

**Form Approved**  
**OMB No.: 09300230**  
**Expiration Date: 04/30/2012**

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

**Adult Community Form**

(Adults ages 18 and older)

Use this **Adult Community Form** for 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.

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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 0.4 hours per response. 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**

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## Adult Community Form

**This form is voluntary. If you choose to take it, you may skip any question you don't want to answer. If you decide not to fill out this form, it will have no effect on your participation in direct service programs.**

This form asks about your experience and opinion on a number of topics related to alcohol, tobacco, and drug use. No one will connect your answers with your name or other identifying information. To help us protect the privacy of your answers, please do not write your name on this form.

The information in this form 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.**

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RECORD MANAGEMENT: Your form 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**

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**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)**

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

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

/

Month      Year

**5. Have you ever served in the Armed Forces, in the Reserves, or the National Guard [select all that apply]?**

- No, **(Skip to #6)**
- Yes, in the Armed Forces
- Yes, in the Reserves
- Yes, in the National Guard

**5a. Are you currently on active duty in the Armed Forces, in the Reserves, or the National Guard [select all that apply]?**

- Yes, in the Armed Forces
- Yes, in the Reserves
- Yes, in the National Guard
- No, separated or retired from Armed Forces, Reserves, or National Guard

**5b. Have you ever been deployed to a combat zone [select all that apply]?**

- Never deployed
- Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)
- Persian Gulf (Operation Desert Shield or Desert Storm)
- Vietnam/Southeast Asia
- Korea
- WWII
- Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)

**6. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or the National Guard, or separated or retired from Armed Forces, Reserves, or the National Guard?**

- Yes
- Yes, more than one
- No, (Skip to #8)

**7. If yes (answer for up to six people):**

<b>7a. What is the relationship of that person (Service Member) to you:</b>	<input type="checkbox"/> Mother/Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Other, Specify _____
<b>7b. Has the Service Member experienced any of the following [select all that apply]:</b>	<input type="checkbox"/> Deployed in support of combat operations (e.g. Iraq or Afghanistan) <input type="checkbox"/> Was physically injured during combat operations <input type="checkbox"/> Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts <input type="checkbox"/> Died or was killed

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

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

			Fill in number of days	Check if don't know or



			(0 – 30)	can't say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	8a.	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	8b.	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	8c.	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	8d.	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 orders</b>, just to “feel good” or to get high</li> </ul>	8e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>

**9. 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	Check if don't know or can't



				(in years)	say
<b>Cigarettes:</b> Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	9a.	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	9b.	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	9c.	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	9d.	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 high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>	9e.	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>

**10. 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
10a.	When they smoke one or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	packs of CIGARETTES per day?					
10b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c.	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.**

**11. 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

**12. 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: 04/30/2012**



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

**Youth Community Form**

(Youth ages 12-17)

Use this **Youth Community Form** for 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.

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**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)**

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

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

/   
Month      Year

**5. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or the National Guard, or separated or retired from Armed Forces, Reserves, or the National Guard?**

- Yes
- Yes, more than one
- No, **(Skip to #7)**

**6. If yes (answer for up to six people):**

<b>6a. What is the relationship of that person (Service Member) to you:</b>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other, Specify_____
<b>6b. Has the Service Member experienced any of the following [select all that apply]:</b>	<input type="checkbox"/> Deployed in support of combat operations (e.g. Iraq or Afghanistan) <input type="checkbox"/> Was physically injured during combat operations <input type="checkbox"/> Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts <input type="checkbox"/> Died or was killed

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

7. 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	7a.	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	7b.	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	7c.	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	7d.	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 orders,</b> just to “feel good” or to get high</li> </ul>	7e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>

**8. 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	8a.	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	8b.	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	8c.	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	8d.	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 high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>	8e.	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>

**9. 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
9a.	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"/>
9b.	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"/>
9c.	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"/>
9d.	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"/>
9e.	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"/>

**10. 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
10a.	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"/>
10b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c.	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.

11. 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
12. 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
13. 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

**Form Approved**  
**OMB No.: 09300230**  
**Expiration Date: 04/30/2012**

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

**Adult Programs Form**

(Adult participants ages 18 and older)

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

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Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland,  
20857.

# Center for Substance Abuse Prevention National Outcome Measures

## Adult Programs Form

**This form is voluntary. If you choose to take it, you may skip any question you don't want to answer. If you decide not to fill out this form, it will have no effect on your participation in direct service programs.**

This form asks about your experience and opinion on a number of topics related to alcohol, tobacco, and drug use. No one will connect your answers with your name or other identifying information. To help us protect the privacy of your answers, please do not write your name on this form.

