



**ATTACHMENT D: NOMS Instruments**



## Center for Substance Abuse Prevention National Outcome Measures

### Adult Community Survey Form

(Adults ages 18 and older)

Use this **Adult Community Survey Form** for surveys of communities in which data may be collected at a single point in time or at multiple time points, each time using different samples of individuals rather than a matched pretest/posttest design.

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Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0230. Public reporting burden for this collection of information is estimated to average 1 hour per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

Center for Substance Abuse Prevention  
National Outcome Measures

## Adult Community Survey Form

**This survey is voluntary. If you choose to take it, you may skip any question you don't want to answer.**

This survey asks about your experience and opinion on a number of topics related to alcohol, tobacco, and drug use. Your answers to these questions will be confidential. That means no one will connect your answers with your name or other identifying information. To help us keep your answers confidential, please do not write your name on this survey form.

The information in this survey will be used to learn more about the effectiveness of programs in preventing substance abuse.

This is not a test, so there are no right or wrong answers. Some questions may ask you to select all of the answers that are relevant, and others ask you to select a single answer. If the question asks for a single answer and you don't find an answer that exactly fits, choose one that comes closest.

**Thank you for agreeing to participate in this survey.**

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RECORD MANAGEMENT: Your survey administrator will tell you what to fill in for these administrative questions. You may leave all but **Date Completed** blank if you are not given any instructions.

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### Participant ID

### Contract/Grant ID

### Date Completed

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Month		Day		Year

Program Name

**Cohort** Number

**These questions ask for general information about you. Please mark the response that best describes you.**

**1. What is your gender? (Check one)**

Male  Female

**2. Are you Hispanic or Latino? (Check one)**

Yes  No

**3. What is your race? (Select one or more)**

- White
- Black or African American
- American Indian
- Native Hawaiian or Other Pacific Islander
- Asian
- Alaska Native

**4. What is your date of birth?**

/  /   
Mont      Da      Year  
h            y

**The next few questions ask about your use of and attitudes toward tobacco, alcohol, and other substances.**

**5. Think back over the past 30 days and report how many days, if any, you used the following substances:**

			Fill in number of days (0 - 30)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	5a.	During the past 30 days, on how many days did you smoke part or all of a cigarette?		<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	5b.	During the past 30 days, on how many days did you use other tobacco products?		<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	5c.	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?		<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	5d.	During the past 30 days, on how many days did you use marijuana or hashish?		<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> </ul>	5e.	During the past 30 days, on how many days did you use any other illegal drug?		<input type="checkbox"/>



<ul style="list-style-type: none"><li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li><li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high)</li><li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li></ul>				
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**6. Think back over your entire lifetime and try to remember whether you have EVER used any of the following substances. If so, what was your age the FIRST TIME you used the substance:**

			Check if NEVER	Fill in your age when you first used (in years)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	6a .	Ever smoked part or all of a cigarette?	<input type="checkbox"/>		<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	6b .	Ever used any other tobacco product?	<input type="checkbox"/>		<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	6c .	Ever had a drink of an alcoholic beverage? Do NOT include any time when you only had a sip or two from a drink.	<input type="checkbox"/>		<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	6d .	Ever used marijuana or hashish?	<input type="checkbox"/>		<input type="checkbox"/>



<p><b>Other illegal drugs:</b> Include substances like:</p> <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>	6e .	Ever used any other illegal drug?	<input type="checkbox"/>		<input type="checkbox"/>
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**7. For each of the three questions below check one box that shows HOW MUCH you think people RISK HARMING themselves physically or in other ways when they engage in the following behaviors:**

		No risk	Slight risk	Moderate risk	Great risk	Don't know or can't say
7a .	When they smoke one or more packs of CIGARETTES per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c .	When they have five or more drinks of an ALCOHOLIC BEVERAGE once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This section asks just a few additional questions about your attitudes and experiences.**



**8. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Check one)**

- More likely
- Less likely
- Would make no difference
- Don't know or can't say

**9. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or drugs?**

- Don't have any children
- 0 times
- 1 to 2 times
- A few times
- Many times
- Don't know or can't say

**Form Approved**  
**OMB No.: 09300230**  
**Expiration Date: 12/31/2008**

## **Center for Substance Abuse Prevention National Outcome Measures**

### **Youth Community Survey Form**

(Youth ages 12-17)

Use this **Youth Community Survey Form** for surveys of communities in which data may be collected at a single point in time or at multiple time points, each time using different samples of individuals rather than a matched pretest/posttest design.

