

OMB No.: 0925-0610  
Expiration Date: 01/31/2013



**2011-12  
Generation Health Study Survey**

This survey asks about your health. You have agreed to participate in this ongoing study of health in U.S. adolescents and young adults. The information you give will be used to improve the health of students like you.

Just like last year, this survey is confidential; what you say on this survey will not be revealed to anyone else. You will be identified by a special ID number.

Answer the questions based on what you really do, think, and feel.

Make sure you read every question. You do not have to answer any question that makes you feel uncomfortable.

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **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.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0610). Do not return the completed form to this address.

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Are you male or female?

- Male
- Female

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Are you currently attending high school, vocational school, or college? If YES, please indicate which type of school and the name of the school.

No, I have not attended school in the last 6 months

High School (type in below)

Technical/Vocational School (type in below)

Community College (type in below)

College/University (type in below)

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What is the most schooling you think you will complete?

*I will...*

- Not finish high school
- Graduate from high school
- Go to trade, technical or vocational school
- Complete 2 years or less of college
- Graduate from a 4-year college or university
- Go to graduate or professional school

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On average, during the school year, how many hours per week do you work in paid or unpaid jobs?

- None (zero)
- 5 hours or less per week
- 6 to 10 hours per week
- 11 to 15 hours per week
- 16 to 20 hours per week
- 21 to 25 hours per week
- 26 to 30 hours per week
- More than 30 hours per week

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How much spending money do you have during an average month?

- Less than \$100 per month
- \$100 to \$199 per month
- \$200 to \$299 per month
- \$300 to \$399 per month
- \$400 to \$499 per month
- \$500 or more per month

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About how many hours a day do you usually play games on a computer or game console (Playstation, Xbox, GameCube, etc.) in your free time? *(Please mark one circle for weekdays and one circle for weekend)*

Weekdays

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

Weekend

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

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Which of the following do you have in the room where you usually sleep?

- Computer  No  Yes  
Television  No  Yes  
Game Console  No  Yes

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About how many hours a day do you usually use a computer or cell phone for chatting on-line, internet, emailing, texting, tweeting or similar social networking (other than for a job or school work) during your free time? *(Please mark one circle for weekdays and one circle for weekend)*

**Weekdays**

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

**Weekend**

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

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About how many hours a day do you usually watch television (including videos or DVDs) or use a DVD player in your free time? *(Please mark one circle for weekdays and one circle for weekend)*

**Weekdays**

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

**Weekend**

- None at all
- About half an hour a day
- About 1 hour a day
- About 2 hours a day
- About 3 hours a day
- About 4 hours a day
- About 5 hours a day
- About 6 hours a day
- About 7 or more hours a day

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Different people have different reasons for deciding how much time they spend doing things. We want to know how true each of these reasons is for you.

The amount of free time I spend watching TV and videos, playing video games, and using computers is because: *(Please mark one circle for each line on a scale from 1 to 7 where 1 means **Not at all True** and 7 means **Very True**.)*

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits in with the person I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoy it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is something my friends approve of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel guilty if I do otherwise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have the opportunity or it is part of how my day is structured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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All families are different (for example, not everyone lives with both their parents, sometimes people live with just one parent, or they have two homes or live with two families). We would like to know about the home where you live all or most of the time.



Please answer this question for the home where you live all or most of the time and mark all the people who live there.

**Adults**

- Mother
- Father
- Stepmother (or father's girlfriend)
- Stepfather (or mother's boyfriend)
- Spouse or romantic partner
- Roommates or housemates
- Grandmother
- Grandfather
- I live alone
- I live in a foster home or children's home
- Other adults: please write down their relationship to you (aunt, uncle, family friend)

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Do you have any children of your own (including step-children or adopted children)?

- No
- Yes, one child
- Yes, two children
- Yes, three or more children

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Are you currently pregnant or breastfeeding?

- No
- Yes, pregnant
- Yes, breastfeeding

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At this time, do you feel you are...

- Very underweight
- Somewhat underweight
- About the right weight
- Somewhat overweight
- Very overweight

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Physical activity can be done in sports, school activities, playing with friends, or walking to work or school. Some examples of physical activity are running, brisk walking, rollerblading, biking, dancing, skateboarding, swimming, soccer, basketball, football, & surfing. For this next question, add up all the time you spent in physical activity each day.

Over the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

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Vigorous physical activity is any activity that increases your heart rate and makes you get out of breath some of the time.

For this next question, add up all the time you spent in vigorous physical activity each day.

How many HOURS a week do you usually engage in vigorous physical activity so much that you get out of breath or sweat?

