The Cleft Collective
Closing the Gap in Cleft Research
A Scar Free Foundation Initiative

ID LABEL

You and Your Child at 10 years

Mother's questionnaire

This questionnaire is for the child's mother.

University of BRISTOL
UWE BRISTOL University of the West of England
THE SCAR FREE FOUNDATION
VTCT WORLD CLASS QUALIFICATIONS

October 2020 - Version 1
For office use only

About this research

You are being asked to complete this questionnaire because you have chosen to participate in The Cleft Collective Cohort Studies. This research is taking place in collaboration with cleft teams in the UK to investigate the causes of cleft, the best treatments for cleft and the long-term impact of cleft on the family and the individual.

About this questionnaire

This questionnaire has seven sections:

A. **Your Child's Health** - This section asks you questions related to the health of your child
B. **Feeding Your Child** - This section asks about your experience of feeding your child and your child's eating and drinking behaviours
C. **Your Child's Teeth** - This section asks questions about your child's teeth and dentist
D. **Additional Questions About Your Child -** This section includes questions not covered in any other section, such as childcare and school
E. **Your Family** - This section asks you questions about where you live, your marital status and your other children (if applicable)
F. **Your Lifestyle** - This section asks questions about your diet, alcohol use, cigarette smoking and exercise
G. **The Wellbeing of You and Your Child** - The last section asks about how you have been feeling recently and your child's development and wellbeing

Please try to answer all of the questions, even if some of them sound strange to you. As so little is known about the causes of cleft, and the impact of having a cleft, we need to ask a broad range of questions about your environment and family history to help us understand what causes cleft and how we can help to support families.

When we ask questions about 'your child' please answer in relation to your child who was born with a cleft. Some of the questions are retrospective. Please fill out the information you can remember.

There are no right or wrong answers. If you do not want to answer a question then just leave it blank.

Some of the questions ask about your health and your lifestyle. We need to know this information to find out if any of these factors could be related to cleft lip and palate, but this does not necessarily mean that any of these factors were involved in the development of your child's cleft.

All of the answers you give us in this questionnaire will be kept anonymous.

How to fill in this questionnaire

Please use a black pen. To answer the questions please put a cross in the box like this:

☒

If you make a mistake, shade the box in like this:

then cross the correct box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes.

Who to contact for support

If you have any questions or if you feel concerned or distressed before/after completing this questionnaire and would like some extra support, please contact your cleft team who can help.

Thank you for completing this questionnaire!

SECTION A - YOUR CHILD'S HEALTH

A1. What is your child's gender? ☐Male ☐Female

A2. How much does your child weigh **now**?

Lbs ☐☐☐ Oz ☐☐ OR Kg ☐☐.☐☐

A3. What is your child's height **now**?

Feet ☐ Inches ☐☐ OR M ☐. Cm ☐☐

A4. What is your child's head circumference **now**?

Inches ☐☐ OR Cm ☐☐. Mm ☐

A5. What type of cleft was your child born with?

☐Cleft lip ☐Cleft palate ☐Cleft lip and palate

☐Submucous cleft palate ☐Don't know

A6. Is your child's cleft unilateral (on one side of their mouth) or bilateral (on both sides of their mouth)?

☐Unilateral ☐Bilateral ☐Don't know

A7. If your child's cleft is unilateral (on one side of their mouth), which side of your child's mouth is the cleft on **(when looking at your child)**?

☐Right ☐Left ☐Don't know

☐Not applicable

A8. Has your child had any other surgery relating to their cleft lip / cleft palate?
(Cross <u>all</u> that apply)

☐a) Grommets ☐b) Bone graft ☐c) Speech surgery

☐d) Palate re-repair ☐e) Lip revision ☐f) Fistula repair

☐g) Other (please specify) ☐h) None of the above

A9. Has your child had any of the following infections? **(Cross all that apply)**

- ☐ 0) None
- ☐ i) German measles / Rubella
- ☐ ii) Measles
- ☐ iii) Chickenpox
- ☐ iv) Mumps
- ☐ v) Meningitis
- ☐ vi) Urinary tract infection (E.g. cystitis)
- ☐ vii) Chest infections / pneumonia
- ☐ viii) Recurrent ear infections
- ☐ ix) Other infection (please specify)

A10. Has your child had / does your child have any of the following conditions or problems? **(Cross all that apply)**

a) Neurological / Sensory Conditions

- ☐ 0) None
- ☐ i) Epilepsy / Fits / Convulsions
- ☐ ii) Cerebral Palsy
- ☐ iii) Developmental delay
- ☐ iv) Hearing loss or impairment
- ☐ v) Glue Ear, OME (Otitis Media with Effusion)
- ☐ vi) Difficulties with vision / blindness
- ☐ vii) Other neurological condition (please specify)

b) Heart / Lungs / Immune system

- ☐ 0) None
- ☐ i) Heart condition
- ☐ ii) Lung condition
- ☐ iii) Asthma / Difficulties breathing
- ☐ iv) Allergies
- ☐ v) Immune deficiency
- ☐ vi) Other problems with heart / lungs/ immune system (please specify)

c) Skin / Musculoskeletal conditions

- ☐ 0) None
- ☐ i) Skin condition
- ☐ ii) Skeletal condition
- ☐ iii) Talipes (Club foot)
- ☐ iv) Spine condition
- ☐ v) Other skin / musculoskeletal condition (please specify)

d) Metabolic conditions

- ☐ 0) None
- ☐ i) Thyroid condition
- ☐ ii) Abnormal calcium levels
- ☐ iii) Blood condition
- ☐ iv) Other metabolic condition (please specify)

e) Abdominal conditions

- ☐ 0) None
- ☐ i) Severe / persistent vomiting
- ☐ ii) Severe / persistent diarrhoea
- ☐ iii) Severe / persistent gut abnormalities
- ☐ iv) Liver problems
- ☐ v) Jaundice
- ☐ vi) Failure to gain weight or grow
- ☐ vii) Other abdominal condition (please specify)

f) Kidney and bladder problems

- ☐ 0) None
- ☐ i) Kidney / bladder problems (please specify)
- ☐ ii) Hypospadias (males only)

A11. Does your child have problems with the structural development of any of the following? **(Cross <u>all</u> that apply)**

