Time to wake up h min

2) Does your child take naps?

1□ No 2□ Yes → About h min

Q6. Below are questions for guardians who have a child aged 2 years or younger. How much does your child exercise?
(Running around indoors, kicking balls, riding tricycles, etc.)

1□ Almost every day 2□ Around 2-4 times per week

3□ Once a week 4□ Almost never

Q7. Below are questions regarding your child's diet.

1) Does your child drink breast milk?

1□ Yes 2□ No

2) Below are questions for guardians who have a child aged 1 year old or more. Please check ✓ in corresponding boxes regarding your child's past month diet.

① Does your child eat seafood 3 days or more per week?・・・・・・・・・・・・・・・ 1□ Yes 2□ No

② Does your child eat food such as vegetables other than pickles, seaweed or mushrooms almost every day?・・・・・ 1□ Yes 2□ No

③ Does your child eat fruits almost every day?・・・・・・・・・・・・・・・・・・・・・・・・・・

1□ Yes 2□ No

④ Does your child eat soy products (Tofu, deep fried tofu, natto, boiled beans, etc.) almost every day?・・ 1□ Yes 2□ No

⑤ Does your child eat dairy products (milk, yogurt, etc.) almost every day?・・・・・・・・・

1□ Yes 2□ No

Q8. Are there ever times when you doubt your ability to raise a child?

1□ Yes 2□ No 3□ Cannot say

※ If you have concerns regarding your child's health or comments regarding this survey, please describe them below.
Your comments will be used for references for future health management and surveys.

That is it for the questions.

Please enclose the questionnaire in a return envelope and send it by mail.

Thank you for your cooperation.

〔Contact〕

○ Exclusively for the Mental Health and Lifestyle Survey
Radiation Medical Science Center, Fukushima Medical University

Phone number: 024-549-5170
(9：00-17：00 with the exception of Dec 29-Jan 3 and weekends/holidays)

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FY 2015 **(Draft)**

Fukushima Health Management Survey
Mental Health and Lifestyle Survey
Questionnaire (For ages 4-6)

〒963-0000
Room 302, Idai Apartment
1, Hikarigaoka, Fukushima city

Taro Idai

00X0X0X

Enter the required items in the fields below.
Please check ✓ in corresponding boxes□.

Date of entry： MM/DD/2016

Child's name：＿＿＿＿＿＿＿＿＿＿＿＿

Sex：$_1$□ M $_2$□ F

Child's DOB：MM/DD/YYYY

Who will respond to the survey?

$_1$□Mother $_2$□Father $_3$□Grandparents $_4$□Other
（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

Name of guardian：
（Relationship：　　）

(Change of mailing address) Please enter if your mailing address differs from the address mentioned above.

〒 ＿＿＿ - ＿＿＿＿ Prefecture ＿＿＿＿＿＿ City, ward, county ＿＿＿＿＿＿ Ward, town, village ＿＿＿＿＿＿

Name of apartment/room number etc.＿＿＿＿＿＿＿＿＿＿

Contact information
Phone number ※The mental health support team may contact you.
Home：（　　） ＿＿＿＿＿＿ － ＿＿＿＿＿＿ （Name＿＿＿＿＿＿ ）
Cell：＿＿＿＿＿＿ － ＿＿＿＿＿＿ － ＿＿＿＿＿＿

Fukushima Prefecture, Fukushima Medical University

Please check ✓ in the corresponding small boxes □ below.

Q1. Describe your child's current health condition.

1□ Very good 2□ Good 3□ Normal 4□ Bad 5□ Very bad

Q2. Please enter your child's current height and weight.

Example : Height 89.9cm, weight 12.6kg (enter values right justified)

Height 1 1 6 . 6 cm Weight 2 1 . 3 kg

Height ☐☐☐.☐ cm Weight ☐☐.☐ kg

Q3. Is your child currently receiving treatment for (a) disease(s), etc.?

1□ No 2□ Yes

If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Allergic rhinitis 3□ Atopic dermatitis
4☐ Allergic diseases other than1-3 5☐ Common Cold
6☐ Influenza
7☐ Tympanitis 8☐ Nasal sinus/empyema 9☐ Odontopathy (Cavities, braces, cleft lip and palate, etc.)
10☐ Epilepsy 11☐ ADHD (attention deficit hyperactivity)
12☐ Other (Specific name of disease) (_____)

Q4. Has your child been hospitalized due to an illness within this year?

1□ No 2□ Yes

If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Pneumonia (acute/bronchial pneumonia) 3☐ Mycoplasma pneumonia
4☐ Respiratory syncytial virus infection (Respiratory syncytial virus pneumonia) 5☐ Common cold 6☐ Bronchitis (Acute bronchitis)
7☐ Influenza 8☐ Gastroenteritis (acute gastroenteritis) 9☐ Rotavirus infection
10☐ Febrile convulsion 11☐ Kawasaki disease 12☐ Inguinal hernia (hernia)
13☐ Other (Specific diseases) (_____)

Q5. Below are questions regarding your child's sleeping habits.