- None
- About half an hour
- About 1 hour
- About 2 to 3 hours
- About 4 to 6 hours
- 7 hours or more

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Think about the last 7 days. How often did you do each of these when making plans for vigorous physical activity? *(Please mark one circle for each line)*

	Not at all	Seldom	Sometimes	Often	Very often
I planned when to exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I planned how often to exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I planned where to exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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During the past 12 months, how many individual sports did you participate in on a competitive level, such as varsity or junior varsity sports, intramurals, sport clubs or leagues, or out-of-school programs?

- None
- One
- Two
- Three
- Four or more

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If one or more, what competitive sports did you participate in?

1.
2.
3.
4.
5.
6.

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How long does it usually take you to travel to school from your home? If you are no longer attending school, how long does it take you to travel from your home to work?

(Please mark one circle only)

- I do not currently work or attend school
- Less than 5 minutes
- 5-15 minutes
- 15-30 minutes
- 30 minutes to 1 hour
- More than 1 hour

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In a typical week, how many days do you use the following to get to and from school or work?

(Please mark one circle for each line)

	Never	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Walk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ride a bike	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ride in a vehicle with someone else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Public transportation (for example, bus, train, or school bus)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Different people have different reasons for deciding whether or not to do things. We want to know how true each of these reasons is for you.

The amount of time I am physically active during a typical day is because:

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all True and 7 means Very True.)

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits with how I see myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoy it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My parents, other family members, or friends tell me to do it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel guilty if I do otherwise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am required to do it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The next four questions ask you to enter times that you wake up and go to sleep. For example, if you usually wake up at 10 minutes after 6 in the morning you would enter:

6 : 10

x AM

   PM

On days that you go to school, work, or similar activities, what time do you usually wake up?

:

AM

PM

On those days, what time do you usually go to sleep the night or day before?

:

AM

PM

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On days that you don't have to get up at a certain time, what time do you usually wake up?

:

- AM  
 PM

On those days, what time do you usually go to sleep the night or day before?

:

- AM  
 PM

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Over the past four weeks:

How often did you have trouble falling asleep?

(Please mark one circle only)

- Never in the past 4 weeks
- Less than once a week
- 1 or 2 times a week
- 3 or 4 times a week
- 5 or more times a week

How often did you have trouble staying asleep through the night? For example, you woke up several times at night or woke up earlier than you planned to?

(Please mark one circle only)

- Never in the past 4 weeks
- Less than once a week
- 1 or 2 times a week
- 3 or 4 times a week
- 5 or more times a week

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Based on what you have noticed or what others have told you, are there times when you snore or you stop breathing during your sleep?

- Yes
- No

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How often do you usually have breakfast within about two hours of waking (more than just coffee, milk or fruit juice)?

(Please mark one circle for [weekdays](#) and one circle for [weekend](#))

Weekdays

- I never have breakfast during weekdays
- One day
- Two days
- Three days
- Four days
- Five days

Weekend

- I never have breakfast during the weekend
- One day (Saturday OR Sunday)
- Two days (Saturday AND Sunday)

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This question asks about food you ate or drank during the past 7 days. Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, school, work, restaurants, or anywhere else.

During the past 7 days, how many times did you...?

(Please mark one circle for each line)

	Never	1 to 3 times	4 to 6 times	1 time per day	2 times per day	3 times per day	4 or more times per day
Drink <b>100% fruit juices</b> such as orange juice, apple juice, or grape juice? (Do <b>not</b> count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat <b>fruit</b> ? (Do <b>not</b> count fruit juice.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat <b>green vegetables</b> such as leafy salad, broccoli, green beans, and peas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat <b>orange vegetables</b> such as carrots or sweet potatoes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat cooked or canned <b>beans</b> like refried or baked beans, lentil soup, or pork and beans?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat <b>whole grain foods</b> such as whole grain bread, whole wheat pasta, whole wheat crackers, brown or wild rice, popcorn, or oatmeal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drink a <b>can, bottle, or glass of soda or pop</b> , such as Coke, Pepsi, or Sprite? (Do <b>not</b> include diet soda or diet pop.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat <b>sweet or salty snacks</b> such as chips, fries, candy, cookies, or cake?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Different people have different reasons for deciding whether or not to do things. We want to know how true each of these reasons is for you.

I eat the way I do most days because:

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all True and 7 means Very True.)

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits with how I see myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It makes me feel good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is influenced by whether other people would be mad at me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel guilty if I do otherwise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is what is easily available to eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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(Please mark one circle for each line)

	Never	Less than once a week	1-2 days a week	3-4 days a week	5-6 days a week	Every day
How often do you have breakfast together with a parent, stepparent, or guardian?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you have an evening meal together with a parent, stepparent, or guardian?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you watch television during a meal at home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you have a meal with friends outside of school/work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Where do you usually eat your mid-day meal on school or work days?

