

Paediatric Measuring Health Equity (MHE) questions – Youth & Family/Caregiver Surveys

Considerations for implementation:

- *There is no standard for when to employ the Caregiver/Family Survey versus the Patient/Youth Survey. The capacity of a child to respond to the survey can vary based on a number of factors. Each organization/program should determine the age at which the patient fills out the survey (versus the caregiver/family) based on their patient population.*
- *Response option for each of the questions can be adjusted based on the needs of the organization and its patient population (e.g., add or remove response options, change the order of response options). However, aim to stay as consistent as possible with the current set of questions and answers to reserve ability to benchmark across organizations and view results from a system perspective.*

Youth Survey			Family/Caregiver Survey		
			What is the relationship to the child you are here with today?		
			<input type="checkbox"/> 1 Parent (e.g. mother, father, step-parent, foster-parent) <input type="checkbox"/> 2 Grandparent <input type="checkbox"/> 3 Relative (e.g. aunt, uncle, sibling) <input type="checkbox"/> 88 Other (please specify): _____ <input type="checkbox"/> 99 Prefer not to answer		
1) What language do you feel most comfortable speaking in with your healthcare provider? (check all that apply)			1a) What language do you feel most comfortable speaking in with your child's/the patient's healthcare provider? (check all that apply)		
<input type="checkbox"/> 1 English* (Canadian Official Language) <input type="checkbox"/> 2 French* (Canadian Official Language) <input type="checkbox"/> 3 Albanian <input type="checkbox"/> 4 Amharic <input type="checkbox"/> 5 Arabic <input type="checkbox"/> 6 ASL (American Sign Language) <input type="checkbox"/> 7 Bengali <input type="checkbox"/> 8 Bulgarian <input type="checkbox"/> 9 Burmese <input type="checkbox"/> 10 Georgian <input type="checkbox"/> 11 Greek <input type="checkbox"/> 12 Cantonese <input type="checkbox"/> 13 Czech <input type="checkbox"/> 14 Dari <input type="checkbox"/> 15 Farsi	<input type="checkbox"/> 16 Gujarati <input type="checkbox"/> 17 Hausa <input type="checkbox"/> 18 Hebrew <input type="checkbox"/> 19 Hindi <input type="checkbox"/> 20 Hungarian <input type="checkbox"/> 21 Italian <input type="checkbox"/> 22 Karen <input type="checkbox"/> 23 Korean <input type="checkbox"/> 24 Mandarin <input type="checkbox"/> 25 Nepali <input type="checkbox"/> 26 Pashto <input type="checkbox"/> 27 Polish <input type="checkbox"/> 28 Portuguese <input type="checkbox"/> 29 Punjabi <input type="checkbox"/> 30 Rohingya <input type="checkbox"/> 31 Romanian <input type="checkbox"/> 32 Russian <input type="checkbox"/> 33 Serbian	<input type="checkbox"/> 35 Somali <input type="checkbox"/> 36 Spanish <input type="checkbox"/> 37 Swahili <input type="checkbox"/> 38 Turkish <input type="checkbox"/> 39 Twi <input type="checkbox"/> 40 Ukrainian <input type="checkbox"/> 41 Tagalog <input type="checkbox"/> 42 Tamil <input type="checkbox"/> 43 Thai <input type="checkbox"/> 44 Tibetan <input type="checkbox"/> 45 Tigrinya <input type="checkbox"/> 46 Taishanese/Toishanese <input type="checkbox"/> 47 Urdu <input type="checkbox"/> 48 Vietnamese <input type="checkbox"/> 49 Another language (please specify): _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 English* (Canadian Official Language) <input type="checkbox"/> 2 French* (Canadian Official Language) <input type="checkbox"/> 3 Albanian <input type="checkbox"/> 4 Amharic <input type="checkbox"/> 5 Arabic <input type="checkbox"/> 6 ASL (American Sign Language) <input type="checkbox"/> 7 Bengali <input type="checkbox"/> 8 Bulgarian <input type="checkbox"/> 9 Burmese <input type="checkbox"/> 10 Georgian <input type="checkbox"/> 11 Greek <input type="checkbox"/> 12 Cantonese <input type="checkbox"/> 13 Czech <input type="checkbox"/> 14 Dari <input type="checkbox"/> 15 Farsi	<input type="checkbox"/> 16 Gujarati <input type="checkbox"/> 17 Hausa <input type="checkbox"/> 18 Hebrew <input type="checkbox"/> 19 Hindi <input type="checkbox"/> 20 Hungarian <input type="checkbox"/> 21 Italian <input type="checkbox"/> 22 Karen <input type="checkbox"/> 23 Korean <input type="checkbox"/> 24 Mandarin <input type="checkbox"/> 25 Nepali <input type="checkbox"/> 26 Pashto <input type="checkbox"/> 27 Polish <input type="checkbox"/> 28 Portuguese <input type="checkbox"/> 29 Punjabi <input type="checkbox"/> 30 Rohingya <input type="checkbox"/> 31 Romanian <input type="checkbox"/> 32 Russian <input type="checkbox"/> 33 Serbian	<input type="checkbox"/> 35 Somali <input type="checkbox"/> 36 Spanish <input type="checkbox"/> 37 Swahili <input type="checkbox"/> 38 Turkish <input type="checkbox"/> 39 Twi <input type="checkbox"/> 40 Ukrainian <input type="checkbox"/> 41 Tagalog <input type="checkbox"/> 42 Tamil <input type="checkbox"/> 43 Thai <input type="checkbox"/> 44 Tibetan <input type="checkbox"/> 45 Tigrinya <input type="checkbox"/> 46 Taishanese/Toishanese <input type="checkbox"/> 47 Urdu <input type="checkbox"/> 48 Vietnamese <input type="checkbox"/> 49 Another language (please specify): _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer

