

## Cell Phone and Computer Use

Do you currently own a cell phone?

- Yes  No, but I share or have access to a cell phone  No

Is the cell phone that you own or use a smartphone?

(A mobile phone that offers functions that are normally found on a computer. Examples: iPhone, Android, Blackberry, Nexus One, Sidekick, treo, Palm.)

- Yes  No

Previous

Next

Finish Later

## Cell Phone and Computer Use

How often do you access the internet from your home?

Never       Less than once a week       A few times a week       Most days of the week       Everyday

What type of device(s) do you use to access the internet? (*Check ALL that apply*)

- A computer in my home       A computer where I work  
 A public computer (at library, café etc.)       A mobile phone  
 A tablet (iPod, iPad, Galaxy, Kindle, Nook, etc.)       Other (family/friend's computer etc.)

Please list:

Do you receive e-mails, text messages or other information that relates to being a mother from the following websites, phone applications or text messaging systems?

*Please check ALL that apply:*

- Americanpregnancy.org       Babycenter.com  
 Babyfit.com       iPregnancy  
 La Leche League (LLLUSA.org)       Pampers.com  
 Parenting.com       Parents.com  
 Pregnancy.org       Text4Baby  
 TheBump.com       WebMD.com  
 Whattoexpect.com       Any other websites or phone applications related to being a new mom  
 None

Please list:

Previous

Next

Finish Later

## Your Eating Patterns

This section asks about the way you are eating now.

I feel my eating habits right now are

- Very healthy
- Need some improvement
- Unhealthy

How has the amount of food you eat now changed compared to the first 6 months after your baby was born?

- Eat a lot more food     Eat a little more food     About the same     Eat a little less food     Eat a lot less food

How would you describe your appetite now, compared to the first 6 months after your baby was born?

- A lot more hungry     A little more hungry     About the same     A little less hungry     A lot less hungry

How many servings of fruits and vegetables (not including juice) do you eat per day?  
(serving=1/2 cup or 1 medium piece)

- Less than one a day     One or two a day     Three or four a day     Five a day or more

How often have you been taking a vitamin or mineral supplement in the last 6 months?

- Never     Once a week or less     2-3 times a week     4-6 times a week     Everyday

Previous

Next

Finish Later

## Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink soda or pop?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

How often were these sodas or pop diet or sugar-free?

- Almost never or never
- About 1/4 of the time
- About 1/2 the time
- About 3/4 of the time
- Almost always or always

Previous

Next

Finish Later

## Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink fruit drinks? Please do not include 100% juice beverages like orange juice, but do include drinks such as cranberry cocktail, Hi-C, lemonade, or Kool-Aid, diet or regular.

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

How often were your fruit drinks diet or sugar-free drinks?

- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

Previous

Next

Finish Later

## Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink sports drinks (such as Propel, PowerAde, or Gatorade)?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

Over the past 30 days, how often did you drink energy drinks (such as Red Bull or Jolt)?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

Previous

Next

Finish Later

## Eating Away from Home

Over the past 30 days, how many times did you buy food at a fast food restaurant, such as McDonald's, Burger King, Arby's, Wendy's, Taco Bell, Chipotle, KFC, Pizza Hut, Panera, Subway, Quiznos?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Not including the fast food restaurants listed above, in the past 30 days, how many times did you buy food at any other sit down (full service) restaurant and order from a waiter/waitress?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Previous

Next

Finish Later

## Eating Away from Home

Over the past 30 days, how many times did you buy food from an all-you-can-eat buffet, such as Golden Corral, CiCi's Pizza, Sweet Tomatoes, Old Country Buffet, Grand Super Buffet, China Buffet, all-you-can-eat café at college or university dining halls?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Over the past week, how many times did you eat the following meals that were prepared in your home or in the place where you live? (Fill in the number of days for each meal)

Breakfast	days per week
Lunch	days per week
Dinner	days per week

Previous

Next

Finish Later



## Daily Meal Patterns

In a *typical week*, how many times do you (count an eating occasion in only one row):

	0 times	1-2 times	3-4 times	5-6 times	7 times
Eat breakfast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat mid-morning snack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat lunch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat mid-afternoon snack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat dinner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat evening snack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat within an hour of bedtime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Meals and Eating

Are you the main person to plan the meals for your household?