- At school/work
- At home
- At someone else's home
- In a snack-bar, fast food restaurant, café
- Somewhere else: (Please specify)
- I never eat a mid-day meal

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How often do you eat in a fast food restaurant (for example, McDonalds, KFC, Pizza Hut, Taco Bell)?

- Never
- Rarely (less than once a month)
- Once a month
- 2-3 times a month
- Once a week
- 2-4 days a week
- 5 or more days a week

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How much do you weigh without clothes? (In pounds)

If you don't know how much you weigh (within a few pounds), check this box:

**Example-152 lbs.**

Weight in pounds		
1	5	2
	<input type="radio"/> 0	<input type="radio"/> 0
	<input type="radio"/> 1	<input type="radio"/> 1
	<input type="radio"/> 2	<input checked="" type="radio"/> 2
	<input type="radio"/> 3	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 4
	<input checked="" type="radio"/> 5	<input type="radio"/> 5
	<input type="radio"/> 6	<input type="radio"/> 6
	<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8	<input type="radio"/> 8
	<input type="radio"/> 9	<input type="radio"/> 9

**Your Response**

Weight in pounds		
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 4
	<input type="radio"/> 5	<input type="radio"/> 5
	<input type="radio"/> 6	<input type="radio"/> 6
	<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8	<input type="radio"/> 8
	<input type="radio"/> 9	<input type="radio"/> 9

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How tall are you without shoes?

If you don't know how tall you are (within an inch or two), check this box:

**Example-5 ft., 2 in.**

Feet	Inches
5	2
<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input checked="" type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input checked="" type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

**Your Response**

Feet	Inches
<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

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Have you heard about (or are you aware of):

(Please mark one circle for each line)

	No	Yes
My Pyramid?	<input type="radio"/>	<input type="radio"/>
The Dietary Guidelines for Americans?	<input type="radio"/>	<input type="radio"/>
MyPlate?	<input type="radio"/>	<input type="radio"/>

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At present, are you on a diet or doing something else to lose weight?

- No, my weight is fine
- No, but I should lose some weight
- No, because I need to put on weight
- Yes

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Different people have different reasons for deciding whether or not to do things. We want to know how true each of these reasons is for you.

I am doing something to lose weight because:

(Please mark one circle for each line on a scale of 1 to 7 where 1 means Not at all True and 7 means Very True.)

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits with how I see myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It makes me feel good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family, doctor, or friends tell me to do it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel guilty if I do otherwise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is part of how my day is structured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Would you say your health is...?

(Please mark one circle)

- Excellent
- Good
- Fair
- Poor

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How often do you brush your teeth?

- More than once a day
- Once a day
- At least once a week but not daily
- Less than once a week
- Never

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In the last 6 months, how often have you had the following...?

(Please mark one circle for each line)

	Rarely or never	About every month	About every week	More than once a week	About every day
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach-ache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back ache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling low	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability or bad temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulties in getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling dizzy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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During the last month have you taken any medicine or tablets for the following?

	No	Yes, once	Yes, more than once
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach-ache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulties in getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Something else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If yes something else, what?

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Do you have a long-term illness, disability, or medical condition (like diabetes, arthritis, asthma, allergy, ADHD or cerebral palsy) that has been diagnosed by a doctor?

Yes. If yes, please specify what they are:

No

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Do you take medicine for your long-term illness, disability or medical condition?

Yes. If yes, please write what it is:

No

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Does your long-term illness, disability or medical condition affect your attendance and performance at school or work?

- Yes
- No

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Think about how you have been feeling over the last 7 days. How often has each of these been true?

(Please mark one circle for each line)

	Never	Almost Never	Sometimes	Often	Almost Always
I felt like I couldn't do anything right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt everything in my life went wrong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt unhappy.	<input type="radio"/>	<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"/>	<input type="radio"/>
I felt sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I thought that my life was bad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not stop feeling sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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How much does your mother (or female guardian) really know about...?

(Please mark one circle for each line)

	Don't have/see mother/guardian	She doesn't know anything	She knows a little	She knows a lot
Who your friends are	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How you spend your money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where you are after school or work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where you go at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What you do with your free time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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How much does your father (or male guardian) really know about...?

(Please mark one circle for each line)

	Don't have/see father/guardian	He doesn't know anything	He knows a little	He knows a lot
Who your friends are	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How you spend your money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where you are after school or work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where you go at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What you do with your free time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In general, how satisfied are you with the relationships in your family?