	<input type="checkbox"/> 34 Slovak		<input type="checkbox"/> 34 Slovak	
		1b) What language does your child/the patient feel most comfortable speaking in with their healthcare provider? (check all that apply)		
		<input type="checkbox"/> 1 English* (Canadian Official Language) <input type="checkbox"/> 2 French* (Canadian Official Language) <input type="checkbox"/> 3 Albanian <input type="checkbox"/> 4 Amharic <input type="checkbox"/> 5 Arabic <input type="checkbox"/> 6 ASL (American Sign Language) <input type="checkbox"/> 7 Bengali <input type="checkbox"/> 8 Bulgarian <input type="checkbox"/> 9 Burmese <input type="checkbox"/> 10 Georgian <input type="checkbox"/> 11 Greek <input type="checkbox"/> 12 Cantonese <input type="checkbox"/> 13 Czech <input type="checkbox"/> 14 Dari <input type="checkbox"/> 15 Farsi	<input type="checkbox"/> 16 Gujarati <input type="checkbox"/> 17 Hausa <input type="checkbox"/> 18 Hebrew <input type="checkbox"/> 19 Hindi <input type="checkbox"/> 20 Hungarian <input type="checkbox"/> 21 Italian <input type="checkbox"/> 22 Karen <input type="checkbox"/> 23 Korean <input type="checkbox"/> 24 Mandarin <input type="checkbox"/> 25 Nepali <input type="checkbox"/> 26 Pashto <input type="checkbox"/> 27 Polish <input type="checkbox"/> 28 Portuguese <input type="checkbox"/> 29 Punjabi <input type="checkbox"/> 30 Rohingya <input type="checkbox"/> 31 Romanian <input type="checkbox"/> 32 Russian <input type="checkbox"/> 33 Serbian <input type="checkbox"/> 34 Slovak	<input type="checkbox"/> 35 Somali <input type="checkbox"/> 36 Spanish <input type="checkbox"/> 37 Swahili <input type="checkbox"/> 38 Turkish <input type="checkbox"/> 39 Twi <input type="checkbox"/> 40 Ukrainian <input type="checkbox"/> 41 Tagalog <input type="checkbox"/> 42 Tamil <input type="checkbox"/> 43 Thai <input type="checkbox"/> 44 Tibetan <input type="checkbox"/> 45 Tigrinya <input type="checkbox"/> 46 Taishanese/Toishanese <input type="checkbox"/> 47 Urdu <input type="checkbox"/> 48 Vietnamese <input type="checkbox"/> 49 Another language (please specify): _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
2a) Were you born in Canada?		2a) Were you born in Canada?		
<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	<input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	<input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
2b) If no, when did you arrive?		2b) If no, when did you arrive?		
<input type="checkbox"/> 1 Less than 5 years ago <input type="checkbox"/> 2 5 to 9 years ago	<input type="checkbox"/> 3 10 years ago, or more <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Less than 5 years ago <input type="checkbox"/> 2 5 to 9 years ago	<input type="checkbox"/> 3 10 years ago, or more <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
		2c) Was your child/the patient born in Canada?		
		<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	<input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
		2d) If no, when did they arrive?		
		<input type="checkbox"/> 1 Less than 5 years ago <input type="checkbox"/> 2 5 to 9 years ago	<input type="checkbox"/> 3 10 years ago, or more <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
3) Do you identify as First Nations, Metis and/or Inuk/Inuit? (check all that apply). This question is about how you identify yourself (e.g. includes status or non-status)		3a) Do you identify as First Nations, Metis and/or Inuk/Inuit? (check all that apply). This question is about how you identify yourself (e.g. includes status or non-status)		