- ☐ a) Eyes (not including vision impairments)
- ☐ b) Ears (not including hearing impairments)
- ☐ c) Cheekbones
- ☐ d) Jaw
- ☐ e) Tongue
- ☐ f) Hands
- ☐ g) Feet
- ☐ h) Spine
- ☐ i) Other developmental condition (please specify)
- ☐ j) None of the above

A12. Has **your child** been diagnosed with any of the following syndromes / genetic conditions? **(Cross all that apply)**

- ☐ a) Pierre Robin sequence (PRS)
- ☐ b) Van der Woude syndrome
- ☐ c) Treacher Collins syndrome
- ☐ d) Hemifacial Microsomy / Goldenhar syndrome
- ☐ e) Stickler syndrome
- ☐ f) 22q 11.2 deletion syndrome (also known as Velocardiofacial syndrome, Shprintzen syndrome, DiGeorge syndrome)
- ☐ g) Craniosynostosis (including Crouzon syndrome, Apert syndrome, Pfeiffer syndrome, Saethre-Chotzen syndrome)
- ☐ h) Cornelia de Lange syndrome
- ☐ i) Other syndrome / genetic condition (please specify)
- ☐ j) We are currently undergoing genetic testing at the hospital
- ☐ k) None

A13. Has **your child** ever had difficulties with any of the following? **(Cross all that apply)**

- ☐ a) Attention/concentration
- ☐ b) Hyperactivity
- ☐ c) Behavioural problems
- ☐ d) Emotional difficulties
- ☐ e) Social interaction
- ☐ f) Learning to read/or write
- ☐ g) Movement
- ☐ h) Co-ordination
- ☐ i) Other (please specify)
- ☐ j) None

A14. a) Has **your child** been diagnosed with any of the following conditions?
(Cross all that apply)

- ☐ i) Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ ii) Autism Spectrum Disorder
- ☐ iii) A learning disability
- ☐ iv) Dyslexia
- ☐ v) Depression
- ☐ vi) Anxiety
- ☐ vii) Dyspraxia
- ☐ viii) Speech-Sound Disorder
- ☐ ix) Chronic Fatigue Syndrome (CFS)/ME
- ☐ x) Other (please specify) [ ]
- ☐ xi) None

A14. b) If you answered yes to question A14. a) x), please tell us more in the box below.

[ ]

A15. Has your child been diagnosed with any other condition not mentioned above?
(please specify below)

[ ]

For A16, if you have more than one child with these conditions, please make a note in the comments at the back of the questionnaire.

A16. Have **you, the child's biological father, or any of your other children** been diagnosed with any of the following conditions? (For other children, please also give their date of birth)

	i) You	ii) Child's father	iii) Other child	iv) Other child's DOB (if applicable) in dd/mm/yy
a) Pierre Robin sequence (PRS)	☐	☐	☐	☐☐/☐☐/☐☐
b)Van der Woude syndrome	☐	☐	☐	☐☐/☐☐/☐☐
c) Treacher Collins syndrome	☐	☐	☐	☐☐/☐☐/☐☐
d) Hemifacial Microsomy / Goldenhar syndrome	☐	☐	☐	☐☐/☐☐/☐☐
e) Stickler syndrome	☐	☐	☐	☐☐/☐☐/☐☐
f) 22q 11.2 deletion syndrome (also known as Velocardiofacial syndrome, Shprintzen syndrome, DiGeorge syndrome)	☐	☐	☐	☐☐/☐☐/☐☐
g) Craniosynostosis (including Crouzon syndrome, Apert syndrome, Pfeiffer syndrome, Saethre-Chotzen syndrome)	☐	☐	☐	☐☐/☐☐/☐☐
h) Cornelia de Lange syndrome	☐	☐	☐	☐☐/☐☐/☐☐
i) We are currently undergoing genetic testing at the hospital	☐	☐	☐	☐☐/☐☐/☐☐
j) Other syndrome / genetic condition (please specify)	☐	☐	☐	☐☐/☐☐/☐☐
k) No	☐	☐	☐	

A17. Does your child have a regular sleeping routine? ☐ Yes ☐ No

A18. How often during the night does your child usually wake? ☐ times

A19. In the past year has your child regularly:

	No, did not happen	Yes, but did not worry me	Yes, and worried me a bit	Yes, and worried me greatly	Don't know
a) Refused to go to bed	☐	☐	☐	☐	☐
b) Woken very early	☐	☐	☐	☐	☐
c) Had difficulty going to sleep	☐	☐	☐	☐	☐
d) Had nightmares	☐	☐	☐	☐	☐
e) Continued to get up after being put to bed	☐	☐	☐	☐	☐
f) Got up after only a few hours sleep	☐	☐	☐	☐	☐

SECTION B - FEEDING YOUR CHILD

B1. Did your child have any nasal regurgitation (food coming down their nose)?

☐ Yes, often ☐ Yes, sometimes ☐ No

B2. Approximately how old was your child when they first had something other than milk to drink (e.g. tap water, mineral water, fruit juice)?

☐☐ Months

B3. Approximately how old was your child when they were first given solids to eat (e.g. baby food in a jar, packet or tin, or homemade food such as baby rice, pureed fruit or vegetables)?

☐☐ Months

B4. a) Since your child was 6 months old, have they at any time:

	Yes, and worried me greatly	Yes, and worried me a bit	Some-times	Almost never
i) Not eaten a sufficient amount of food	☐	☐	☐	☐
ii) Refused to eat the right food	☐	☐	☐	☐
iii) Been choosy with food	☐	☐	☐	☐
iv) Overeaten	☐	☐	☐	☐
v) Been difficult to get into an eating routine	☐	☐	☐	☐

b) Is this still a problem now? ☐Yes, always ☐Yes, sometimes ☐No

B5. a) Up to the age of **3 years**, did your child have difficulties with particular tastes or textures? ☐ Yes ☐ No **If no, go to question B6**

If Yes b) please specify

c) Is this still a problem now? ☐Yes, always ☐Yes, sometimes ☐No

B6. When did your child first begin drinking from a cup or a beaker?