1) When does your child regularly sleep or wake up?

Enter right justified based on 24-hour clock.
(Ex) 7:10PM→ 1 9 10 7:10AM→ 7 10

Bedtime ☐☐ h ☐☐ min Time to wake up ☐☐ h ☐☐ min

2) Does your child take naps?

$_1$□ No $_2$□ Yes → About ☐☐ h ☐☐ min

Q6. Below are questions for guardians who have a child aged 2 years or younger. How much does your child exercise?
(Running around indoors, kicking balls, riding tricycles, etc.)

$_1$□ Almost every day $_2$□ Around 2-4 times per week

$_3$□ Once a week $_4$□ Almost never

Q7. Please check ✓ in the corresponding boxes □ below regarding your child's diet during the past month.

1) Does your child eat fast compared to others?・・・・・・・・ $_1$□ Fast $_2$□ Normal $_3$□ Slow

2) Does your child drink beverages containing sugar (juice, soft drinks) every day?・・・・ $_1$□ Yes $_2$□ No

3) Does your child eat seafood 3 days or more per week?・・・・・・・・・・・・・・・・ $_1$□ Yes $_2$□ No

4) Does your child eat food such as vegetables other than pickles, seaweed or mushrooms almost every day?・・・・・ $_1$□ Yes $_2$□ No

5) Does your child eat fruits almost every day?・・・・・・・・・・・・・・・・・・・・・・・・・・

$_1$□ Yes $_2$□ No

6) Does your child eat soy products (Tofu, deep fried tofu, natto, boiled beans, etc.) almost every day?・・ $_1$□ Yes $_2$□ No

7) Does your child eat dairy products (milk, yogurt, etc.) almost every day?・・・・・・・・・・・・

$_1$□ Yes $_2$□ No

8) Does your child eat pre-cooked food such as side dishes and boxed meal (including instant food) almost every day?・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ $_1$□ Yes $_2$□ No

9) Does your child eat out (including fast food) almost every day?・・・・・・・・・・

$_1$□ Yes $_2$□ No

Q8. For each question item below, please check the box "Does not apply", "Somewhat applies" or "Applies" (Ex: ☑). Even if you are unsure of your answer, or if you think the question is absurd, please make sure to answer all questions.

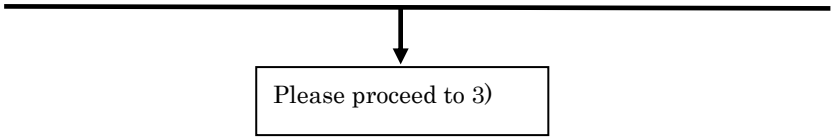
1) Please describe your child's behavior in the past 6 months.

		Does not apply	Some-what applies	Applies
1	My child is often considerate towards feelings of others.	□	□	□
2	My child is restless and can't stay put for a long period of time.	□	□	□
3	My child often complains of headaches, stomachaches and feeling sick.	□	□	□
4	My child often shares things (snacks, toys, pencils, etc.) with other children.	□	□	□
5	My child often gets angry or loses his/her temper.	□	□	□
6	My child likes being alone and often plays alone.	□	□	□
7	My child is obedient and usually listens to adults.	□	□	□
8	My child has many concerns and always seems nervous.	□	□	□
9	My child proactively helps others if somebody is hurt, depressed or harassed.	□	□	□
10	My child is always restless and fidgets often.	□	□	□
11	My child has at least one close friend.	□	□	□
12	My child has fights with or bullies other children often.	□	□	□
13	My child often feels down or has tears in his/her eyes.	□	□	□
14	My child is mostly liked by other children.	□	□	□
15	My child has difficulty paying attention and cannot focus on one thing.	□	□	□
16	My child easily loses confidence, gets nervous, and hangs on my arm when he or she is confronted with a new situation.	□	□	□
17	My child is kind to younger children.	□	□	□
18	My child often covers up the truth or lies.	□	□	□
19	My child has been bullied or made fun of by other children.	□	□	□
20	My child often helps others (parents, teachers, other children, etc.) proactively.	□	□	□
21	My child thinks thoroughly before taking action.	□	□	□
22	My child often steals from home, school, and others.	□	□	□
23	My child seems more comfortable with adults than spending time with other children.	□	□	□
24	My child is a coward and gets scared easily.	□	□	□

25	My child finishes tasks to the end and has good focus.	□	□	□

2) Overall, do you think your child has any issues in one or more of the following areas: emotions, paying attention, behaviors or relationships with others?

$_1$□ No $_2$□ Yes (small issues) $_3$□ Yes (clear issues) $_4$□ Yes (serious issues)



3) Below are questions for guardians who responded "yes" above. Does your child worry or become upset about these issues?