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**These questions ask for general information about you. Please mark the response that best describes you.**

**5. What is your gender? (Check one)**

Male  Female

**6. Are you Hispanic or Latino? (Check one)**

Yes  No

**7. What is your race? (Select one or more)**

- White
- Black or African American
- American Indian
- Native Hawaiian or Other Pacific Islander
- Asian
- Alaska Native

**8. What is your date of birth?**

/  /   
Mont      Da      Year  
h            y

**The next few questions ask about your use of and attitudes toward tobacco, alcohol, and other substances.**

**5. Think back over the past 30 days and report how many days, if any, you used the following substances:**

			Fill in number of days (0 - 30)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	5a.	During the past 30 days, on how many days did you smoke part or all of a cigarette?		<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	5b.	During the past 30 days, on how many days did you use other tobacco products?		<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	5c.	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?		<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	5d.	During the past 30 days, on how many days did you use marijuana or hashish?		<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> </ul>	5e.	During the past 30 days, on how many days did you use any other illegal drug?		<input type="checkbox"/>



<ul style="list-style-type: none"> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>				
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**6. Think back over your entire lifetime and try to remember whether you have EVER used any of the following substances. If so, what was your age the FIRST TIME you used the substance:**

			Check if NEVER	Fill in your age when you first used (in years)	Check if don’t know or can’t say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	6a .	Ever smoked part or all of a cigarette?	<input type="checkbox"/>		<input type="checkbox"/>

\_\_\_\_\_

<p><b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe</p>	6b .	Ever used any other tobacco product?	<input type="checkbox"/>		<input type="checkbox"/>
<p><b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor</p>	6c.	Ever had a drink of an alcoholic beverage? Do NOT include any time when you only had a sip or two from a drink.	<input type="checkbox"/>	_____	<input type="checkbox"/>
<p><b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil</p>	6d .	Ever used marijuana or hashish?	<input type="checkbox"/>		<input type="checkbox"/>
<p><b>Other illegal drugs:</b> Include substances like:</p> <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high)</li> <li>• <b>Prescription drugs without a doctor’s orders,</b> just to “feel good” or to get high</li> </ul>	6e .	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>

**7. For each of the following five questions below check the box that shows how YOU think or feel.**

		Neither approve nor disapprove	Somewh at disappro ve	Strongly disappro ve	Don't know or can't say
7a.	How do <i>you</i> feel about someone your age smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b.	How do you think <i>your close friends</i> would feel about YOU smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c.	How do <i>you</i> feel about someone your age trying marijuana or hashish once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7d.	How do <i>you</i> feel about someone your age using marijuana once a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7e.	How do <i>you</i> feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. For each of the three questions below check one box that shows HOW MUCH you think people RISK HARMING themselves physically or in other ways when they do the following things:**

		No risk	Slight risk	Moderate risk	Great risk	Don't know or can't say
8a.	When they smoke one or more packs of CIGARETTES per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8c.	When they have five or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





	more drinks of an ALCOHOLIC BEVERAGE once or twice a week?						
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**This section asks just a few additional questions about your attitudes and experiences.**

- 9. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Check one)**
- More likely  
 Less likely  
 Would make no difference  
 Don't know or can't say
- 10. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By PARENTS, we mean your biological parents, adoptive parents, stepparents, or adult guardians—whether or not they live with you.**
- Yes  
 No  
 Don't know or can't say
- 11. During the past 12 months, do you recall hearing, reading, or watching an advertisement about prevention of substance abuse?**
- Yes  
 No  
 Don't know or can't say



## Center for Substance Abuse Prevention National Outcome Measures

### Adult Programs Survey Form

(Adult participants ages 18 and older)

Use this **Adult Programs Survey Form** for participants in prevention interventions who are expected to complete survey forms at baseline, exit, and followup periods.