		Months

B7. Up to the age of **3 years**, what did your child normally drink? **(Cross <u>all</u> that apply)**

☐ a) Water ☐ b) Milk ☐ c) Fruit juice

☐ d) Squash ☐ e) Fizzy drinks ☐ f) Other (please specify)

B8. What does your child normally drink **<u>now</u>**? **(Cross <u>all</u> that apply)**

☐ a) Water ☐ b) Milk ☐ c) Fruit juice

☐ d) Squash ☐ e) Fizzy drinks ☐ f) Other (please specify)

B9. Where does your child normally eat their meals? **(Cross <u>all</u> that apply)**

☐ a) At the table ☐ b) In front of the TV

☐ c) In their bedroom ☐ d) Other (please specify)

B10. Does your child normally eat... **(Cross <u>all</u> that apply)**

☐ a) Alone ☐ b) With siblings

☐ c) With the whole of the family ☐ d) Other (please specify)

B11. Does your child eat the same foods as the rest of the family?

☐ Usually ☐ Sometimes ☐ No

B12. Does your child have snacks in the day, between meals?

☐ No ☐ Once ☐ Twice ☐ More than twice

B13. Now that your child is 10 years old, do you have any concerns about their eating habits?

a) ☐ Yes ☐ No

If Yes b) Please specify

SECTION C - YOUR CHILD'S TEETH

C1. How many teeth does your child have now? ☐☐

C2. Did any of the adult back teeth or front teeth (incisors) come through with yellow/brown or opaque white patches?

☐ Yes ☐ No ☐ Don't know

C3. Does your child have any extra adult teeth?

☐ Yes ☐ No ☐ Don't know

C4. Does your child have any missing permanent/adult teeth? (Not because they were removed by a dentist)

☐ Yes ☐ No ☐ Don't know

C5. When does your child brush their teeth?

☐ Morning ☐ Evening ☐ Morning and Evening

☐ Never ☐ Other (please specify) ☐

C6. Do you help your child with brushing?

☐ Never ☐ Sometimes ☐ Always

C7. What toothpaste is your child using?

☐ None ☐ Children's toothpaste (over 3 years)

☐ Adult toothpaste ☐ Other (please specify) ☐

C8. Has the dentist recommended that your child uses a daily fluoride mouthwash?

☐ Yes, after brushing ☐ Yes, at a separate time to brushing ☐ No

☐ Don't know

C9. a) Does your child have a drink in the last hour before bed? ☐ Yes ☐ No

If Yes b) What does your child drink? **(Cross <u>all</u> that apply)**

☐ i) Water ☐ ii) Milk ☐ iii) Fruit juice

☐ iv) Squash ☐ v) Fizzy drinks ☐ vi) Other (please specify) ☐

If Yes c) Does your child brush their teeth afterwards? ☐ Yes ☐ No

C10. Does your child eat in the last hour before bed? ☐ Yes ☐ No

C11. Do you regularly see a family dentist? (Approximately every 6 months)

☐ Yes ☐ No

C12. How old was your child when you first took them to the dentist?

Years ☐☐ Months ☐☐

☐ Don't know

☐ Not applicable

C13. Has your child ever been told they have dental caries (tooth decay)?

☐ Yes ☐ No ☐ Don't know

C14. Has your child had any of the following procedures? **(Cross <u>all</u> that apply)**

☐ a) Filling ☐ b) Metal crown ☐ c) Tooth removed

☐ d) None of these ☐ e) Don't know

C15. Has your child ever had gas and air inhalational sedation to help them have dental treatment?

☐ Yes ☐ No ☐ Don't know

C16. If you have other children without cleft have you received different advice about tooth brushing for your child born with a cleft?

☐ Yes ☐ No ☐ Not applicable

C17. Does the dentist normally place fluoride varnish on your child's teeth?

☐ Yes, every 3 months ☐ Yes, every 4 months ☐ Yes, every 6 months

☐ Yes, every year ☐ No ☐ Don't know

C18. a) Do you like the way your child's teeth look now? ☐ Yes ☐ No

If no b) What don't you like about them? **(Cross <u>all</u> that apply)**

☐ i) Gaps between teeth ☐ ii) Crooked ☐ iii) Too small

☐ iv) Too big ☐ v) Too brown ☐ vi) Too white

☐ vii) Blotchy ☐ viii) Other (please specify)

C19. a) Has your child had an orthodontic assessment by the Cleft Team Orthodontist? ☐ Yes ☐ No **If no, go to question C20**

If yes b) How old was your child at the first orthodontic assessment?

Years		Months	

c) If the assessment was carried out by a team, who did it include?
(Cross all that apply)

☐ i) Paediatric dentist ☐ ii) Orthodontist ☐ iii) Surgeon

d) Where were the orthodontics mainly carried out?

☐ Your main cleft centre ☐ Your local hospital ☐ Don't know

☐ Other (please specify)

e) Were you advised that orthodontic treatment was necessary?

☐ Yes ☐ No

f) Were you advised that early treatment prior to the age of 12 would be needed to correct teeth that were far out of line?

☐ Yes ☐ No

g) Were you advised that your child would be monitored regularly by the Cleft Unit until they were ready for orthodontic treatment when more adult teeth were present?

☐ Yes ☐ No

C20. a) Has your child attended a specific Bone Graft Clinic?

☐ Yes ☐ No **If no, go to question C21**

If yes b) Were you advised that a bone graft was required?

☐ Yes ☐ No **If no, go to question C21**

c) Did your child require orthodontic/brace treatment prior to the alveolar bone graft?

☐ Yes ☐ No

d) Approximately how long did the treatment take before the bone graft?

☐ 6 - 11 months ☐ 12 - 17 months ☐ 18 + months ☐ Not applicable

e) How many days did your child stay in hospital to have the graft carried out?

☐☐ Days ☐ Not applicable

f) Were there any complications with the graft?

☐ Yes ☐ No ☐ Not applicable

C21. a) Is your child wearing or has your child worn braces? **(Cross <u>all</u> that apply)**

☐ Yes, fixed braces (train tracks) ☐ Yes, removable braces

☐ None

b) How long after the operation (if applicable) were the braces removed?

☐ 6 - 11 months ☐ 12 - 17 months ☐ 18 + months

☐ Not applicable

SECTION D - ADDITIONAL QUESTIONS ABOUT YOUR CHILD

We are interested to know who is involved in caring for your child to see whether this has an impact on children's overall development.