$_1$□ Not at all $_2$□ Just a little $_3$□ Very $_4$□Greatly

Q9. Does your child ever refuse to go to nursery school or kindergarten?

$_1$□ Yes $_2$□ No $_3$□ My child is currently not enrolled in nursery school or kindergarten.

※ If you have any concerns regarding your child's health or comments regarding this survey, please describe them below.
Your comments will be used for references for future health management and surveys.

That is it for the questions.
Please enclose the questionnaire in a return envelope and sent it by mail.
Thank you for your cooperation.

0000000000

〔Contact〕

○ Exclusively for the Mental Health and Lifestyle Survey
Radiation Medical Science Center, Fukushima Medical University
Phone number:　024-549-5170
(9：00-17：00 with the exception of Dec 29-Jan 3 and weekends/holidays)

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FY 2015 **(Draft)**

Fukushima Health Management Survey
Mental Health and Lifestyle Survey
Questionnaire (For elementary school students)

〒963-0000
Room 302, Idai Apartment
1, Hikarigaoka, Fukushima city

Taro Idai

00X0X0X

Enter the required items in the fields below.
Please check ✓ in corresponding boxes□.

Date of entry： MM/DD/2016

Child's name：＿＿＿＿＿＿＿＿＿＿＿＿

Sex：$_1$□ M $_2$□ F

Child's DOB：MM/DD/YYYY

Who will respond to the survey?

$_1$□Mother $_2$□Father $_3$□Grandparents $_4$□Other
（＿＿＿＿＿＿＿＿＿＿＿＿）

Signature of guardian：
（Relationship：＿＿＿＿＿＿）

(Change of mailing address) Please enter if your mailing address differs from the address mentioned above.

〒＿＿＿ - ＿＿＿＿ Prefecture ＿＿＿＿＿＿ City, ward, county ＿＿＿＿＿＿ Ward, town, village ＿＿＿＿＿＿

Name of apartment/room number etc.＿＿＿＿＿＿＿＿＿＿

Contact information
Phone number ※The mental health support team may contact you.

Home：（ ） ＿＿＿＿＿＿ － ＿＿＿＿＿＿ （Name＿＿＿＿＿＿ ）

Cell：＿＿＿＿＿＿ － ＿＿＿＿＿＿ － ＿＿＿＿＿＿

Fukushima Prefecture, Fukushima Medical University

Please check ✓ in the corresponding small boxes □ below.

Q1. Describe your child's current health condition.

1□ Very good 2□ Good 3□ Normal 4□ Bad 5□ Very bad

Q2. Please enter your child's current height and weight.

Example：Height 145.0cm, weight 38.0kg (enter values right justified)

Height 1 4 5 . 0 cm Weight 3 8 . 0 kg

Height cm Weight kg

Q3. Is your child currently receiving treatment for (a) disease(s), etc.?

1□ No 2□ Yes If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Allergic rhinitis 3□ Atopic dermatitis
4☐ Allergic diseases other than 1-3 5☐ Common Cold
6☐ Influenza
7☐ Tympanitis 8☐ Nasal sinus/empyema
9☐ Odontopathy (Cavities, braces, cleft lip and palate, etc.)
10☐ Epilepsy 11☐ ADHD (attention deficit hyperactivity)
12☐ Other (Specific name of disease) (_____)

Q4. Has your child been hospitalized due to an illness within this year?

1□ No 2□ Yes If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Pneumonia (acute/bronchial pneumonia) 3☐ Mycoplasma pneumonia
4☐ Respiratory syncytial virus infection (Respiratory syncytial virus pneumonia)
5☐ Common cold 6☐ Bronchitis (Acute bronchitis)
7☐ Influenza 8☐ Gastroenteritis (acute gastroenteritis) 9☐ Rotavirus infection
10☐ Febrile convulsion 11☐ Kawasaki disease 12☐ Inguinal hernia (hernia)
13☐ Other (Specific diseases) (_____)

Q5. When does your child regularly go to sleep and wake up?

Enter right justified based on 24-hour clock.
(Ex) 7:10PM→ 1 9 1 0 7:10AM→ 7 1 0

Bedtime h min Time to wake up h min

Q6. How much does your child exercise regularly aside from physical education classes (club activities, sport-related lessons, etc.)?

$_1$□ Almost every day $_2$□ Around 2-4 times per week

$_3$□ Once a week $_4$□ Almost never

Q7. Please check ✓ in the corresponding boxes □ below regarding your child's diet during the past month.

