

COHORT ID	SITE ID	PARTICIPANT ID	PIN	COHORT VISIT ID	FORM COMPLETED
_____	_____	_____	_____	_____	___/___/___ mm dd yyyy
ECHO LIFE STAGE			RESPONDENT		
<input type="checkbox"/> ₀₁ Prenatal	<input type="checkbox"/> ₀₂ Perinatal		<input type="checkbox"/> ₀₁ Participant	<input type="checkbox"/> ₀₂ Biological Mother	
<input type="checkbox"/> ₀₃ Infancy	<input type="checkbox"/> ₀₄ Early Childhood		<input type="checkbox"/> ₀₃ Biological Father	<input type="checkbox"/> ₀₄ Other Respondent	
<input type="checkbox"/> ₀₅ Middle Childhood	<input type="checkbox"/> ₀₆ Adolescence				Code: __ __

STUDY STAFF INSTRUCTION: This form should be completed by the pregnant woman during the prenatal life stage using the woman’s pregnancy ID and by the child’s primary caregiver during the infancy and early childhood life stages using the child’s participant ID. This form is also recommended to be completed by the child’s primary caregiver during the middle childhood and adolescence life stages using the child’s participant ID. If a question is not applicable, instruct participants to select ‘No’.

INSTRUCTIONS

The following questions ask about everyday life events that people experience. Please indicate whether the event has occurred in the **past 12 months** and whether it was positive, negative, or neutral for you. If a question is not applicable, please select ‘No’.

a. Has this event happened to you in the <u>past 12 months</u> ? <i>Answer ‘Yes’ or ‘No’ for each row. If ‘Yes’, answer Question b →</i>	b. Overall, was (this event) positive, negative, or neutral for you?				
	Yes	No	Positive	Negative	Neutral (Neither)
1. Did your income increase by a lot?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
2. Did you go deeply in debt?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
3a. Did your income decrease by a lot?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
3b. Did you give money to support family or friends not living with you?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
4. Did you go without food because you didn’t have the money to pay for it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
5. Did you go without some clothing because you couldn’t pay for it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
6. Did you miss a rent or mortgage payment because you couldn’t pay for it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
7. Did the utility or phone company threaten to cut off your service because you couldn’t pay the bills?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
8. Was your telephone, electricity, or gas turned off?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
9. Did you go without furniture because you did not have the money to pay for it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
10. Did you go without appliances because you did not have the money to pay for them?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
11. Did you lose your housing?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
12. Did you miss an appointment or have to change your plans because you had no transportation to get there?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

a. Has this event happened to you in the <u>past 12 months</u> ? <i>Answer 'Yes' or 'No' for each row. If 'Yes', answer Question b →</i>	b. Overall, was (this event) positive, negative, or neutral for you?				
	Yes	No	Positive	Negative	Neutral (Neither)
13a. Did you have legal problems?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
13b. Did you go without legal advice when you needed it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
13c. Was anyone in your family pulled over or questioned by the police?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
13d. Were you or your partner questioned about your legal status?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
14. Did anyone in your family get arrested?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
15a. Did anyone in your family go to jail?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
15b. Did anyone bully your child or children?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
15c. Did your child or children challenge your family values and beliefs?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
15d. Did any of your children get bad grades or bad marks in school?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
16a. Did your child or children get into trouble?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
16b. Were any of your children involved with someone who you think is a gang member?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
17a. Did you have trouble reading or understanding something that was important to you?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
17b. Did you have trouble communicating with someone about something that was important to you?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
18. Did you return to school?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
19. Did you have trouble with your teacher(s)?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
20. Did your regular child care arrangements change in any way?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
21a. Did you get married?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
21b. Did you and your partner disagree about raising your children?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
21c. Did you and your partner disagree about your roles and responsibilities?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
21d. Did you miss an important family event that you wanted to attend?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

a. Has this event happened to you in the <u>past 12 months</u> ? <i>Answer 'Yes' or 'No' for each row. If 'Yes', answer Question b →</i>	b. Overall, was (this event) positive, negative, or neutral for you?				
	Yes	No	Positive	Negative	Neutral (Neither)
22. Did you get a divorce or break up with a partner?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
23. Did you get back together with a partner?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
24. Did a family member die?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
25. Did a friend die?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
26. Did anything happen in your neighborhood that made you feel unsafe?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
27. Did you feel emotionally or physically abused?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
28. Did your child or children feel emotionally or physically abused?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
29. Were you a victim of a crime while you were in your own home?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
30. Were you a victim of a crime while you were outside or away from your home?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
31. Did you hear violence outside your home (for example, gunfire)?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
32. Did you see violence?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
33. Did your child or children see violence?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
34. Was your child (or were your children) a victim of a crime?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
35. Was anyone else in your household a victim of a crime?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
36. Did you see drug dealing in your building or neighborhood?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
37. Did you or your partner get pregnant?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
38a. Did you or your partner have a baby?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
38b. Did any of your children get pregnant or get someone else pregnant?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
39. Did you or your partner have a miscarriage?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
40. Did you or your partner have an abortion?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
41a. Did you ever use alcohol or drugs to get through a day?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03
41b. Did your partner ever drink too much or use drugs?	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _01	<input type="checkbox"/> _02	<input type="checkbox"/> _03

a. Has this event happened to you in the <u>past 12 months</u> ? <i>Answer 'Yes' or 'No' for each row. If 'Yes', answer Question b →</i>			b. Overall, was (this event) positive, negative, or neutral for you?		
	Yes	No	Positive	Negative	Neutral (Neither)
42. Did you become ill or did you have a flare up of a chronic illness?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
43a. Did your child or children become ill or have a flare up of a chronic illness?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
43b. Did you go without medical care when you needed it?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
44. Did you get admitted to the hospital?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
45. Did your child or children get admitted to the hospital?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
46. Did another family member become ill?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
47. Did a friend become ill?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
48. Did a relative or friend move into your home?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
49. Did a relative or friend move out of your home?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
50. Did you move?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
51. Did rats, mice, or insects bother you in your home?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
52. Did you have trouble with your landlord?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
53. Did you have trouble with your neighbors?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
54. Did you have trouble with social service agencies?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
55. Did you have trouble with medical or health professionals?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
56. Did someone treat you unfairly because of your age?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
57. Did someone treat you unfairly because of your sex?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
58. Did someone treat you unfairly because of your race?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
59a. Did someone treat you unfairly because you didn't have a lot of money?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
59b. Did someone treat you unfairly because of the way you speak?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

a. Has this event happened to you in the <u>past 12 months</u> ? <i>Answer 'Yes' or 'No' for each row. If 'Yes', answer Question b →</i>	b. Overall, was (this event) positive, negative, or neutral for you?				
	Yes	No	Positive	Negative	Neutral (Neither)
60. Did you work in the last 12 months? IF NO, SKIP TO Question 64	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
61. Did you begin a new job or get promoted?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
62. Did you get laid off?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
63. Did you have trouble with superiors at work?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
64. Did you look for a job?	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

Setting	Mode
<input type="checkbox"/> ₀₁ Clinic or site <input type="checkbox"/> ₀₂ Phone <input type="checkbox"/> ₀₃ Other location	<input type="checkbox"/> ₀₁ Self-administered <input type="checkbox"/> ₀₂ Staff-administered