The following questions ask about who has regularly looked after your child since they were 8 years old **(Cross all that apply)**

D1. Apart from yourself and your partner, who has regularly looked after your child **on school days?**

☐ a) No one else looks after my child

Who looks after your child?	How often does this person / organisation look after your child each week?			
	Less than 1 day per week	1 to 2 days per week	3 to 4 days per week	More than 4 days per week
b) Child's grandparent	☐	☐	☐	☐
c) Other relative	☐	☐	☐	☐
d) Friend or neighbour	☐	☐	☐	☐
e) Paid person outside the home (e.g.child -minder)	☐	☐	☐	☐
f) Paid person inside the home (e.g. nanny /babysitter)	☐	☐	☐	☐
g) After school club	☐	☐	☐	☐
h) Other (please specify)	☐	☐	☐	☐

D2. What type of school does your child attend?

☐ Primary school ☐ Special school

☐ Private or independent primary school ☐ Other (please specify)

D3. a) Does your child have any additional needs which means the school should make (or has made) special arrangements (e.g. sit them at the front of the classroom/take them out of lessons/provide extra teaching or help)?

☐ Yes ☐ No

If Yes b) Please tell us which additional needs your child has which means special arrangements need to be made **(Cross <u>all</u> that apply)**

☐ i) A learning disability

☐ ii) Speech, language or communication needs

☐ iii) Hearing difficulties

☐ iv) Eyesight difficulties

☐ v) Physical problems

☐ vi) Reading difficulties

☐ vii) Emotional or behavioural problems

☐ viii) Other (please specify)

D4. Has your child been given a Statement of Special Educational Needs (SEN) or an Education, Health and Care (EHC) plan?

☐ Yes, my child has a Statement/EHC plan

☐ No, but my child is being assessed

☐ No, my child was refused a Statement/EHC plan

☐ No, my child has never been considered for a Statement/EHC plan

D5. If applicable, how happy are you with the special arrangements that have been made for your child?

☐ Very happy ☐ Somewhat happy ☐ Somewhat unhappy

☐ Very unhappy ☐ Not applicable

D6. Do you feel that you have a good relationship with your child's school?

☐ Yes, always ☐ Yes, most of the time ☐ Sometimes

☐ Not very often ☐ No

D7. a) Has your child ever received speech and language therapy? **(Cross <u>all</u> that apply)**

☐ i) Yes, from the cleft team

☐ ii) Yes, at school

☐ iii) Yes, other (please specify)

☐ iv) No

If Yes b) Is your child still receiving speech and language therapy? **(Cross <u>all</u> that apply)**

- ☐ i) Yes, from the cleft team
- ☐ ii) Yes, at school
- ☐ iii) Yes, other (please specify)
- ☐ iv) No

D8. In general, how happy are you with the progress your child is making at school?

☐ Very happy ☐ Somewhat happy ☐ Somewhat unhappy
☐ Very unhappy ☐ Not applicable

D9. How do you think your child feels about school?

My child...	**Always**	**Usually**	**Some -times**	**Not at all**
a) Looks forward to going	☐	☐	☐	☐
b) Enjoys it	☐	☐	☐	☐
c) Is stimulated by it	☐	☐	☐	☐
d) Is frightened by it	☐	☐	☐	☐
e) Talks about his/her friends	☐	☐	☐	☐
f) Seems bored by it	☐	☐	☐	☐
g) Likes the teacher(s)	☐	☐	☐	☐
h) Does not like school	☐	☐	☐	☐

D10. Do you have any other concerns about the time your child spends at school?

- ☐ No
- ☐ Yes (please tell us more)

SECTION E - YOUR FAMILY

E1. a) Since the birth of your child with a cleft, have you had any more children?

☐ Yes ☐ No

If Yes b) How many? ☐

If Yes, please give us the following information
If No, please go to F1

c) Child 1

i) Date of birth DD / MM / YY

ii) Gender
- ☐ Male
- ☐ Female

iii) What is their cleft type?
- ☐ This child does not have a cleft
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iv) Is their cleft:
- ☐ This child does not have a cleft
- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

v) Are they enrolled in the study?
- ☐ Yes
- ☐ No

d) Child 2

i) Date of birth DD / MM / YY

ii) Gender
- ☐ Male
- ☐ Female

iii) What is their cleft type?
- ☐ This child does not have a cleft
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iv) Is their cleft:
- ☐ This child does not have a cleft
- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

v) Are they enrolled in the study?
- ☐ Yes
- ☐ No

e) Child 3

i) Date of birth DD / MM / YY

ii) Gender
- ☐ Male
- ☐ Female

iii) What is their cleft type?
- ☐ This child does not have a cleft
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iv) Is their cleft:
- ☐ This child does not have a cleft
- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

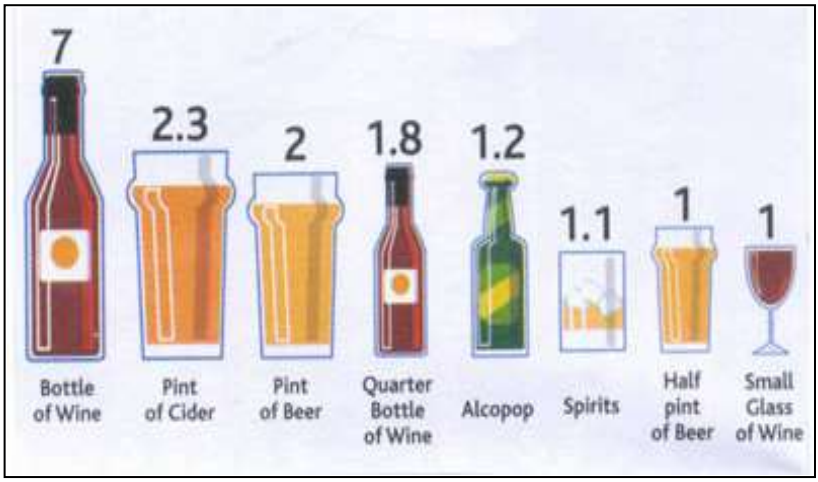
v) Are they enrolled in the study?
- ☐ Yes
- ☐ No

SECTION F - YOUR LIFESTYLE

F1. Do you currently drink alcohol? ☐ Yes **(Go to question F2)**

☐ No **(Go to question F3)**

Please use the image below to help you answer question F2



F2. On average, how many units of alcohol do you drink **per week?**

☐ None ☐ One to two units

☐ Three to five units ☐ Five to ten units

☐ Ten to twenty units ☐ Twenty to thirty units

☐ More than thirty units

F3. Do you currently smoke cigarettes? ☐ Yes **(Go to question F4)**

☐ No **(Go to question F5)**

F4. On average, how many cigarettes do you currently smoke **per day?**

☐ Less than one per day ☐ One pack (15-24 per day)

☐ One per day ☐ One & ½ packs (25-34 per day)

☐ Two to four per day ☐ Two packs (35-44 per day)

☐ ½ a pack (5 to 14 per day) ☐ More than two packs per day

F5. Is your child ever exposed to passive smoke? ☐ Yes **(Go to question F6)**

☐ No **(Go to question F7)**

F6. How many hours per day is your child exposed to passive smoke?