The information in this form 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.**

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**RECORD MANAGEMENT:** Your form 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**

 /  / 

Month

Day

Year

**Form Type (Check one)**

Baseline    Exit    First followup after exit    Second followup

**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)**

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

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

/   
Month Year

**5. Have you ever served in the Armed Forces, in the Reserves, or the National Guard?**

- No, **(Skip to #6)**
- Yes, in the Armed Forces
- Yes, in the Reserves
- Yes, in the National Guard

**5b. Are you currently on active duty in the Armed Forces, in the Reserves, or the National Guard [select all that apply]?**

- Yes, in the Armed Forces
- Yes, in the Reserves
- Yes, in the National Guard
- No, separated or retired from Armed Forces, Reserves, or National Guard

**5c. Have you ever been deployed to a combat zone [select all that apply]?**

- Never deployed
- Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)
- Persian Gulf (Operation Desert Shield or Desert Storm)
- Vietnam/Southeast Asia
- Korea
- WWII
- Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)

**6. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or the National Guard, or separated or retired from Armed Forces, Reserves, or the National Guard?**

- Yes
- Yes, more than one
- No, (Skip to #8)

**7. If yes (answer for up to six people):**

<p><b>7a. What is the relationship of that person (Service Member) to you:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Mother/Father</li> <li><input type="checkbox"/> Brother/Sister</li> <li><input type="checkbox"/> Spouse/Partner</li> <li><input type="checkbox"/> Child</li> <li><input type="checkbox"/> Other, Specify _____</li> </ul>
<p><b>7b. Has the Service Member experienced any of the following [select all that apply]:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Deployed in support of combat operations (e.g. Iraq or Afghanistan)</li> <li><input type="checkbox"/> Was physically injured during combat operations</li> <li><input type="checkbox"/> Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts</li> <li><input type="checkbox"/> Died or was killed</li> </ul>

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

**8. 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	8a.	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	8b.	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	8c.	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	8d.	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 orders,</b> just to “feel good” or to get high</li> </ul>	8e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>

**9. 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	9a.	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	9b.	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	9c.	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	9d.	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 high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>	9e.	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>

**10. 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
10a.	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"/>
10b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c.	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.**

**11. 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

**12. 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

**13. 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: 04/30/2012**

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

**Youth Programs Form**

(Participants ages 12-17)

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

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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 0.4 hours per response. 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**

**Youth Programs Form**

**This form is voluntary. If you choose to take it, you may skip any question you don't want to answer. If you decide not to fill out this form, it will have no effect on your participation in direct service programs.**

This form asks about your experience and opinion on a number of things related to alcohol, tobacco, and drug use. 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 form.

The information in this form 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.**

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**RECORD MANAGEMENT:** Your form 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

**Form Type (Check one)**

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

**Program Name**

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**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)**

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

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

/  |  
Month      Year

**5. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or the National Guard, or separated or retired from Armed Forces, Reserves, or the National Guard?**

- Yes
- Yes, more than one
- No, (Skip to #7)

**6. If yes (answer for up to six people above):**

<b>6a. What is the relationship of that person (Service Member) to you:</b>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other, Specify _____
<b>6b. Has the Service Member experienced any of the following [select all that apply]:</b>	<input type="checkbox"/> Deployed in support of combat operations (e.g. Iraq or Afghanistan) <input type="checkbox"/> Was physically injured during combat operations <input type="checkbox"/> Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts <input type="checkbox"/> Died or was killed

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

**7. 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	7a.	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	7b.	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	7c.	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	7d.	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 orders</b>, just to “feel good” or to get high</li> </ul>	7e.	During the past 30 days, on how many days did you use any other illegal drug?	_____	<input type="checkbox"/>

**8. 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	8a.	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	8b.	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	8c.	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	8d.	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 high)</li> <li>• <b>Prescription drugs without a doctor’s orders</b>, just to “feel good” or to get high</li> </ul>	8e.	Ever used any other illegal drug?	<input type="checkbox"/>	_____	<input type="checkbox"/>

**9. 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
9a.	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"/>
9b.	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"/>
9c.	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"/>
9d.	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"/>
9e.	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"/>

**10. 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
10a.	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"/>
10b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10c.	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.

11. **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
12. **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
13. **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
14. **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