Yes  No

How many adults and children eat at your home on a regular basis?

# of adults (count yourself)

# of children

Please rate how confident you are that you can do these things consistently for the next six months

	I know I cannot	I probably cannot	Not sure	I probably can	I know I can
Plan healthy meals daily for you and your family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plan meals that include baking, grilling, stir-frying, roasting, stewing or steaming foods instead of frying.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plan new meals using leftovers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plan meals with basic ingredients such as fresh/frozen vegetables, raw meats, whole grains.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rate how much you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I think planning a healthy meal is easy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not like to cook because it takes too much time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meal planning is frustrating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is too much work to plan meals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find planning meals in advance to be tiring.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think planning a healthy meal is something I can do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Feelings About Eating

The next part includes some statements on how sure you feel about being able to eat in healthy ways.

How much do you want to make changes in your eating habits?

0 Not at All      1      2      3      4      5      6 Completely Change My Eating

For the next sections, select the answer which is closest to how you feel about each statement.

How sure are you that you will be able to avoid overeating.

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
When you are stressed...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you have cravings...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you are at parties...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you feel your life is out of control...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Feelings About Eating

How sure are you that you will be able to eat a healthy diet.

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
When you are busy...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When cooking takes a lot of effort...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When others around you eat unhealthy foods...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you are in a bad mood...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When eating out...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Feelings About Eating

Please choose a response that best expresses how well each statement describes you.

This describes me...	Not at all	Slightly	More or less	Pretty well	Completely
I purposefully hold back at meals to not gain weight ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I tend to eat more when I am anxious, worried, or tense ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I count calories as a conscious means of controlling my weight ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I feel lonely I console myself by eating ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I tend to eat more food than usual when I have more available places that serve or sell food ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I tend to eat when I am disappointed or feel let down ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often refuse foods or drinks offered because I am concerned about my weight ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I see others eating, I have a strong desire to eat too ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please choose a response that best expresses how well each statement describes you.

This describes me...	Not at all	Slightly	More or less	Pretty well	Completely
Some foods taste so good I eat more even when I am no longer hungry ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I have eaten too much during the day, I will often eat less than usual on the following day ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often eat so quickly I don't notice I'm full until I've eaten too much ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I eat more than usual during a meal, I try to make up for it at another meal ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm offered delicious food, it's hard to resist eating it even if I've just eaten ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I eat more when I'm having relationship problems ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm under a lot of stress, I eat more than I usually do ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I know I'll be eating a big meal during the day, I try to make up for it by eating less before or after that meal ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Physical Activity

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Preparing meals (cook, set table, wash dishes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing, bathing, feeding children while you are <u>sitting</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing, bathing, feeding children while you are <u>standing</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Playing with children while you are <u>sitting or standing</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Playing with children while you are <u>walking or running</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrying children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking care of an older adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and using a computer or writing, while <u>not</u> at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 2 hours per day	2 to almost 4 hours per day	4 to almost 6 hours per day	6 or more hours per day
Watching TV or a video	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and reading, talking, or on the phone, while <u>not</u> at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Physical Activity

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Playing with pets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light cleaning (make beds, laundry, iron, put things away)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping (for food, clothes, or other items)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past 30 days, when you are NOT at work, how much time during the week do you usually spend:

	None	Less than 1/2 hour per week	1/2 to almost 1 hour per week	1 to almost 2 hours per week	2 to almost 3 hours per week	3 or more hours per week
Heavier cleaning (vacuum, mop, sweep, wash windows)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mowing lawn while on a riding mower	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mowing lawn using a walking mower, raking, gardening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Physical Activity

### Going Places...

During the past 30 days, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Walking <u>slowly</u> to go places (such as to the bus, work, visiting) <u>Not</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking quickly to go places (such as to the bus, work, or school) <u>Not</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving or riding in a car or bus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### For Fun or Exercise...