☐ Less than one hour per day ☐ Three to four hours per day

☐ One to two hours per day ☐ More than four hours per day

F7. a) Do you currently use any drugs? ☐Yes ☐No

If yes b) How often do you use these substances? **(Cross <u>all</u> that apply)**

	Never	Once a year	Twice a year	Once every two months	Once a month	Twice a month	Once a week or more
i) Cannabis	☐	☐	☐	☐	☐	☐	☐
ii) Cocaine	☐	☐	☐	☐	☐	☐	☐
iii) Ecstasy	☐	☐	☐	☐	☐	☐	☐
iv) Amphetamine	☐	☐	☐	☐	☐	☐	☐
v) Heroin	☐	☐	☐	☐	☐	☐	☐
vi) Other (specify below)	☐	☐	☐	☐	☐	☐	☐

F8. During a typical week, how many minutes/times on average do you do the following types of exercise?

i) Vigorous exercise (breathing hard, heart beats rapidly).
For example: running, aerobics, martial arts, fast swimming, or a team sport such as football or hockey ☐☐☐ minutes per week

ii) Moderate exercise (heart rate increases slightly, but is not exhausting).
For example: fast walking or gentle cycling ☐☐☐ minutes per week

iii) Muscle strengthening activities
For example: lifting weights, push-ups and sit-ups, heavy gardening or yoga ☐☐ times per week

SECTION G - THE WELLBEING OF YOU AND YOUR CHILD

G1. Families sometimes have special concerns or difficulties because of their child's health. Below is a list of things that might be a problem for you.

In the past **one month, as a result of your child's health**, how much of a problem have **you** had with the following...

	Never	Almost never	Some-times	Often	Almost always
a) I feel tired during the day	☐	☐	☐	☐	☐
b) I feel tired when I wake up in the morning	☐	☐	☐	☐	☐
c) I feel too tired to do the things I like to do	☐	☐	☐	☐	☐
d) I get headaches	☐	☐	☐	☐	☐
e) I feel physically weak	☐	☐	☐	☐	☐
f) I feel sick to my stomach	☐	☐	☐	☐	☐
g) I feel anxious	☐	☐	☐	☐	☐
h) I feel sad	☐	☐	☐	☐	☐
i) I feel angry	☐	☐	☐	☐	☐
j) I feel frustrated	☐	☐	☐	☐	☐
k) I feel helpless or hopeless	☐	☐	☐	☐	☐
l) I feel isolated from others	☐	☐	☐	☐	☐
m) I have trouble getting support from others	☐	☐	☐	☐	☐
n) It is hard to find time for social activities	☐	☐	☐	☐	☐
o) I do not have enough energy for social activities	☐	☐	☐	☐	☐

G1 continued...

	Never	Almost never	Some-times	Often	Almost always
p) It is hard for me to keep my attention on things	☐	☐	☐	☐	☐
q) It is hard for me to remember what people tell me	☐	☐	☐	☐	☐
r) It is hard for me to remember what I just heard	☐	☐	☐	☐	☐
s) It is hard for me to think quickly	☐	☐	☐	☐	☐
t) I have trouble remembering what I was just thinking	☐	☐	☐	☐	☐
u) I feel that others do not understand my family's situation	☐	☐	☐	☐	☐
v) It is hard for me to talk about my child's health with others	☐	☐	☐	☐	☐
w) It is hard for me to tell doctors and nurses how I feel	☐	☐	☐	☐	☐
x) I worry about whether or not my child's medical treatments are working	☐	☐	☐	☐	☐
y) I worry about the side effects of my child's medications/medical treatments	☐	☐	☐	☐	☐
z) I worry about how others will react to my child's condition	☐	☐	☐	☐	☐
aa) I worry about how my child's illness is affecting other family members	☐	☐	☐	☐	☐
bb) I worry about my child's future	☐	☐	☐	☐	☐

G2. Below is a list of things that might be a problem for your **family**.
In the past **<u>one month</u>**, **<u>as a result of your child's health</u>**, how much of a problem has **<u>your family</u>** had with...

	Never	Almost never	Some-times	Often	Almost Always
a) Family activities taking more time and effort	☐	☐	☐	☐	☐
b) Difficulty finding time to finish household tasks	☐	☐	☐	☐	☐
c) Feeling too tired to finish household tasks	☐	☐	☐	☐	☐
d) Lack of communication between family members	☐	☐	☐	☐	☐
e) Conflicts between family members	☐	☐	☐	☐	☐
f) Difficulty making decisions together as a family	☐	☐	☐	☐	☐
g) Difficulty solving family problems together	☐	☐	☐	☐	☐
h) Stress or tension between family members	☐	☐	☐	☐	☐

G3. Please answer the following questions telling us how happy you are with the care **you, your child, and your family** have received at the hospital from the staff.

Please cross N/A (not applicable) if the item does not apply to you.

How happy are you with... (For example, 'Never happy', 'Often happy' etc)	Never	Some-times	Often	Almost always	Always	N/A
a) How much information was provided to you about your child's diagnosis?	☐	☐	☐	☐	☐	☐
b) How much information was provided to you about the treatment and course of your child's health condition?	☐	☐	☐	☐	☐	☐
c) How much information was provided to you about the side effects of your child's treatment?	☐	☐	☐	☐	☐	☐

G3 continued...