1) Does your child eat fast compared to others?・・・・・・・・ $_1$□ Fast $_2$□ Normal $_3$□ Slow

2) Does your child skip breakfast often?・・・・・・・・・・・・・・・・・・・・・・・・・ $_1$□ Yes $_2$□ No

3) Does your child drink beverages containing sugar (juice, soft drinks) every day?・・・・

$_1$□ Yes $_2$□ No

4) Does your child eat seafood 3 days or more per week?・・・・・・・・・・・・・・・・ $_1$□ Yes $_2$□ No

5) Does your child eat food such as vegetables other than pickles, seaweed or mushrooms almost every day?・・・・・ $_1$□ Yes $_2$□ No

6) Does your child eat fruits almost every day?・・・・・・・・・・・・・・・・・・・・・・・・・

$_1$□ Yes $_2$□ No

7) Does your child eat soy products (Tofu, deep fried tofu, natto, boiled beans, etc.) almost every day?・・ $_1$□ Yes $_2$□ No

8) Does your child eat dairy products (milk, yogurt, etc.) almost every day?・・・・・・・・・・・・

$_1$□ Yes $_2$□ No

9) Does your child eat pre-cooked food such as side dishes and boxed meal (including instant food) almost every day?・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ $_1$□ Yes $_2$□ No

10) Does your child eat out (including fast food) almost every day?・・・・・・・・・・

$_1$□ Yes $_2$□ No

Q8. For each question item below, please check the box "Does not apply", "Somewhat applies" or "Applies" (Ex: ☑). Even if you are unsure of your answer, or if you think the question is absurd, please make sure to answer all questions.

1) Please describe your child's behavior in the past 6 months.

		Not apply	Some-what applies	Applies
1	My child is often considerate towards feelings of others.	□	□	□
2	My child is restless and can't stay put for a long period of time.	□	□	□
3	My child often complains of headaches, stomachaches and feeling sick.	□	□	□
4	My child often shares things (snacks, toys, pencils, etc.) with other children.	□	□	□
5	My child often gets angry or loses his/her temper.	□	□	□
6	My child likes being alone and often plays alone.	□	□	□
7	My child is obedient and usually listens to adults.	□	□	□
8	My child has many concerns and always seems nervous.	□	□	□
9	My child proactively helps others if somebody is hurt, depressed or harassed.	□	□	□
10	My child is always restless and fidgets often.	□	□	□
11	My child has at least one close friend.	□	□	□
12	My child has fights with or bullies other children often.	□	□	□
13	My child often feels down or has tears in his/her eyes.	□	□	□
14	My child is mostly liked by other children.	□	□	□
15	My child has difficulty paying attention and cannot focus on one thing.	□	□	□
16	My child easily loses confidence, gets nervous, and hangs on my arm when he or she is confronted with a new situation.	□	□	□
17	My child is kind to younger children.	□	□	□
18	My child often covers up the truth or lies.	□	□	□
19	My child has been bullied or made fun of by other children.	□	□	□
20	My child often helps others (parents, teachers, other children, etc.) proactively.	□	□	□
21	My child thinks thoroughly before taking action.	□	□	□
22	My child often steals from home, school, and others.	□	□	□
23	My child seems more comfortable with adults than spending time with other children.	□	□	□
24	My child is a coward and gets scared easily.	□	□	□

25	My child finishes tasks to the end and has good focus.	□	□	□

2) Overall, do you think your child has any issues in one or more of the following areas: emotions, paying attention, behaviors or relationships with others?

$_1$□ No $_2$□ Yes (small issues) $_3$□ Yes (clear issues) $_4$□ Yes (serious issues)

Please proceed to 3)

3) Below are questions for guardians who responded "yes" above. Does your child worry or become upset about these issues?

$_1$□ Not at all $_2$□ Just a little $_3$□ Very $_4$□Greatly

Q9. Does your child ever refuse to go to school?

$_1$□ Yes $_2$□ No

※ If you have any concerns regarding your child's health or comments regarding this survey, please describe them below.
Your comments will be used for references for future health management and surveys.

That is it for the questions.

Please enclose the questionnaire in a return envelope and send it by mail.

Thank you for your cooperation.

〔Contact〕

○ Exclusively for the Mental Health and Lifestyle Survey
Radiation Medical Science Center, Fukushima Medical University
Phone number: 024-549-5170
(9：00-17：00 with the exception of Dec 29-Jan 3 and weekends/holidays)

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FY 2015 **(Draft)**

Fukushima Health Management Survey
Mental Health and Lifestyle Survey
Questionnaire (For middle school students)

〒963-0000
Room 302, Idai Apartment
1, Hikarigaoka, Fukushima city

Taro Idai

00X0X0X

Enter the required items in the fields below.
Please check ✓ in corresponding boxes□.

Date of entry： MM/DD/2016

Child's name：_____

Sex：1□ M 2□ F

Child's DOB：MM/DD/YYYY

Who will respond to the survey?
1□Mother 2□Father 3□Grandparents 4□Other
（ ）

Signature of guardian (If you are a minor responding to this survey, please have your guardian sign for this study upon consent.)