During the past 30 days, how much time during the week do you usually spend:

	None	Less than 1/2 hour per week	1/2 to almost 1 hour per week	1 to almost 2 hours per week	2 to almost 3 hours per week	3 or more hours per week
Walking <u>slowly</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking more <u>quickly</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> up hills for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jogging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swimming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dancing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doing other things for fun or exercise? - Other activity 1:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doing other things for fun or exercise? - Other activity 2:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later



## Physical Activity

### At Work...

Do you work for wages, as a volunteer, or are you a student?

Yes  No

During the past 30 days, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 2 hours per day	2 to almost 4 hours per day	4 to almost 6 hours per day	6 or more hours per day
Sitting at work or in class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing or slowly walking at work while carrying things (heavier than a 1 gallon milk jug)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing or <u>slowly</u> walking at work <u>not</u> carrying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> at work while <u>carrying</u> things (heavier than a 1 gallon milk jug)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> at work <u>not</u> carrying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Physical Activity

Please tell us about your physical activity. It is very important that you tell us about yourself honestly. There are no right or wrong answers. We just want to know about the things you have been doing in the last month.

How often did you do physical activity that makes your heart and breathing rate moderately increase?

Often (everyday)      Sometimes (every other day)      Rarely (once a week)      Hardly ever      Never

*You may click anywhere on the line that represents where you fall between the two ends of the scale.*

How likely is it that you will engage in 30 minutes of moderate-intensity physical activity on 5 or more days per week for the next 6 months?

Likely      Unlikely

How important is it to you to engage in 30 minutes of moderate-intensity physical activity for 5 or more days per week for the next 6 months?

Very important      Important      Neither important or unimportant      Unimportant      Very unimportant

Previous

Next

Finish Later

## Physical Activity

How sure are you that you will be able to complete 30 minutes of moderate-intensity physical activity on 5 or more days per week for the next 6 months?

Very sure      Somewhat sure      Neither sure or unsure      Somewhat unsure      Very unsure

How sure are you that you will be able to be physically active when:

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
You are tired ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are in a bad mood ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You don't feel you have the time...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are on vacation ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is raining or snowing ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Physical Activity

Was there anything about the past week that made exercising especially different for you in terms of extended illness, injury, or vacation?

Yes  No

Previous

Next

Finish Later

## Physical Activity

Please complete the following questions about this past week.

First, we are interested in the number of flights of stairs you climbed on average EACH DAY in this week. We only want to know the number of flights you climb going UP - not down.

*When answering this question, One Flight of Stairs = 10 steps if you know the number of steps.*

Flights per day

We want to know how much time you spent this past week brisk walking for exercise or transportation. We are interested in bouts of walking that were at least 10 continuous minutes in duration. *This would include walking outside, at an indoor facility, or on a treadmill.*

How many days this week did you walk briskly for the purpose of exercise or transportation for at least 10 continuous minutes outside, at an indoor facility, or on a treadmill?

Days in the past week

On these days in which you walked briskly at least 10 continuous minutes, on average, how many minutes per day did you walk briskly?

Minutes per day

Previous

Next

Finish Later

## Physical Activity

Please complete the following questions about this past week.

Were there any other sport, fitness, or recreational activities in which you participated? We are interested only in time that you were physically active while participating in these activities. Please add as many activities as are applicable below.

Please enter only one activity per line. Use the "Add Another Activity" button to add additional activities.

Sport, Fitness, or Recreation	Days per Week	Average Time per Day
		Minutes per Day

Add Another Activity

Previous

Next

Finish Later

## Physical Activity

**Please complete the following questions about this past week.**

**Would you say that during the past week (the week you are thinking about in this survey) you were:**

- Less active than usual
- More active than usual
- About as active as usual

**In general, at least once per week, do you engage in regular activity similar to brisk walking, jogging, bicycling, etc. long enough to work up a sweat, get your heart thumping, or get out of breath?**

- Yes
- No

**Please indicate the number of days per week:**

[Previous](#)

[Next](#)

[Finish Later](#)

## Activities While You Sit: Weekday

On a typical **WEEKDAY**, how much time do you spend (from when you wake up until you go to bed) doing the following? Please check one answer per question.