How happy are you with...	Never	Some-times	Often	Almost always	Always	N/A
d) How soon information was given to you about your child's test results?	☐	☐	☐	☐	☐	☐
e) How often you are updated about your child's health?	☐	☐	☐	☐	☐	☐
f) The sensitivity shown to you and your family during your child's treatment?	☐	☐	☐	☐	☐	☐
g) The willingness to answer questions that you and your family may have?	☐	☐	☐	☐	☐	☐
h) The effort to include your family in discussion of your child's care and other information about your child's health condition?	☐	☐	☐	☐	☐	☐
i) How much time the staff give you to ask any questions you may have had about your child's health condition and treatment?	☐	☐	☐	☐	☐	☐
j) How well the staff explain your child's health condition and treatment to **your child** in a way that she/he can understand?	☐	☐	☐	☐	☐	☐
k) The time taken to explain your child's health condition and treatment to **you** in a way that you could understand?	☐	☐	☐	☐	☐	☐
l) How well the staff listen to you and your concerns?	☐	☐	☐	☐	☐	☐
m) The preparation provided for **you** about what to expect during tests and procedures?	☐	☐	☐	☐	☐	☐

G3 continued...

How happy are you with...	Never	Some-times	Often	Almost always	Always	N/A
n) The preparation provided for **your child** about what to expect during tests and procedures?	☐	☐	☐	☐	☐	☐
o) How well the staff respond to your child's needs?	☐	☐	☐	☐	☐	☐
p) Efforts to keep your child comfortable and as pain-free as possible?	☐	☐	☐	☐	☐	☐
q) How much time the staff take to help you with your child coming back home after hospitalisation?	☐	☐	☐	☐	☐	☐
r) The amount of time given to your child to play, talk about her/his feelings, and any questions she/he may have?	☐	☐	☐	☐	☐	☐
s) The amount of time spent helping your child with going back to school after hospitalisation?	☐	☐	☐	☐	☐	☐
t) The amount of time spent attending to **your child's** emotional needs?	☐	☐	☐	☐	☐	☐
u) The amount of time spent attending to **your** emotional needs?	☐	☐	☐	☐	☐	☐
v) The overall care your child is receiving?	☐	☐	☐	☐	☐	☐
w) How friendly and helpful the staff are?	☐	☐	☐	☐	☐	☐
x) The way your child is treated at the hospital?	☐	☐	☐	☐	☐	☐

G4. **We are asking these questions to help us understand how children with cleft lip and/or palate develop.**

These questions ask you about your **child's behaviour.** To what extent are each of these statements true of your child's behaviour over the last **six months?**

	Not true	Somewhat true	Certainly true
a) Considerate of other people's feelings	☐	☐	☐
b) Restless, overactive, cannot stay still for long	☐	☐	☐
c) Often complains of headaches, stomach-aches or sickness	☐	☐	☐
d) Shares readily with other children (treats, toys, pencils etc)	☐	☐	☐
e) Often has temper tantrums or hot tempers	☐	☐	☐
f) Rather solitary, tends to play alone	☐	☐	☐
g) Generally obedient, usually does what adults request	☐	☐	☐
h) Many worries, often seems worried	☐	☐	☐
i) Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
j) Constantly fidgeting or squirming	☐	☐	☐
k) Has at least one good friend	☐	☐	☐

G4 continued...

	Not true	Somewhat true	Certainly true
l) Often fights with other children or bullies them	☐	☐	☐
m) Often unhappy, down-hearted or tearful	☐	☐	☐
n) Generally liked by other children	☐	☐	☐
o) Easily distracted, concentration wanders	☐	☐	☐
p) Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
q) Kind to younger children	☐	☐	☐
r) Often lies or cheats	☐	☐	☐
s) Picked on or bullied by other children	☐	☐	☐
t) Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
u) Thinks things out before acting	☐	☐	☐
v) Steals from home, school or elsewhere	☐	☐	☐
w) Gets on better with adults than with other children	☐	☐	☐
x) Many fears, easily scared	☐	☐	☐
y) Sees tasks through to the end, good attention span	☐	☐	☐

G5. Overall, do you think that **your child** has difficulties in **one or more** of the following areas: emotions, concentration, behaviour or being able to get on with other people?

☐ Yes - minor difficulties ☐ Yes - severe difficulties

☐ Yes - definite difficulties ☐ No **If no, go to G7**

G6. **<u>If you have answered "yes" to G5</u>**, please answer the following questions about these difficulties:

a) How long have these difficulties been present?

☐ Less than a month ☐ 1-5 months ☐ 6-12 months ☐ Over a year

b) Do the difficulties upset or distress your child?

☐ Not at all ☐ Only a little ☐ Quite a lot ☐ A great deal

c) Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
i) Home life	☐	☐	☐	☐
ii) Friendships	☐	☐	☐	☐
iii) Classroom learning	☐	☐	☐	☐
iv) Leisure activities	☐	☐	☐	☐

d) Do the difficulties put a burden on you or the family as a whole?

☐ Not at all ☐ Only a little ☐ Quite a lot ☐ A great deal

G7. These questions are about how **your child** may have been feeling or acting recently. For each question, please say how much he/she has felt or acted this way in the **past two weeks.**

In the past two weeks my child...

	True	Sometimes true	Not true
a) Felt miserable or unhappy	☐	☐	☐
b) Didn't enjoy anything at all	☐	☐	☐
c) Felt so tired that he/she just sat around and did nothing	☐	☐	☐
d) Was very restless	☐	☐	☐
e) Felt like he/she was no good anymore	☐	☐	☐
f) Cried a lot	☐	☐	☐
g) Found it hard to think properly or concentrate	☐	☐	☐
h) Hated him/herself	☐	☐	☐
i) Felt he/she was a bad person	☐	☐	☐
j) Felt lonely	☐	☐	☐
k) Thought nobody really loved him/her	☐	☐	☐
l) Thought he/she could never be as good as other kids	☐	☐	☐
m) Felt he/she did everything wrong	☐	☐	☐

Please contact your Doctor if you have any concerns.

G8. Below is a list of sentences that describe how people feel.
For each statement, please tick the response that seems to describe **your child <u>for the last 3 months.</u>** Please respond to all statements as well as you can, even if some do not seem to concern your child.

	Not true or hardly ever true	Somewhat true or Sometimes true	Very true or often true
a) When my child feels frightened it is hard for them to breathe	☐	☐	☐
b) My child gets headaches when they are at school	☐	☐	☐
c) My child doesn't like to be with people they don't know well	☐	☐	☐
d) My child gets scared if they sleep away from home	☐	☐	☐
e) My child worries about other people liking them	☐	☐	☐
f) When my child gets frightened, they feel like passing out	☐	☐	☐
g) My child is nervous	☐	☐	☐
h) My child follows me wherever I go	☐	☐	☐
i) People tell me that my child looks nervous	☐	☐	☐
j) My child feels nervous with people they don't know well	☐	☐	☐
k) My child gets stomach-aches at school	☐	☐	☐
l) When my child gets frightened, they feel like they are going crazy	☐	☐	☐
m) My child worries about sleeping alone	☐	☐	☐
n) My child worries about being as good as other kids	☐	☐	☐
o) When my child gets frightened, they feel like things are not real	☐	☐	☐

G8 continued...