<input type="checkbox"/> 1 Yes, First Nations <input type="checkbox"/> 2 Yes, Inuk/Inuit <input type="checkbox"/> 3 Yes, Métis	<input type="checkbox"/> 4 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Yes, First Nations <input type="checkbox"/> 2 Yes, Inuk/Inuit <input type="checkbox"/> 3 Yes, Métis	<input type="checkbox"/> 4 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
		3b) Does your child/the patient identify as First Nations, Metis and/or Inuk/Inuit? (check all that apply). This question is about how you identify yourself (e.g. includes status or non-status)	
		<input type="checkbox"/> 1 Yes, First Nations <input type="checkbox"/> 2 Yes, Inuk/Inuit <input type="checkbox"/> 3 Yes, Métis	<input type="checkbox"/> 4 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
4) What is your ethnic or cultural background? For example: Canadian, Chinese, East Indian, English, Filipino, French, German, Irish, Italian, Jamaican, Jewish, Polish, Portuguese, Scottish, etc.	4a) What is your ethnic or cultural background? For example: Canadian, Chinese, East Indian, English, Filipino, French, German, Irish, Italian, Jamaican, Jewish, Polish, Portuguese, Scottish, etc		
<input type="checkbox"/> 1 Please specify _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Please specify _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer		
		4b) What is your child's/the patient's ethnic or cultural background? For example: Canadian, Chinese, East Indian, English, Filipino, French, German, Irish, Italian, Jamaican, Jewish, Polish, Portuguese, Scottish, etc.	
		<input type="checkbox"/> 1 Please specify _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
5) Which of the following best describes your racial group? (check all that apply, for example if you are multi-racial or mixed race)	5a) Which of the following best describes your racial group? (check all that apply, for example if you are multi-racial or mixed race)		
<input type="checkbox"/> 1 Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.) <input type="checkbox"/> 2 Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.) <input type="checkbox"/> 3 East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.) <input type="checkbox"/> 4 Latin American (Hispanic or Latin American descent) <input type="checkbox"/> 5 South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.) <input type="checkbox"/> 6 Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.) <input type="checkbox"/> 7 White (e.g., European descent) <input type="checkbox"/> 8 Another race/ethnic group (please specify): _____ <input type="checkbox"/> 9 Not Applicable (e.g. Identified as Indigenous in question #3) <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.) <input type="checkbox"/> 2 Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.) <input type="checkbox"/> 3 East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.) <input type="checkbox"/> 4 Latin American (Hispanic or Latin American descent) <input type="checkbox"/> 5 South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.) <input type="checkbox"/> 6 Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.) <input type="checkbox"/> 7 White (e.g., European descent) <input type="checkbox"/> 8 Another race/ethnic group (please specify): _____ <input type="checkbox"/> 9 Not Applicable (e.g. Identified as Indigenous in question #3) <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer		