	None	15 min. or less	30 min.	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours or more
Sitting while watching television (including videos on VCR/DVD).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting at work/school doing computer work (email, word or data processing, web-based applications, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while using the computer for non-work/school activities or playing video games.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting at work/school doing non-computer office/school work or paperwork.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while doing non-computer office work or paperwork <u>not</u> related to your job/school (paying bills, etc).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting listening to music, reading a book or magazine, or doing arts and crafts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking on the phone or texting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting in a car, bus, train or other mode of transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later



## Activities While You Sit: Weekend Day

On a typical **WEEKEND DAY**, how much time do you spend (from when you wake up until you go to bed) doing the following? Please check one answer per question.

	None	15 min. or less	30 min.	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours or more
Sitting while watching television (including videos on VCR/DVD).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting at work/school doing computer work (email, word or data processing, web-based applications, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while using the computer for non-work/school activities or playing video games.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting at work/school doing non-computer office/non-school work or paperwork.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while doing non-computer office work or paperwork <u>not</u> related to your job/school (paying bills, etc).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting listening to music, reading a book or magazine, or doing arts and crafts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking on the phone or texting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting in a car, bus, train or other mode of transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Weight Management Practices

**How often do you weigh yourself?**

- Never
- Once a year or less
- Every couple of months
- About once a month
- About once a week
- About once a day
- More than once a day

**Do you have access to a bathroom scale at home?**

- Yes
- No

Previous

Next

Finish Later

## Your Feelings about Weight Control

The next set of statements asks about your feelings about weight and weight control. *(Please select the answer which is closest to how you feel about each statement.)*

How important is it to you to lose the weight you gained during this most recent pregnancy?

Very important      Important      Neither important or unimportant      Unimportant      Very unimportant

How sure are you that you will be able to lose the weight you gained during your most recent pregnancy?

Very sure      Sure      Neither sure nor unsure      Unsure      Very Unsure

The next set of statements asks about your feelings about weight and weight control. *(Please select the answer which is closest to how you feel about each statement.)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The best way for me to lose weight after pregnancy is to eat the right amount of healthy food.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The best way for me to lose weight after pregnancy is to be physically active on most days of the week.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The best way for me to lose weight after pregnancy is to breastfeed exclusively for up to six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Your Feelings about Weight Control

The next set of statements asks for your perceptions about how others feel about your weight and weight control.  
(Please select the answer which is closest to how you feel about each statement.)

	Very important	Important	Neither important or unimportant	Unimportant	Very unimportant	Not Applicable
How important is it to your spouse/significant other that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is it to your family members that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is it to your friends that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Your Feelings about Weight Control

The next set of statements asks for your perceptions of how others feel about your weight control efforts. *(Please select the answer which is closest to how you feel about each statement.)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicable
My spouse/significant other supports my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse/significant other supports my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse or significant other eats the same meals as me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse/significant other joins in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members support my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members support my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members join in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends support my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends support my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends join in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Your Weight Changes

Please tell us about your weight changes since your baby was born.

How much do you weigh now without clothes or shoes?

pounds

When was this weight measured?

--Month-- --Day-- --Year--

Since your baby was about six months old has your weight:

- Increased
- Stayed The Same
- Decreased

How much of the weight that you gained during your pregnancy do you still have on your body now?

- None – I Weigh Less Than Before I Got Pregnant
- Between 0-5 Pounds
- Between 6-10 Pounds
- Between 11-20 Pounds
- More Than 20 Pounds

Previous

Next

Finish Later

## Your Weight Changes

Would you say your present **weight** is:

- Too Low
- About Right
- Too High

How satisfied are you with your **weight** now?

- Very satisfied       Somewhat satisfied       Not very satisfied       Not at all satisfied

Since your baby was about six months old, have you done anything special to lose weight or control your weight?