	Not true or hardly ever true	Somewhat true or Sometimes true	Very true or often true
p) My child has nightmares about something bad happening to their parents	☐	☐	☐
q) My child worries about going to school	☐	☐	☐
r) When my child gets frightened, their heart beats fast	☐	☐	☐
s) They get shaky	☐	☐	☐
t) My child has nightmares about something bad happening to them	☐	☐	☐
u) My child worries about things working out for them	☐	☐	☐
v) When my child gets frightened, they sweat a lot	☐	☐	☐
w) My child is a worrier	☐	☐	☐
x) My child gets really frightened for no reason at all	☐	☐	☐
y) My child is afraid to be alone in the house	☐	☐	☐
z) It is hard for my child to talk with people they don't know well	☐	☐	☐
aa) When my child gets frightened, they feel like they are choking	☐	☐	☐
bb) People tell me that my child worries too much	☐	☐	☐
cc) My child doesn't like to be away from their family	☐	☐	☐
dd) My child is afraid of having anxiety (or panic) attacks	☐	☐	☐
ee) My child worries that something bad might happen to their parents	☐	☐	☐
ff) My child feels shy with people they don't know well	☐	☐	☐

G8 continued...

	Not true or hardly ever true	Somewhat true or Sometimes true	Very true or often true
gg) My child worries about what is going to happen in the future	☐	☐	☐
hh) When my child gets frightened, they feel like throwing up	☐	☐	☐
ii) My child worries about how well they do things	☐	☐	☐
jj) My child is scared to go to school	☐	☐	☐
kk) My child worries about things that have already happened	☐	☐	☐
ll) When my child gets frightened, they feel dizzy	☐	☐	☐
mm) My child feels nervous when they are with other children or adults and they have to do something while they watch them (for example: read aloud, speak, play a game, play a sport)	☐	☐	☐
nn) My child feels nervous when they are going to parties, dances, or any place where there will be people they don't know well	☐	☐	☐
oo) My child is shy	☐	☐	☐

G9. We are asking these questions to help us understand more about communication strengths and difficulties in children.

My child...	Less than once a week	At least once a week	Once or twice a day	Several times a day
a) Simplifies words by leaving out some sounds, e.g. "crocodile" pronounced as "cockodile", or "stranger" as "staynger"	☐	☐	☐	☐
b) Pronounces words in a babyish way, such as "chimbley" for "chimney" or "bokkle" for "bottle"	☐	☐	☐	☐
c) Leaves off beginnings or ends of words, e.g. says "roe" instead of "road" or "nana" instead of "banana"	☐	☐	☐	☐
d) Makes mistakes in pronouncing long words; e.g. says "vegebable" rather than "vegetable"or "trellistope" rather than "telescope"	☐	☐	☐	☐
e) Mispronounces "th" for "s" or "w" for "r". E.g. says "thoap" instead of "soap" or "wabbit" instead of "rabbit"	☐	☐	☐	☐
f) Speaks clearly so that words can be easily understood by someone who doesn't know him/her very well	☐	☐	☐	☐
g) Speaks fluently and clearly, producing all speech sounds accurately and without hesitation	☐	☐	☐	☐
h) Gets mixed up between he and she so might say "he" when talking about a girl, or "she" when talking about a boy	☐	☐	☐	☐

G9 continued...

My child...	Less than once a week	At least once a week	Once or twice a day	Several times a day
i) Gets mixed up between he/him or she/her, so might say "him is working" rather than "he is working", or "her have a cake" rather than "she has a cake"	☐	☐	☐	☐
j) Produces utterances that sound babyish because they are just 2 or 3 words long, such as "me got ball" instead of "I've got a ball" or "give dolly" instead of "give me the dolly"	☐	☐	☐	☐
k) Leaves off past tense -ed endings on words, so might say "John kick the ball" instead of "John kicked the ball", or "Sally play over there" instead of "Sally played over there"	☐	☐	☐	☐
l) Leaves out "is" and so says "Daddy going to work" rather than "Daddy's going to work" or "Daddy is going to work". Or might say " The boy big" rather than "The boy is big"	☐	☐	☐	☐
m) Produces long and complicated sentences such as: "When we went to the park I had a go on the swings"; "I saw this man standing on the corner"	☐	☐	☐	☐
n) Produces sentences containing "because" such as "John had a cake because it was his birthday"	☐	☐	☐	☐

G9 continued...

My child...	Less than once a week	At least once a week	Once or twice a day	Several times a day
o) Makes false starts, and appears to grope for the right words; e.g. might say "can I - can I - can I - can I have an ice cream"	☐	☐	☐	☐
p) Forgets words he/she knows e.g. instead of "rhinocerous" may say "you know the animal with the horn on its nose"	☐	☐	☐	☐
q) Mixes up words of similar meaning e.g. might say "dog" for "fox", or "screwdriver" for "hammer"	☐	☐	☐	☐
r) Mixes up words that sound similar e.g. might say "telephone" for "television" or "magician" for "musician"	☐	☐	☐	☐
s) Is vague in choice of words, making it unclear what he/she is talking about, e.g. saying "that thing" rather than "kettle"	☐	☐	☐	☐
t) Uses abstract words that refer to general concepts rather than something you can see, e.g. "knowledge", "politics", "courage"	☐	☐	☐	☐
u) Uses words that refer to whole classes of objects, rather than a specific item, e.g. refers to a table, chair and drawers as "furniture", or to apples, bananas and pears as "fruit"	☐	☐	☐	☐

G10. a) How noticeable do you think your child's cleft is to other people?