	<p>5b) Which of the following best describes your child's/the patient's racial group? (check all that apply, for example If you are multi-racial or mixed race)</p>
	<ul style="list-style-type: none"> <input type="checkbox"/> 1 Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.) <input type="checkbox"/> 2 Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.) <input type="checkbox"/> 3 East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.) <input type="checkbox"/> 4 Latin American (Hispanic or Latin American descent) <input type="checkbox"/> 5 South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.) <input type="checkbox"/> 6 Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.) <input type="checkbox"/> 7 White (e.g., European descent) <input type="checkbox"/> 8 Another race/ethnic group (please specify): _____ <input type="checkbox"/> 9 Not Applicable (e.g. Identified as Indigenous in question #3) <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
<p>6a) Do you identify as a person with a disability? (e.g., mental health condition, physical disability, sensory disability, chronic conditions)</p>	<p>6a) Do you identify as a person with a disability? (e.g., mental health condition, physical disability, sensory disability, chronic conditions)</p>
<ul style="list-style-type: none"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 If you wish, please specify _____ <input type="checkbox"/> 3 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer 	<ul style="list-style-type: none"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 If you wish, please specify _____ <input type="checkbox"/> 3 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
<p>6b) Could you benefit from support related to any of the following? (check all that apply)</p>	<p>6b) Could you benefit from support related to any of the following? (check all that apply)</p>
<ul style="list-style-type: none"> <input type="checkbox"/> 1 Autism Spectrum Disorder <input type="checkbox"/> 2 Chronic Illness (e.g. sickle cell, diabetes etc.) <input type="checkbox"/> 3 Cognitive Disability <input type="checkbox"/> 4 Developmental Disability <input type="checkbox"/> 5 Drug or Alcohol Dependence <input type="checkbox"/> 6 Learning Disability <input type="checkbox"/> 7 Mental Illness <input type="checkbox"/> 8 Physical Disability <input type="checkbox"/> 9 Sensory Disability (e.g., low vision, blindness, deafness, hard of hearing etc.) <input type="checkbox"/> 10 Other (please specify) _____ <input type="checkbox"/> 11 None <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer 	<ul style="list-style-type: none"> <input type="checkbox"/> 1 Alzheimer's Disease <input type="checkbox"/> 2 Dementia <input type="checkbox"/> 3 Autism Spectrum Disorder <input type="checkbox"/> 4 Chronic Illness (e.g. sickle cell, diabetes etc.) <input type="checkbox"/> 5 Cognitive Disability <input type="checkbox"/> 6 Developmental Disability <input type="checkbox"/> 7 Drug or Alcohol Dependence <input type="checkbox"/> 8 Learning Disability <input type="checkbox"/> 9 Mental Illness <input type="checkbox"/> 10 Physical Disability <input type="checkbox"/> 11 Sensory Disability (e.g., low vision, blindness, deafness, hard of hearing etc.) <input type="checkbox"/> 12 Other (please specify) _____ <input type="checkbox"/> 13 None <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer

			6c) Does your child/the patient identify as a person with a disability? (e.g., mental health condition, physical disability, sensory disability, chronic conditions)		
			<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 If you wish, please specify_____ <input type="checkbox"/> 3 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer		
			6d) Could your child/the patient benefit from support related to any of the following? (check all that apply)		
			<input type="checkbox"/> 1 Autism Spectrum Disorder <input type="checkbox"/> 2 Chronic Illness (e.g. sickle cell, diabetes etc.) <input type="checkbox"/> 3 Cognitive Disability <input type="checkbox"/> 4 Developmental Disability <input type="checkbox"/> 5 Drug or Alcohol Dependence <input type="checkbox"/> 6 Learning Disability <input type="checkbox"/> 7 Mental Illness <input type="checkbox"/> 8 Physical Disability <input type="checkbox"/> 9 Sensory Disability (e.g., low vision, blindness, deafness, hard of hearing etc.) <input type="checkbox"/> 10 Other (please specify)_____ <input type="checkbox"/> 11 None <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer		
7) What was your sex assigned at birth? (check one)			7) What was your child's/the patient's sex assigned at birth? (check one)		
<input type="checkbox"/> 1 Male	<input type="checkbox"/> 3 Intersex	<input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Male	<input type="checkbox"/> 3 Intersex	<input type="checkbox"/> 99 Prefer not to answer
<input type="checkbox"/> 2 Female	<input type="checkbox"/> 88 Do not know		<input type="checkbox"/> 2 Female	<input type="checkbox"/> 88 Do not know	
			<i>Please note: The following questions (8, 9, 10) relate to gender identity and sexual orientation. As children are growing and developing, parents and caregivers may not know the answers to all these questions yet. Please select "don't know" or "prefer not to answer" if that feels most appropriate for your child, their age and development.</i>		
8) What is your gender identity? (check all that apply)			8a) What is your gender identity? (check all that apply)		
<input type="checkbox"/> 1 Genderfluid or genderqueer <input type="checkbox"/> 2 Boy/Man <input type="checkbox"/> 3 Nonbinary <input type="checkbox"/> 4 Two- Spirit <input type="checkbox"/> 5 Girl/Woman <input type="checkbox"/> 6 Questioning or unsure <input type="checkbox"/> 7 Another gender identity (please specify)_____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer			<input type="checkbox"/> 1 Genderfluid or genderqueer <input type="checkbox"/> 2 Boy/Man <input type="checkbox"/> 3 Nonbinary <input type="checkbox"/> 4 Two- Spirit <input type="checkbox"/> 5 Girl/Woman <input type="checkbox"/> 6 Questioning or unsure <input type="checkbox"/> 7 Another gender identity (please specify)_____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer		
			8b) What is your child's/the patient's gender identity? (check all that apply)		

