HOUSEHOLD SURVEY SHEET

IV) Health and Functioning

Child Serial No	**Name of child** Children of 3-16 age group regularly living in the household)	1) Does your child have difficult seeing, even if wearing glasses?				2) Does your child have difficulty hearing, even if wearing hearing aids?				3) Does your child have difficulty walking, compared with children of the same age?				4) Does your child has difficulty with self care such as feeding or dressing him/herself, compared with children of the same age?				5) Does your child has difficulty in being understood by others using customary/usual language, compared with children of the same age,?				6) Does your child have difficulty in remembering things that he/she has learned, compared with children of the same age?				7) Does your child use any additional aids and appliances such as			
		No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	No difficulty	Yes – some difficulty	Yes – a lot of difficulty	Cannot do at all	Glasses	Hearing aids	Mobility aids	others