(Signature of guardian) (Relationship：)

(Change of mailing address) Please enter if your mailing address differs from the address mentioned above.

〒 _____ - _____ Prefecture _____ City, ward, county _____ Ward, town, village _____

Name of apartment/room number etc._____

Phone number ※The mental health support team may contact you.

Home：（ ） _____ － _____ （Name_____ ）

Cell：_____ － _____ － _____

Fukushima Prefecture, Fukushima Medical University

Please check ✓ in the corresponding small boxes □ below.

For questions 1-5, please have your child answer in person.

Respondent：$_1$☐ Self　　$_2$☐ On behalf（Relationship＿＿＿＿＿＿）

Q1. How is your current health condition?

$_1$□ Very good　$_2$□ Good　$_3$□ Normal　$_4$□ Bad　$_5$□ Very bad

Q2. Please enter your current height and weight.

Example：Height 159.6cm, weight 54.2kg (enter values right justified)

Height 1 5 9 . 6 cm　　Weight 5 4 . 2 kg

Q3. Below are questions regarding your sleeping habits.

1) What are your usual average hours of sleep (including naps) per day?

Around ☐☐ h ☐☐ min

2) Do you think your daily hours of sleep are sufficient?

$_1$□ Sufficient　$_2$□ Not quite sufficient　$_3$□ Not sufficient

Q4. How much do you exercise aside from physical education classes? (Including club activities, sport-related lessons, etc.)

$_1$□ Almost every day　$_2$□ 2-4 times per week

$_3$□ Once a week　$_4$□ Almost never

Q5. Check ✓ in the boxes □ below that correspond to your diet during the past month.

1) Do you eat fast compared to others?・・・・・・・・ 1□ Fast 2□ Normal 3□ Slow

2) Do you often skip breakfast?・・・・・・・・・・・・・・・・・・・・・・・・・・ 1□ Yes 2□ No

3) Do you go to sleep within 1-2 hours after dinner?・・・・・・・・・・・・ 1□ Yes 2□ No

4) Do you drink beverages that contain sugar (coffee, juice, soft drinks) almost every day?・・

1□ Yes 2□ No

5)） Do you eat seafood 3 days or more per week?・・・・・・・・・・・・・・・・ 1□ Yes 2□ No

6） Do you eat foods such as vegetables other than pickles, seaweed, and

mushrooms?・・・・・・・・ 1□ Yes 2□ No

7) Do you eat fruits almost every day?・・・・・・・・・・・・・・・・・・・・・・・ 1□ Yes 2□ No

8) Do you eat soy products (Tofu, deep fried tofu, natto, boiled beans, etc.) almost every

day?・・ 1□ Yes 2□ No

9) Do you eat dairy products (milk, yogurt, etc.) almost every day?・・・・・・・・・ 1□ Yes 2□ No

10) Do you eat pre-cooked food such as side dishes and boxed meal (including instant food)

almost every day?

・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 1□ Yes 2□ No

11) Do you eat out (including fast food) almost every day?・・・・・・・・・・ 1□ Yes 2□ No

※ If you have any concerns regarding your health or comments regarding this survey, please describe them below. Your comments will be used for references for future health management and surveys.

That is it for the questions to you. Please give this questionnaire to your guardian. Thank you for your cooperation.

For the questions below, the **guardian** must respond on the child's behalf.

Q6. Is your child currently receiving treatment for (a) disease(s), etc.?

1☐ No 2☐ Yes

If so, please check ✓ the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Allergic rhinitis 3☐ Atopic dermatitis
4☐ Allergic diseases other than1-3 5☐ Common Cold
6☐ Influenza
7☐ Tympanitis 8☐ Nasal sinus/empyema
9☐ Odontopathy (Cavities, braces, cleft lip and palate, etc.)
10☐ Epilepsy 11☐ ADHD (attention deficit hyperactivity)
12☐ Other (Specific name of disease) (_____)

Q7. Has your child been hospitalized due to an illness within this year?

1☐ No 2☐ Yes

If so, please check ✓ in the corresponding boxes☐.

1☐ Asthma (Infantile Asthma/bronchial asthma) 2☐ Pneumonia (acute/bronchial pneumonia) 3☐ Mycoplasma pneumonia
4☐ Respiratory syncytial virus infection (Respiratory syncytial virus pneumonia) 5☐ Common cold 6☐ Bronchitis (Acute bronchitis)
7☐ Influenza 8☐ Gastroenteritis (acute gastroenteritis) 9☐ Rotavirus infection
10☐ Febrile convulsion 11☐ Kawasaki disease 12☐ Inguinal hernia (hernia)
13☐ Other (Specific diseases) (_____)

Q8. For each question item below, please check the box "Does not apply", "Somewhat applies" or "Applies" (Ex: ☑). Even if you are unsure of your answer, or if you think the question is absurd, please make sure to answer all questions.