	<input type="checkbox"/> 1 Genderfluid or genderqueer <input type="checkbox"/> 2 Boy/Man <input type="checkbox"/> 3 Nonbinary <input type="checkbox"/> 4 Two- Spirit <input type="checkbox"/> 5 Girl/Woman <input type="checkbox"/> 6 Questioning or unsure <input type="checkbox"/> 7 Another gender identity (please specify) _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
9) Do you identify as transgender? Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from the sex they were assigned at birth.	9a) Do you identify as transgender? Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from the sex they were assigned at birth.
<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
	9b) Does your child/the patient identify as transgender? Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from the sex they were assigned at birth.
	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
10) Which category(ies) best describe your sexual orientation? (check all that apply)	10a) Which category(ies) best describe your sexual orientation? (check all that apply)
<input type="checkbox"/> 1 Asexual <input type="checkbox"/> 2 Bisexual <input type="checkbox"/> 3 Demisexual <input type="checkbox"/> 4 Gay <input type="checkbox"/> 5 Lesbian <input type="checkbox"/> 6 Pansexual <input type="checkbox"/> 7 Queer <input type="checkbox"/> 8 Questioning or unsure <input type="checkbox"/> 9 Same-gender loving <input type="checkbox"/> 10 Straight/Heterosexual <input type="checkbox"/> 11 Two-spirit <input type="checkbox"/> 12 Another sexual orientation (please specify) _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Asexual <input type="checkbox"/> 2 Bisexual <input type="checkbox"/> 3 Demisexual <input type="checkbox"/> 4 Gay <input type="checkbox"/> 5 Lesbian <input type="checkbox"/> 6 Pansexual <input type="checkbox"/> 7 Queer <input type="checkbox"/> 8 Questioning or unsure <input type="checkbox"/> 9 Same-gender loving <input type="checkbox"/> 10 Straight/Heterosexual <input type="checkbox"/> 11 Two-spirit <input type="checkbox"/> 12 Another sexual orientation (please specify) _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
	10b) Which category(ies) best describe your child's/the patient's sexual orientation? (check all that apply)
	<input type="checkbox"/> 1 Asexual <input type="checkbox"/> 2 Bisexual <input type="checkbox"/> 3 Demisexual <input type="checkbox"/> 4 Gay <input type="checkbox"/> 5 Lesbian <input type="checkbox"/> 6 Pansexual <input type="checkbox"/> 7 Queer <input type="checkbox"/> 8 Questioning or unsure <input type="checkbox"/> 9 Same-gender loving <input type="checkbox"/> 10 Straight/Heterosexual <input type="checkbox"/> 11 Two-spirit <input type="checkbox"/> 12 Another sexual orientation (please specify) _____ <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
11) Do you/your household experience difficulty paying for basic needs? (Basic needs can include one or more of the	11) Do you currently have difficulty paying for basic needs?

following: housing, food, utility bills, transportation, internet & phone, clothing.)		
<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not applicable, I do not have to pay for basic needs <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not applicable, I do not have to pay for basic needs <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	
	12) What was your total family income before taxes last year?	
	<input type="checkbox"/> 1 \$0 - \$19,999 <input type="checkbox"/> 2 \$20,000 - \$39,999 <input type="checkbox"/> 3 \$40,000 - \$59,999 <input type="checkbox"/> 4 \$60,000 - \$79,999	<input type="checkbox"/> 5 \$80,000 - \$119,999 <input type="checkbox"/> 6 \$120,000 - \$149,999 <input type="checkbox"/> 7 \$150,000 or more <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer
	13) How many people does this income support?	
	<input type="checkbox"/> 1 _____ persons <input type="checkbox"/> 88 Do not know <input type="checkbox"/> 99 Prefer not to answer	