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**These questions ask for general information about you. Please mark the response that best describes you.**

**9. What is your gender? (Check one)**

Male  Female

**10. Are you Hispanic or Latino? (Check one)**

Yes  No

**11. What is your race? (Select one or more)**

- White
- Black or African American
- American Indian
- Native Hawaiian or Other Pacific Islander
- Asian
- Alaska Native

**12. What is your date of birth?**

/  /   
Mont      Da      Year  
h            y

**The next few questions ask about your use of and attitudes toward tobacco, alcohol, and other substances.**

**5. Think back over the past 30 days and report how many days, if any, you used the following substances:**

			Fill in number of days (0 - 30)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	5a.	During the past 30 days, on how many days did you smoke part or all of a cigarette?	_____	<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	5b.	During the past 30 days, on how many days did you use other tobacco products?	_____	<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	5c.	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	_____	<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	5d.	During the past 30 days, on how many days did you use marijuana or hashish?	_____	<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint</li> </ul>	5e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>

thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high) • <b>Prescription drugs without a doctor’s orders</b> , just to “feel good” or to get high				
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**6. Think back over your entire lifetime and try to remember whether you have EVER used any of the following substances. If so, what was your age the FIRST TIME you used the substance:**

			Check if NEVER	Fill in your age when you first used (in years )	Check if don’t know or can’t say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	6a.	Ever smoked part or all of a cigarette?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	6b.	Ever used any other tobacco product?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	6c.	Ever had a drink of an alcoholic beverage? Do NOT include any time when you only had a sip or two from a drink.	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	6d.	Ever used marijuana or hashish?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: • <b>Heroin, crack or cocaine, methamphetamine</b> • <b>Hallucinogens</b> (drugs that cause people to see or	6e.	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>





<p>experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</p> <ul style="list-style-type: none"> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>					
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**7. For each of the three questions below check one box that shows HOW MUCH you think people RISK HARMING themselves physically or in other ways when they engage in the following behaviors:**

		No risk	Slight risk	Moderate risk	Great risk	Don’t know or can’t say
7a.	When they smoke one or more packs of CIGARETTES per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c.	When they have five or more drinks of an ALCOHOLIC BEVERAGE once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This section asks just a few additional questions about your attitudes and experiences.**

- 8. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Check one)**
- More likely  
 Less likely  
 Would make no difference  
 Don’t know or can’t say
- 9. DURING THE PAST 12 MONTHS, have you driven a vehicle while you were under the influence of alcohol?**
- Yes  
 No

Don't know or can't say

**10. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or drugs?**

Don't have any children

0 times

1 to 2 times

A few times

Many times

Don't know or can't say

## Center for Substance Abuse Prevention National Outcome Measures

### Youth Programs Survey Form

(Participants ages 12-17)

Use this **Youth Programs Survey Form** for participants in prevention interventions who are expected to complete survey forms at baseline, exit, and followup periods.

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**Center for Substance Abuse Prevention**

# National Outcome Measures

## Youth Programs Survey Form

**This survey is voluntary. If you choose to take it, you may skip any question you don't want to answer.**

This survey asks about your experience and opinion on a number of things related to alcohol, tobacco, and drug use. Your answers to these questions will be confidential. That means no one will connect your answers with your name or any other information about you that can identify who you are. To help us keep your answers secret, please do not write your name on this survey form.

The information in this survey will be used to learn more about the effectiveness of programs in preventing substance abuse and protecting youth.

This is not a test, so there are no right or wrong answers. Some questions may ask you to select all of the answers that are relevant, and others ask you to select a single answer. If the question asks for a single answer and you don't find an answer that exactly fits, choose one that comes closest.

**Thank you for agreeing to participate in this survey.**

**RECORD MANAGEMENT:** Your survey administrator will tell you what to fill in for these administrative questions. You may leave all but **Date Completed** blank if you are not given any instructions.