1) Please describe your child's behavior in the past 6 months.

		Does not apply	Some-what applies	Applies
1	My child is often considerate towards feelings of others.	□	□	□
2	My child is restless and can't stay put for a long period of time.	□	□	□
3	My child often complains of headaches, stomachaches and feeling sick.	□	□	□
4	My child often shares things (snacks, toys, pencils, etc.) with other children.	□	□	□
5	My child often gets angry or loses his/her temper.	□	□	□
6	My child likes being alone and often plays alone.	□	□	□
7	My child is obedient and usually listens to adults.	□	□	□
8	My child has many concerns and always seems nervous.	□	□	□
9	My child proactively helps others if somebody is hurt, depressed or harassed.	□	□	□
10	My child is always restless and fidgets often.	□	□	□
11	My child has at least one close friend.	□	□	□
12	My child has fights with or bullies other children often.	□	□	□
13	My child often feels down or has tears in his/her eyes.	□	□	□
14	My child is mostly liked by other children.	□	□	□
15	My child has difficulty paying attention and cannot focus on one thing.	□	□	□
16	My child easily loses confidence, gets nervous, and hangs on my arm when he or she is confronted with a new situation.	□	□	□
17	My child is kind to younger children.	□	□	□
18	My child often covers up the truth or lies.	□	□	□
19	My child has been bullied or made fun of by other children.	□	□	□
20	My child often helps others (parents, teachers, other children, etc.) proactively.	□	□	□
21	My child thinks thoroughly before taking action.	□	□	□
22	My child often steals from home, school, and others.	□	□	□
23	My child seems more comfortable with adults than spending time with other children.	□	□	□
24	My child is a coward and gets scared easily.	□	□	□
25	My child finishes tasks to the end and has good focus.	□	□	□

2) Overall, do you think your child has any issues in one or more of the following areas: emotions, paying attention, behaviors or relationships with others?

$_1$□No $_2$□Yes (small issues) $_3$□Yes (clear issues) $_4$□Yes (serious issues)

Please proceed to 3)

3) Below are questions for guardians who responded "yes" above. Does your child worry or become upset about these issues?

$_1$□Not at all $_2$□Just a little $_3$□Very $_4$□Greatly

Q9. Does your child ever refuse to go to school?

$_1$□ Yes $_2$□ No

※ If you have any concerns regarding your child's health or comments regarding this survey, please describe them below.
Your comments will be used for references for future health management and surveys.

That is it for the questions. Please enclose the survey in a return envelope and send it by mail.

Thank you for your cooperation.

〔Contact〕

○ Exclusively for the Mental Health and Lifestyle Survey
Radiation Medical Science Center, Fukushima Medical University
Phone number:　024-549-5170
(9：00-17：00 with the exception of Dec 29-Jan 3 and weekends/holidays)

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FY 2015 **(Draft)**

Fukushima Health Management Survey
Mental Health and Lifestyle Survey
Questionnaire (For the general public)

〒963-0000
Room 302, Idai Apartment
1, Hikarigaoka, Fukushima city

Taro Idai

00X0X0X

Enter the required items in the fields below. Please check ✓ in corresponding boxes□.

Date of entry： MM/DD/2016	Respondent：$_1$□Self $_2$□Representative （Relationship ）
Name：_____	Sex：$_1$□ M $_2$□ F
DOB：MM/DD/YYYY	
Signature of guardian (If you are a minor responding to this survey, please have your guardian sign for this study upon consent.) (Signature of guardian) (Relationship：)	
(Change of mailing address) Please enter if your mailing address differs from the address mentioned above. 〒 _____ - _____ Prefecture _____ City, ward, county _____ Ward, town, village _____ Name of apartment/room number etc._____	
Contact information Phone number ※The mental health support team may contact you. Home：（ ） _____ － _____ （Name_____ ） Cell：_____ － _____ － _____	

Fukushima Prefecture, Fukushima Medical University

Please check ✓ in the corresponding small boxes □ below.

Q1. How is your current health condition?

$_1$□ Very good $_2$□ Good $_3$□ Normal $_4$□ Bad $_5$□ Very bad

Q2. Please enter your current height and weight.

Example : Height 171.7cm Weight 70.0kg

Height 1 7 1 . 7 cm Weight 7 0 . 0 kg

1) Please enter your current height and weight.

Height ☐☐☐.☐ cm Weight ☐☐☐.☐ kg (Right justified)

2) Has there been any changes in your body weight compared to one year ago?

$_1$□ Increased by 3kg or more $_2$□ Almost no change (within ± 3kg) $_3$□ Decreased by 3kg or more

Q3. Have you been diagnosed with any of the diseases below within the past year?

