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QUESTION_ID	QUESTION	RESPONSE_ID	RESPONSE
1	Do you have any health concerns?	1	Yes
		2	No
2	Do you need help with any of your health concerns?	1	Yes
		2	No
3	Do you take any medications?	1	Yes
		2	No
4	Have you been seen by a doctor in the last six months?	1	Yes
		2	No
5	Have you been seen by a doctor in the emergency room in the last six months?	1	Yes
		2	No
6	Have you been a patient in the hospital in the last six months?	1	Yes
		2	No
7	Do you use or need anything to help you walk, talk, hear, see, bathe, toilet or eat?	1	Yes
		2	No
8	Do you feel down, anxious or have little interest in doing things?	1	Yes
		2	No
9	Do you use tobacco or vaping products of any kind?	1	Yes
		2	No
10	Do you worry about things like where you live? Getting food every day? Getting to the grocery or doctor appointments? Feeling safe?	1	Yes
		2	No
11	Have all children in the home been tested for lead poisoning?	1	Yes
		2	No
12 (females only)	Are you currently pregnant?	1	Yes
		2	No
13 (females only)	Have you had a baby in the last twelve months?	1	Yes
		2	No

EXAMPLE