### Participant ID

### Contract/Grant ID

### Date Completed

 /  /   
Month          Day          Year

### Survey Type (Check one)

Baseline     Exit     First follow-up after exit     Second follow-up

### Study Design Group (Check one)

Intervention     Comparison

### Program Name

### Cohort Number

**These questions ask for general information about you. Please mark the response that best describes you.**

**13. What is your gender? (Check one)**

Male  Female

**14. Are you Hispanic or Latino? (Check one)**

Yes  No

**15. What is your race? (Select one or more)**

- White
- Black or African American
- American Indian
- Native Hawaiian or Other Pacific Islander
- Asian
- Alaska Native

**16. What is your date of birth?**

/  /   
Mont      Da      Year  
h              y

**The next few questions ask about your use of and attitudes toward tobacco, alcohol, and other substances.**

**5. Think back over the past 30 days and report how many days, if any, you used the following substances:**

			Fill in number of days (0 - 30)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	5a.	During the past 30 days, on how many days did you smoke part or all of a cigarette?	_____	<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	5b.	During the past 30 days, on how many days did you use other tobacco products?	_____	<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	5c.	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	_____	<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	5d.	During the past 30 days, on how many days did you use marijuana or hashish?	_____	<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to "feel good" or to get high)</li> <li>• <b>Prescription drugs without a doctor's</b></li> </ul>	5e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>



<b>orders</b> , just to “feel good” or to get high				
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**6. Think back over your entire lifetime and try to remember whether you have EVER used any of the following substances. If so, what was your age the FIRST TIME you used the substance:**

			Check if NEVER	Fill in your age when you first used (in years)	Check if don't know or can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	6a .	Ever smoked part or all of a cigarette?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Other tobacco products:</b> Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	6b .	Ever used any other tobacco product?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Alcoholic beverages:</b> Include beer, wine, wine coolers, malt beverages, and liquor	6c .	Ever had a drink of an alcoholic beverage? Do NOT include any time when you only had a sip or two from a drink.	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Marijuana or hashish:</b> Also known as grass, pot, hash, or hash oil	6d .	Ever used marijuana or hashish?	<input type="checkbox"/>	_____	<input type="checkbox"/>
<b>Other illegal drugs:</b> Include substances like: <ul style="list-style-type: none"> <li>• <b>Heroin, crack or cocaine, methamphetamine</b></li> <li>• <b>Hallucinogens</b> (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)</li> <li>• <b>Inhalants or sniffed substances</b> such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish (used to “feel good” or to get</li> </ul>	6e .	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>





high) <ul style="list-style-type: none"><li>• <b>Prescription drugs without a doctor's orders,</b> just to "feel good" or to get high</li></ul>					
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**7. For each of the following five questions below check the box that shows how YOU think or feel.**

		Neither approve nor disapprove	Somewhat disapprove	Strongly disapprove	Don't know or can't say
7a.	How do <i>you</i> feel about someone your age smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b.	How do you think <i>your close friends</i> would feel about YOU smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c.	How do <i>you</i> feel about someone your age trying marijuana or hashish once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7d.	How do <i>you</i> feel about someone your age using marijuana once a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7e.	How do <i>you</i> feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. For each of the three questions below check one box that shows HOW MUCH you think people RISK HARMING themselves physically or in other ways when they do the following things:**

		No risk	Slight risk	Moderate risk	Great risk	Don't know or can't say
8a.	When they smoke one or more packs of CIGARETTES per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8c.	When they have five or more drinks of an					

ALCOHOLIC BEVERAGE once or twice a week?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This section asks just a few additional questions about your attitudes and experiences.**

**9. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Check one)**

- More likely
- Less likely
- Would make no difference
- Don't know or can't say

**10. DURING THE PAST 12 MONTHS, have you driven a vehicle while you were under the influence of alcohol?**

- Yes
- No
- Don't know or can't say

**11. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By PARENTS, we mean your biological parents, adoptive parents, stepparents, or adult guardians—whether or not they live with you.**

- Yes
- No
- Don't know or can't say

**12. During the past 12 months, do you recall hearing, reading, or watching an advertisement about prevention of substance abuse?**

- Yes
- No
- Don't know or can't say