- Yes
- No

If you did something special to lose weight or control your weight, which of the following things did you do?  
(check all that apply)

- Ate less food
- Ate different kinds of food (e.g. low-cal, low-fat, etc.)
- Got more exercise
- Breastfed my baby
- Other - please specify

Which of the things that you selected on the above list was the most successful method in helping you lose weight or control your weight?

- Nothing worked
- Ate less food
- Ate different kinds of food (e.g. low-cal, low-fat, etc.)
- Got more exercise
- Breastfed my baby
- Other - please specify \_\_\_\_\_

If you haven't done something special to lose weight or control your weight, what is the reason?

- It just came off by itself
- I can't think about losing weight right now
- I weighed too little before I was pregnant, so I don't want to lose weight now

Previous

Next

Finish Later

## Health (Mood)

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
<b>During the <i>past week</i>:</b>				
I was bothered by things that usually don't bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not "get going".	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later



## Health (Mood)

**Please tell us about your health in the last 6 months.**

How would you describe your health in the last 6 months?

Excellent

Good

Fair

Poor

Previous

Next

Finish Later

## Health (Mood)

In the last 6 months, have you felt depressed?

Yes  No

Are you taking medication or seeing a health professional because you are feeling depressed?

Yes  No

Previous

Next

Finish Later

## Smoking

Do you currently use chewing tobacco, snuff, snus, pipes, cigars or any other tobacco product other than cigarettes?

Yes  No

Have you smoked at least 100 cigarettes in your entire life? NOTE: 5 packs = 100 cigarettes

Yes  No

Previous

Next

Finish Later

## Smoking

**Do you now smoke cigarettes every day, some days, or not at all?**

- Every day  Some days  Not at all

**On average, how many cigarettes do you smoke each day?**

- I did not smoke cigarettes during the past 30 days
- 1 cigarette or less per day
- 2 to 5 cigarettes per day
- 6 to 10 cigarettes per day
- 11 to 20 cigarettes per day
- More than 20 cigarettes per day

Previous

Next

Finish Later

## Smoking

**During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?**

- Yes  No

**How long has it been since you last smoked cigarettes regularly?**

- Within the past month (*less than 1 month ago*)
- Within the past 3 months (*1 month but less than 3 months ago*)
- Within the past 6 months (*3 months but less than 6 months ago*)
- Within the past year (*6 months but less than 1 year ago*)
- Within the past 5 years (*1 year but less than 5 years ago*)
- Within the past 10 years (*5 years but less than 10 years ago*)
- 10 years or more

Previous

Next

Finish Later

## Alcohol

During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? (One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.)

Yes  No

Previous

Next

Finish Later

## Alcohol

During the past past 30 days, how many days did you have at least one drink of any alcoholic beverage? -- Select --

During the past 30 days, on the days when you drank, about how many drinks did you drink on average?

**NOTE:** A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.  drinks per day

Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 or more drinks?

Number of times

No times

Previous

Next

Finish Later

## Sleep

**In the past 24 hours, what is the longest stretch of time that you have slept without waking up?**

hours *(answer to the nearest half hour)*

**In the past 24 hours, how many hours did you sleep in total?**

hours *(answer to the nearest half hour)*

**Please rate your general level of tiredness during the past week.**

*You may click anywhere on the line that represents where you fall between the two ends of the scale.*

**Not at all  
tired**

**The most  
tired I  
could be**

Previous

Next

Finish Later



## Sleep

### During the *last month*:

What time do you usually go to bed in the evening (turn out the lights in order to go to sleep)(Please also check AM or PM)?

*Example: 07:00 PM; Midnight= A.M.*

Weekday --Hour-- : --Minute-- --AM/PM--

Weekend --Hour-- : --Minute-- --AM/PM--

What time do you usually get out of bed in the morning (Please also check AM or PM)? *Example: 07:00 AM; Midnight= A.M.*

Weekday --Hour-- : --Minute-- --AM/PM--

Weekend --Hour-- : --Minute-- --AM/PM--

Previous

Next

Finish Later

## Sleep

On average, how often has it taken you more than 30 minutes to fall asleep after lights out? Please check the appropriate response

- 0-2 nights/week  3-5 nights/week  6-7 nights/week

During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? Please fill in your estimate of the number of days.

days

In the past week, how many days have you had trouble staying awake while driving, eating meals, in class or engaging in social activity? Please check the appropriate response.