1) High blood pressure

$_1$□ No $_2$□ Yes → Are you currently attending a hospital as outpatient?
$_1$☐ Yes $_2$☐ No

2) Diabetes (high blood-sugar level)

$_1$□ No $_2$□ Yes → Are you currently attending a hospital as outpatient?
$_1$☐ Yes $_2$☐ No

3) Hyperlipidaemia (or has high cholesterol or high neutral fat)

$_1$□ No $_2$□ Yes → Are you currently attending a hospital as outpatient?
$_1$☐ Yes $_2$☐ No

4) Mental disorder (diagnosed by a doctor (Ex: depression, sleep disorder, panic disorder, schizophrenia))

$_1$□ No $_2$□ Yes → Are you currently attending a hospital as outpatient?
$_1$☐ Yes
$_2$☐ Not any more since I have improved
$_3$☐ No

5) Cancer (including leukemia and lymphoma)

$_1$□ No $_2$□ Yes → Which parts of your body are affected by cancer? (Please answer all the parts.)
(_____)、(_____)、(_____)

6) Stroke

$_1$□ No $_2$□ Yes

A disease caused by blocked blood vessels in the brain

What type of stroke? (Multiple answers possible)

$_1$□ Stroke (cerebral embolism, cerebral thrombosis)

$_2$□ Cerebral hemorrhage $_3$□ Subarachnoid hemorrhage

$_4$□ Other (_____) $_5$□ I don't know

7) Heart disease

$_1$□ No $_2$□ Yes

A disease caused by blocked blood vessels in the heart

What type of heart disease? (Multiple answers possible)

$_1$□ Myocardial infarction $_2$□ Angina

$_3$□ Arrhythmia

$_4$□ Other (_____) $_5$□ I don't know

8) Pneumonia

$_1$□ No $_2$□ Yes

9) Fracture

$_1$□ No $_2$□ Yes

10) Thyroid disease

$_1$□ No $_2$□ Yes

What type pf thyroid disease?

$_1$☐ Hyperthyroidism (Basedow disease)

$_2$☐ Hypothyroidism

$_3$☐ Other (_____)

Q4. Below are questions regarding your sleeping habits.

1) What are your usual average hours of sleep per day? (including naps)

Around ☐☐ h ☐☐ mm

2) Are you satisfied with your quality of sleep (regardless of the length) during the past month?

$_1$□ Yes $_2$□ Not quite $_3$□ No $_4$□ Not at all, I didn't get any sleep

3) Have you experienced the items below at least 3 times a week?

		Yes	No
1	It takes time for me to fall asleep, even after I'm in bed	$_1$□	$_2$□
2	I wake up during the night in the middle of sleep	$_1$□	$_2$□
3	I wake up before the time I set and can't go back to sleep.	$_1$□	$_2$□
4	I don't get enough total sleep.	$_1$□	$_2$□
5	I feel depressed during the day.	$_1$□	$_2$□
6	My daily physical and mental activity levels are low.	$_1$□	$_2$□
7	I feel sleepy during the day.	$_1$□	$_2$□

Q5. Do you exercise regularly?

1□ Almost every day　　2□ 2-4 times per week

3□ Once a week　　4□ Almost never

※ Questions 6 and 7 target adults only.
If you are a minor, proceed to Q8.

Q6. Do you smoke tobacco (cigarettes)? These do not include cigars or pipes.

1□ I have never smoked　　2□ I quit　　3□ Yes, I do.

Proceed to Q7.

For individuals who smoke:
Tell us the number of tobacco/cigarettes you regularly smoke.
※I smoke around [ ][ ][ ] per day.

Q7. The questions below are regarding alcohol.

1) Do you currently drink alcohol?

1□ No, or rarely (Less than once a month)　　2□ I quit　　3□ Yes (At least once a month)

Proceed to Q8.　　Proceed to 2).

2) How often do you drink alcohol?　　Around [ ] days per week

3) Please tell us your alcohol intake per day.

Amount converted to Japanese sake※

Around [ ][ ].[ ] *go* per day

※Reference　Japanese sake 1 *go* (0.18 liters) conversion chart

Beer/Sparkling liquor 1 middle bottle	About	500 ml
5 Shochu highballs 1 long can		500 ml
25% shochu	1 cup	100 ml
Whisky	2 singles	60 ml
Wine	2 glasses	240 ml

4) The questions below are regarding your past 30 days.

		No	Yes
1	Have you ever felt you should cut down on your drinking?	1□	2□
2	Have people annoyed you by criticizing your drinking?	1□	2□
3	Have you ever felt bad or guilty about your drinking?	1□	2□
4	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	1□	2□

Q8. How frequently have you lost your appetite during the past two weeks?

1□ Never 2□ Several days 3□ At least half of the time 4□ Almost every day

Q9. Check ✓ in the boxes □ below that correspond to your dietary habits during the past month.