☐ Not at all noticeable ☐ A little noticeable ☐ Quite noticeable

☐ Very noticeable

b) These questions ask you about **your** feelings about your child's cleft. To what extent are each of these statements true of your feelings over the last **six months?**

	Never	Almost never	Some-times	Often	Almost always
i) I feel that the cleft is dominating my experience of bringing up my child	☐	☐	☐	☐	☐
ii) I worry that the cleft is affecting my relationship with my child	☐	☐	☐	☐	☐
iii) I worry about the impact of the cleft on my child's learning at school	☐	☐	☐	☐	☐
iv) I worry about the impact of the cleft on my child's self-confidence	☐	☐	☐	☐	☐
v) I worry about the impact of the cleft on my child's ability to get on with other children	☐	☐	☐	☐	☐
vi) I worry about any other treatment that my child might need	☐	☐	☐	☐	☐
vii) I feel comfortable talking to my child about their cleft	☐	☐	☐	☐	☐
viii) My child is able to explain to other people about their cleft	☐	☐	☐	☐	☐
ix) I feel optimistic about my child's future	☐	☐	☐	☐	☐
x) I feel that there are positives to having a child with a cleft (please specify below)	☐	☐	☐	☐	☐

G11. How many close friends do **you** (not your child) have (other than your partner if applicable)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

G12. Overall, how would you rate your relationships with your close friends?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

G13. In the last year, did you experience a period of acute stress or an emotional event which had an influence on your state of mind? **(Please cross <u>all</u> boxes that apply to you)**

☐ i) Death of a partner

☐ ii) Divorce

☐ iii) Marital separation

☐ iv) Prison sentence

☐ v) Death of a parent or close family member

☐ vi) Personal injury or illness

☐ vii) Marriage

☐ viii) Being sacked or laid off from work

☐ ix) Marital reconciliation

☐ x) Retirement

☐ xi) Change in health of family member

☐ xii) Pregnancy

☐ xiii) Sex difficulties

☐ xiv) Gaining a new family member

☐ xv) Business readjustment

☐ xvi) Change in financial state

☐ xvii) Death of a close friend

☐ xviii) Change to a different line of work

G13 continued...

- ☐ xix) Change in number of arguments with spouse
- ☐ xx) Setting up a mortgage
- ☐ xxi) Foreclosure of mortgage or loan
- ☐ xxii) Change in responsibilities at work
- ☐ xxiii) Son or daughter leaving home
- ☐ xxiv) Trouble with in-laws
- ☐ xxv) Outstanding personal achievement
- ☐ xxvi) Partner begins or stops work
- ☐ xxvii) Begin or end school/higher education
- ☐ xxviii) Change in living conditions
- ☐ xxix) Change in personal habits
- ☐ xxx) Trouble with your boss at work
- ☐ xxxi) Change in work hours or conditions
- ☐ xxxii) Moving house
- ☐ xxxiii) Change in schools/higher education
- ☐ xxxiv) Change in hobbies
- ☐ xxxv) Change in church activities
- ☐ xxxvi) Change in social activities
- ☐ xxxvii) Getting a small loan
- ☐ xxxviii) Change in sleeping habits
- ☐ xxxix) Change in the number of family get-togethers
- ☐ xl) Change in eating habits
- ☐ xli) Holiday
- ☐ xlii) Christmas
- ☐ xliii) Minor breaches of the law

G14. These questions ask about your relationship with your current partner (if applicable).

☐ I do not currently have a partner

	Agree	Agree Somewhat	Neutral	Disagree Somewhat	Disagree
a) My partner and I have a close relationship	☐	☐	☐	☐	☐
b) My partner and I have problems in our relationship	☐	☐	☐	☐	☐
c) I am very happy in my relationship	☐	☐	☐	☐	☐
d) My partner is usually understanding	☐	☐	☐	☐	☐
e) I often think about ending our relationship	☐	☐	☐	☐	☐
f) I am satisfied with my relationship with my partner	☐	☐	☐	☐	☐
g) We often disagree about important decisions	☐	☐	☐	☐	☐
h) I have been lucky in my choice of a partner	☐	☐	☐	☐	☐
i) We agree about how children should be raised	☐	☐	☐	☐	☐
j) I think my partner is satisfied with our relationship	☐	☐	☐	☐	☐

The Cleft Lip and Palate Association (CLAPA) is a UK charity which provides support to families affected by cleft lip/palate. CLAPA are separate from your cleft team.

G15. Since your child's cleft was diagnosed, have you received any support from CLAPA?

☐ Yes ☐ No **If no, go to section H**

G16. What type of support have you received from CLAPA? **(Cross <u>all</u> that apply)**

☐ a) Information about cleft lip and palate

☐ b) Information about treatment

☐ c) Emotional support

☐ d) I have attended a family event

☐ e) My child has attended an event

☐ f) I have volunteered/fundraised for CLAPA

☐ g) My child has volunteered/fundraised for CLAPA

☐ h) Other (specify below) ☐

G17. How often have you been satisfied with the support you have received from CLAPA?

☐ Never ☐ Sometimes ☐ Often

☐ Almost always ☐ Always

G18. When did you first hear about CLAPA (if applicable)?

☐ When my child was diagnosed ☐ When my child was born

☐ When my child was ☐ years old

SECTION H - ADDITIONAL QUESTIONS FOR THE MOTHER

H1. a) Does the child's biological father currently live with you? ☐Yes ☐No

If No b) How old was your child when the biological father left the home?

i) Years ☐☐ Months ☐☐ Weeks ☐☐

ii) Biological father never lived at home / left the home before child was born ☐

H2. a) Does the child's biological father have a cleft lip or cleft palate? ☐Yes ☐No

If Yes b) What type of cleft?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

c) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

H3. a) To the best of your knowledge, have any of the biological father's relatives been diagnosed with a cleft lip or cleft palate? ☐Yes ☐No

If Yes

b) i) Please tell us who?

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

c) i) Please tell us who?

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

d) i) Please tell us who?

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

SECTION Z

Z1. This questionnaire was completed by:

a) Child's biological mother ☐

b) Someone else (please specify) ☐ _____

Z2. Do you live in the same house as your child? ☐ Yes ☐ No

Z3. On what date did you complete this questionnaire? DD MM YYYY

Z4. Please give **your** date of birth DD MM YYYY

Z5. Please give **your child's** date of birth DD MM YYYY

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Please use this space for any additional comments you would like to make:

When completed please send this back in the freepost brown envelope to:

The Cleft Collective
University of Bristol
Oakfield House
Oakfield Grove
Bristol, BS8 2BN

Office use only ☐

http://www.bristol.ac.uk/cleft-collective

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