- 0-2 days/week  3-5 days/week  6-7 days/week

In the past year, have you been told that you snore loudly or gasp or stop breathing during sleep?

- Yes  No

[Previous](#)

[Next](#)

[Finish Later](#)

## Family Planning

**What kind of birth control are you or your husband or partner using now? (Check all that apply)**

- Not using any kind of birth control
- Shot once a month (Lunelle)
- Not having sex (abstinence)
- Shot once every 3 months (Depo-Provera)
- Tubes tied or closed (female sterilization)
- Contraceptive patch (OrthoEvra)
- Vasectomy (male sterilization)
- Diaphragm, cervical cap, or sponge
- Mini-pill
- Pill
- Cervical ring (NuvaRing or others)
- Hormonal IUD (Mirena)
- Non-hormonal IUD (Paragard)
- Implant (Implanon)
- Condoms
- Rhythm method or natural family planning
- Withdrawal (pulling out)

[Previous](#)

[Next](#)

[Finish Later](#)

## Feelings

Thinking about yourself and how you normally feel, in the past month, how often did you feel?

*You may click anywhere on the line that represents where you fall between the two ends of the scale.*

**Upset**

Never

Always

**Hostile**

Never

Always

**Alert**

Never

Always

**Ashamed**

Never

Always

**Inspired**

Never

Always

**Nervous**

Never

Always

**Determined**

Never

Always

**Attentive**

Never

Always

**Afraid**

Never

Always

**Active**

Never

Always

Previous

Next

Finish Later

## Your Baby's Health and Nutrition

**Please tell us about your baby's health over the past six months.**

**Has your baby been ill, had surgery, been hospitalized or passed away?**

Yes  No

**Has your baby passed away?**

Yes  No

**Would you prefer to skip further questions about this baby?**

Yes  No

**What illnesses have occurred in the past 6 months?**

**If hospitalized in the past 6 months, for how many days?**

days

[Previous](#)

[Next](#)

[Finish Later](#)

## Your Baby's Health and Nutrition

Are you breastfeeding your baby now?

Yes  No

How many times in 24 hours?

\_\_\_\_\_ times

In addition to your breast milk, are you giving your baby any infant formula or milk other than breast milk now?

Yes  No

How often are you giving your baby formula or milk other than breast milk?

Times Per Day

OR

\_\_\_\_\_ Per Week

How many ounces of formula or milk, other than breast milk do you give your baby at one time?

\_\_\_\_\_ ounces

How old was your baby when you started giving infant formula or milk other than breast milk?

\_\_\_\_\_ weeks

OR

\_\_\_\_\_ months

Previous

Next

Finish Later

## Your Baby's Health and Nutrition

Did you ever breastfeed your baby?

Yes  No

How old was your baby when you started giving infant formula or milk other than breast milk?

\_\_\_\_\_ weeks

OR

\_\_\_\_\_ months

How old was your baby when you stopped breastfeeding?

\_\_\_\_\_ weeks

OR

\_\_\_\_\_ months

Did you breastfeed for as long as you wanted to?

Yes  No

Previous

Next

Finish Later

## Your Baby's Health and Nutrition

Did any of the following people *help you* to continue to breastfeed or breastfeed for as long as you wanted? (Mark "does not apply" if you do not have the person listed, such as "employer" if you do not work for pay.)

	Yes	No	Does not apply/ don't know
The baby's father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mother-in-law	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A doctor or other health professional, including a lactation consultant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your employer or supervisor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A breastfeeding support group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The eMomsRoc community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later



## Supportive Relationships

Now we would like to ask you about support from family and friends.

