

What do you think of this guide?

"A Guide for Moms" is designed to give mothers with young children information about people, services, and resources that may help them through pregnancy and beyond. We would love to know what **YOU** think. Could you please take a moment to complete a few questions about your impressions of this resource guide? Your answers are anonymous and will really help us. **THANKS!**

1. First impressions: What do you think about the layout of the guide or how it looks?

A. This guide is easy to read.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

B. The inserts are easy to use

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

C. The layout of the guide is easy to follow.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

D. Any other comments on how the guide looked? _____

2. This guide addresses important topics for moms.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

3. The guide is helpful to me personally.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

4. In the future, this guide will be helpful to me.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

5. I would give this guide to a friend.

- 1-Strongly Agree 2-Agree
 3-Disagree 4-Strongly Disagree

6. What is your favorite part of the guide?

7. Do you plan to call any of the numbers in the future? 1-Yes 2-No 3-Maybe

9. Overall, the quality of this guide is:

- 1-Excellent 2-Good
 3-Fair 4-Poor

10. Which resource listings do you think are most helpful to mothers or mothers-to-be?

- 1-State information 2-Both
 3-Local information 4-Neither

11. Which resources do you think are most helpful to mothers or mothers-to-be? (Check all that apply)

<input type="checkbox"/> 1-Parenting Support	<input type="checkbox"/> 2-Stress/Depression
<input type="checkbox"/> 3-Referrals & Counseling	<input type="checkbox"/> 4-Child Support
<input type="checkbox"/> 5-Alcohol, Tobacco, & Drugs	<input type="checkbox"/> 6-Health Care
<input type="checkbox"/> 7-Food, Shelter & Housing	<input type="checkbox"/> 8-Jobs and Money
<input type="checkbox"/> 9-Children with Special Needs	<input type="checkbox"/> 10-Legal Assistance
<input type="checkbox"/> 11-On-line Information	<input type="checkbox"/> 12-Financial Assistance
<input type="checkbox"/> 13-Events/Activities for Moms	

12. Can you think of any other topics that would be helpful to you or other mothers? Do you have any other comments about the guide?

13. Who gave you the guide?

- 1-My pediatric health care provider
 2-A nurse in the practice
 3-A staff member in the practice
 4-Other _____

14. At which check-up did you receive the guide?

- 2 week visit 2 month visit
 4 month visit 6 month visit
 9 month visit other _____

Finally, some questions that describe you:

15. How old are you? _____ Years
16. Do you consider yourself (please choose one):
- 1-Hispanic or Latino
 - 2-Not Hispanic or Latino
17. How would you describe your race?
- 1-American Indian or Alaska Native
 - 2-Asian
 - 3-Black or African American
 - 4-Native Hawaiian or other Pacific Islander
 - 5-White
 - 6-Other _____
18. What language do you usually speak?
- 1-English only
 - 2-English and another language (what other language? _____)
 - 3-Other language (what language? _____)
19. Please circle the highest grade or amount of schooling you completed?
- 1-Never attended
 - 2-Less than high school
 - 3-High school graduate or GED
 - 4-College or Trade/technical School
 - 5-Graduate school
 - 6-Other _____
20. Do you now have or have you ever had a steady job?
- 1-No, never worked
 - 2-yes, currently work full-time
 - 3-Yes, currently work part-time
 - 4-yes, but not currently
21. During the past year, have you or anyone in your household received any income from Public Assistance (Home Relief, Aid to Dependent Children, Welfare)?
- 1-Yes
 - 2-No

22. Are you pregnant? 1-Yes 2-No
If no, what is the age of your **youngest** child? _____ months
23. How many people live in your home, including yourself? _____ Children (under 18)
_____ Adults (over 18 plus yourself)
24. What is your marital status now? (Choose one)
- 1-Married
 - 2-Living with a partner
 - 3-Widowed, divorced or separated and not living with a partner
 - 4-Never married and not living with a partner
25. During the past two weeks, have you ever felt down, depressed or hopeless?
- 1-Yes
 - 2-No
26. During the past two weeks, have you felt little interest or pleasure in doing things?
- 1-Yes
 - 2-No
27. Have you ever talked to your own health care provider about any of your own emotional issues or problems that concerned you?
- 1-Yes
 - 2-No
28. Have you ever talked to your child's health care provider about any of your own emotional issues or problems that concerned you?
- 1-Yes
 - 2-No
29. What is today's date? _____
30. How old is your child today? _____
months

Thanks! That's all!