1) Do you eat fast compared to others?····· 1□ Fast 2□ Normal 3□ Slow

2) Do you skip breakfast often?····· 1□ Yes 2□ No

3) Do you eat snacks during the day or night almost every day?····· 1□ Yes 2□ No

4) Do you eat within 2 hours of bedtime 3 or more days per week?····· 1□ Yes 2□ No

5) Do you eat pre-cooked food such as side dishes and boxed meals (including instant food) almost every day?····· 1□ Yes 2□ No

Q10. For the past 30 days, how often did you experience the items below?
Please circle the corresponding numbers.

		Never	A little	Some-times	Most of the time	Always
1	How often did you feel nervous?	0	1	2	3	4
2	How often did you feel hopeless?	0	1	2	3	4
3	How often did you feel restless or fidgety?	0	1	2	3	4
4	How often did you feel so depressed that nothing could cheer you up?	0	1	2	3	4
5	How often did you feel that everything was an effort?	0	1	2	3	4

6	How often did you feel worthless?	0	1	2	3	4
7	Due to such conditions, have you even experienced inconveniences in your daily life?	0	1	2	3	4

Q11. Below are questions regarding your daily living conditions.

1）Are you currently living away from your family because of the earthquake disaster?

$_1$□ Yes $_2$□ No

2) Please indicate the number of people you are currently living with (<u>including yourself</u>).

Before the earthquake disaster（ ） At present（ ）

3）Where do you currently live? Check ✓ in the corresponding boxes below.

$_1$□ Municipally subsidized rental housing $_2$□ Temporary housing $_3$□ Restoration public housing $_4$□ Rented house/Apartment $_5$□Relative's house

$_6$□ Owned house $_7$□ Other（ ）

4) Please tell us your current working hours.

$_1$□ Full-time/self-employed $_2$□ Part-time $_3$□ Unemployed (Including students and housewives)

5) How do you feel about your current living condition economically?

$_1$□ Tough $_2$□ Slightly tough $_3$□ Normal $_4$□ Slightly comfortable $_5$□ Comfortable

6) Were you (or your spouse) pregnant <u>before the earthquake disaster</u>? Also, were you living together with your <u>child who is underage</u>? (Multiple answers possible）

$_1$□ No $_2$□ Yes

$_1$☐ I (or my spouse) was pregnant.
$_2$☐ I was living with my pre-school or younger child.
$_3$☐ I was living with my elementary school child.
$_4$☐ I was living with my middle school child.
$_5$☐ I was living with my underage child who has at least graduated from middle school.

7) Are you (or your spouse) currently pregnant? Or are you currently living with your child who is underage? (Multiple answers possible)

$_1$□ No $_2$□ Yes

$_1$☐ I am (or my spouse) is currently pregnant.
$_2$☐ I live with my preschool or younger child.
$_3$☐ I live with my elementary school child.
$_4$☐ I live with my middle school child.
$_5$☐ I live with my underage child who has at least graduated from middle school.

Q12. Below are questions regarding radiation.

In a disaster caused by something we cannot sense such as ionizing radiation, perceptions of health risk are considered to have an impact on one's mental health.

1) Below are questions regarding your awareness or opinion on the health effects of radiation. Please circle the corresponding number.

		The possibilities are very low			The possibilities are very high
1	How much health disorders (For example, cancer, etc.) do you expect to occur in the future due to the current radiation exposure?	1	2	3	4
2	How much health effects do you think the current radiation exposure will have on the future generations (your future children or grandchildren)?	1	2	3	4

2) For the past month, how frequently did you experience inconveniences in your daily life due to your anxieties about radiation?

$_1$□ Frequently $_2$□ Sometimes $_3$□ Rarely $_4$□ Never

Q13. Do you know anyone or any organization that you can consult regarding mental or physical issues that were caused by the Great East Japan Earthquake?

$_1$□ Yes $_2$□ No

If you do, check ✓ for all corresponding items below.

$_1$□ Family/relatives $_2$□ Friends/acquaintances

$_3$□ Colleagues/superiors

$_4$□ Municipal consultation service (City public health bureau, health center, etc.)

□ Prefectural consultation service（Prefectural public health bureau/public health and welfare office, etc.）

□ Mental health and welfare center

□ Fukushima Kokoro no Care Center (Fukushima mental care center)

□ Visiting care/nursing care service organizations

□ Medical institutions such as psychosomatic medicine/psychiatry/neurology/mental clinics

□ Medical institutions other than the above (general internal medicine, surgical department, ophthalmology, otorhinology, orthopedics, obstetrics and gynecology, etc.

□ Facilities related to religion such as temples, shrines, churches, etc.

□ Other（ ）

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※ If you have any concerns regarding your health or comments regarding this survey, please describe them below. Your comments will be used for references for future health management and surveys.

That is it for the questions. Please enclose the survey in a return envelope and send it by mail. Thank you for your cooperation.

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