*Please read each statement carefully and click on the point of the line below that is closest to your situation.*

**I have people who care what happens to me**

As much  
as I would  
like

Much less  
than I  
would like

**I have love and affection**

As much  
as I would  
like

Much less  
than I  
would like

**I have chances to talk to someone about problems at work or with my housework**

As much  
as I would  
like

Much less  
than I  
would like

**I have chances to talk to someone I trust about my personal and family problems**

As much  
as I would  
like

Much less  
than I  
would like

**I have chances to talk about money matters**

As much  
as I would  
like

Much less  
than I  
would like

Previous

Next

Finish Later

## Supportive Relationships

Now we would like to ask you about support from family and friends.

*Please read each statement carefully and click on the point of the line below that is closest to your situation.*

**I have invitations to go out and do things with other people**

As much  
as I would  
like

Much less  
than I  
would like

**I have useful advice about important things I like**

As much  
as I would  
like

Much less  
than I  
would like

**I have help when I'm sick in bed**

As much  
as I would  
like

Much less  
than I  
would like

**I have help around the house or with child care**

As much  
as I would  
like

Much less  
than I  
would like

**I have people who help me when I can't make ends meet**

As much  
as I would  
like

Much less  
than I  
would like

Previous

Next

Finish Later

## Supportive Relationships

How supportive has the baby's father been?

- Very supportive
- Somewhat supportive
- Not as supportive as I would have liked
- Not at all supportive
- Father not involved

[Previous](#)

[Next](#)

[Finish Later](#)

## Connecting with Others Online

I connected with other people on the eMomsRoc website on the following topics (check all that apply)

- Being a mom
- Nutrition
- Physical activity
- Weight
- Infant feeding
- Other - **please specify:**

For the next set of questions, please tell us whether you agree or disagree.

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
I never posted messages on the eMomsRoc web site.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt comfortable sharing private or personal thoughts with other members of eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
By giving advice to other members of eMomsRoc, my own health efforts were reinforced.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being anonymous made it easier to share personal information with other participants in eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I got advice and support on eMomsRoc that I could not find anywhere else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It was comforting to know that I wasn't alone in being a mom.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The fact that eMomsRoc is available whenever I need it, night or day, was important to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt supported and encouraged by other eMomsRoc members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advice and support from people in different stages of postpartum was helpful to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received negative or critical comments from other eMomsRoc members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received some bad information or advice from someone on eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Your Life Situation

**Please tell us about your life situation.**

**Do you think you will have another baby in the next year or two?**

- Yes
- Probably
- Not Sure
- No

**Are you pregnant now?**

- Yes
- No

**What was the date of your last menstrual period?**

--Month-- --Day-- --Year--

**When is your baby due to be born?**

--Month-- --Day-- --Year--

Previous

Next

Finish Later

## Your Life Situation

Please tell us about your life situation.

Do you have a job for pay now?

Yes  No

How old was your baby when you returned to work?

\_\_\_\_\_ weeks

OR

\_\_\_\_\_ months

How happy are you with your job?

Very happy

Somewhat happy

Not very happy

Not at all happy

How many hours per week do you work?

\_\_\_\_\_ hours per week

Previous

Next

Finish Later

## Dealing with Life Situations

Please rate how much you agree or disagree with the following statements:

	Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly disagree
I am usually able to think up creative and effective alternatives to solve a problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have the ability to solve most problems even though initially no solution is immediately apparent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many problems I face are too complex for me to solve.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I make decisions and am happy with them later.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I make plans to solve a problem, I am almost certain that I can make them work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Given enough time and effort, I believe I can solve most problems that confront me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When faced with a novel situation I have confidence that I can handle problems that may arise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I trust my ability to solve new and difficult problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
After making a decision, the outcome I expected usually matches the actual outcomes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When confronted with a problem, I am unsure of whether I can handle this situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I become aware of a problem, one of the first things I do is to try to find out exactly what the problem is.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

## Your Neighborhood

**Next we have a few questions about your neighborhood.**

**Have you moved in the past 6 months?**

- Yes  No

**What is the main type of housing in your neighborhood (where you currently reside most days of the week)?**

- Dormitory or residence hall
- Detached single-family housing
- Townhouses, row houses, apartments, or condos of 2-3 stories
- Mix of single-family residences and townhouses, row houses, apartments or condos
- Apartments or condos of 4-12 stories
- Apartments or condos of more than 12 stories
- Don't know/Not sure

[Previous](#)

[Next](#)

[Finish Later](#)



## Your Neighborhood

**The fresh fruits and vegetables in my neighborhood are of high quality.**

Strongly agree     Agree     Neither agree or disagree     Disagree     Strongly disagree

**A large selection of fresh fruits and vegetables is available in my neighborhood.**

Strongly agree     Agree     Neither agree or disagree     Disagree     Strongly disagree

**A large selection of low-fat products such as low-fat milk and lean meats is available in my neighborhood.**

Strongly agree     Agree     Neither agree or disagree     Disagree     Strongly disagree

[Previous](#)

[Next](#)

[Finish Later](#)

## Your Neighborhood

**Do you or other members of your household do any vegetable gardening?**

Yes  No

**Do you or other members of your household buy food from a farmers market or farm stand?**

Yes  No

**Do you know of a food pantry, soup kitchen, church or other organization that gives out food that you could go to if you needed to?**

Yes  No

**Have you gotten food from a food pantry, soup kitchen or other organization during the past year?**

Yes  No

[Previous](#)

[Next](#)

[Finish Later](#)

## Neighborhood environment

The next items are statements about your neighborhood related to walking and bicycling.

	Strongly disagree	Disagree	Agree	Strongly agree	Don't Know
Many shops, stores, markets or other places to buy things I need are within easy walking distance of my home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is within a 10-15 minute walk to a transit stop (such as bus, train, trolley, or tram) from my home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are sidewalks on most of the streets in my neighborhood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are facilities to bicycle in or near my neighborhood, such as special lanes, separate paths or trails, shared use paths for cycles and pedestrians.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My neighborhood has several free or low cost recreation facilities, such as parks, walking trails, bike paths, recreation centers, playgrounds, public swimming pools, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The crime rate in my neighborhood makes it unsafe to go on walks at night.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Previous](#)

[Next](#)

[Finish Later](#)

## Neighborhood environment

How many motor vehicles in working order (e.g., cars, trucks, motorcycles) are there at your household?

Motor Vehicles

Don't know / not sure

Previous

Next

Finish Later

## Household Characteristics

**What is the highest grade in school you have finished?**

- Did not finish elementary school
- Finished middle school (8th grade)
- Finished some high school
- High school graduate or G.E.D.
- Vocational or training school after high school
- Some College or Associate degree
- College graduate or Baccalaureate Degree
- Masters or Doctoral Degree (PhD, MD, JD, etc)

**How many children under the age of 18 live in your home?**

**How many adults (age 18 or older) live in your home?** (count yourself)

**Does your child who was born approximately 12 months ago, still live in your household with you?**

- Yes
- No

Previous

Next

Finish Later

## Household Characteristics

Which of these categories best describe your income (not the income of your household, but your own income) for the past 12 months? This should include income (before taxes) from all sources, wages, veteran's benefits, help from relatives, rent from properties and so on.

- Less than \$5,000
- \$5,000 through \$11,999
- \$12,000 through \$15,999
- \$16,000 through \$24,999
- \$25,000 through \$34,999
- \$35,000 through \$49,999
- \$50,000 through \$74,999
- \$75,000 through \$99,999
- \$100,000 and greater
- Don't know

What is your current relationship status?

- Single or casually dating
- In a committed relationship or engaged
- Living in a marriage-like relationship
- Presently married
- Separated
- Divorced
- Widowed

Previous

Next

Finish Later

## Your household

Please select the practice where you currently receive Ob/Gyn care

-- Select --

If your current practice for Ob/Gyn care is not in the above drop down menu, please specify:

Please select you baby's pediatric practice from the list below:

-- Select --

If your pediatrician is not in the above drop down menu, please specify:

Please use the following space to give us any comments you have about the questionnaire

[Previous](#)

[Submit Survey](#)

[Finish Later](#)