(Mark one circle next to the number that best describes your feelings)

<input type="radio"/>	10 We have <u>very good</u> relationships in our family
<input type="radio"/>	9
<input type="radio"/>	8
<input type="radio"/>	7
<input type="radio"/>	6
<input type="radio"/>	5
<input type="radio"/>	4
<input type="radio"/>	3
<input type="radio"/>	2
<input type="radio"/>	1
<input type="radio"/>	0 We have <u>very bad</u> relationships in our family

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How important is it to your parents/guardians that you...

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all and 7 means Extremely.)

	Not at all 1	2	3	Somewhat 4	5	6	Extremely 7
Get daily physical activity and/or exercise?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat a healthful diet (including fruits & vegetables, and limiting junk food, sweets & fatty foods)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limit your time watching TV and videos, playing video games, or using the computer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not use alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not smoke cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not use marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not physically hurt or threaten to hurt a romantic partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not swear at, insult, call names, and/or treat disrespectfully a romantic partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Is your group of friends well accepted by your parents?

- Almost always
- Sometimes
- Never, almost never
- They haven't met your group of friends

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Think of your closest male friends. List up to three of your closest male friends. List your best male friend first, then your next best friend, and so on. Include boys who are friends and boyfriends.

	Male Friend 1	Male Friend 2	Male Friend 3
Enter their initials, first name, or nick name.			
If they are in school, what grade are they in?			
If they are NOT in school, how old are they?			

Check one circle under each friend

	Yes	No	Yes	No	Yes	No
You went to his house in the last seven days when a parent was present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You went to his house in the last seven days without a parent present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He came to your house in the last seven days when a parent was present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He came to your house in the last seven days without a parent present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You met him after school or work to hang out or go somewhere in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You spent time with him last weekend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You talked with him about a problem in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You talked with him on the telephone in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You emailed, text messaged, or twittered him in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	Male Friend 1	Male Friend 2	Male Friend 3
Male initials, first name, or nick name.			

Check one circle under each friend

	Yes	No	Yes	No	Yes	No
You and he are linked through your online network profile ('friend' on Facebook, 'follower' on Twitter).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You exercised or played sports with him in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You ate a meal with him in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You played computer games with him in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You watched television or videos/DVDs with him in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You smoked tobacco with him in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You drank alcohol with him in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You got drunk with him in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You used drugs with him in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Think of your closest female friends. List up to three of your closest female friends. List your best female friend first, then your next best friend, and so on. Include girls who are friends and girlfriends.

	Female Friend 1	Female Friend 2	Female Friend 3
Enter their initials, first name, or nick name.	<input type="text"/>	<input type="text"/>	<input type="text"/>
If they are in school, what grade are they in?	<input type="text"/>	<input type="text"/>	<input type="text"/>
If they are NOT in school, how old are they?	<input type="text"/>	<input type="text"/>	<input type="text"/>

Check one circle under each friend

	Yes	No	Yes	No	Yes	No
You went to her house in the last seven days when a parent was present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You went to her house in the last seven days without a parent present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
She came to your house in the last seven days when a parent was present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
She came to your house in the last seven days without a parent present.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You met her after school or work to hang out or go somewhere in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You spent time with her last weekend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You talked with her about a problem in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You talked with her on the telephone in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You emailed, text messaged, or twittered her in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	Female Friend 1	Female Friend 2	Female Friend 3
Female initials, first name, or nick name.	<input type="text"/>	<input type="text"/>	<input type="text"/>

Check one circle under each friend

	Yes	No	Yes	No	Yes	No
You and she are linked through your online network profile ('friend' on Facebook, 'follower' on Twitter).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You exercised or played sports with her in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You ate a meal with her in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You played computer games with her in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You watched television or videos/DVDs with her in the last seven days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You smoked tobacco with her in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You drank alcohol with her in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You got drunk with her in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You used drugs with her in the last 30 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Think of your closest male friend, your closest female friend, and your 5 closest friends that you spend time with. For each answer on a five-point scale: How often do they do each of these things?

1 = never; 2 = almost never; 3 = sometimes; 4 = often; 5 = almost always

Please mark one circle per friend

	Closest male friend					Closest female friend					Five closest friends				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Do vigorous physical activity at least 3 times a week	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drink soda	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drink alcohol	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Get drunk	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoke cigarettes	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoke/use marijuana	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take other drugs	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play computer games at least 2 hours every day	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watch TV at least 2 hours every day	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend free time with you in the afternoons or evenings hanging out without adults around	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Closest male friend					Closest female friend					Five closest friends				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

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Here are some questions about bullying. We say someone is **BEING BULLIED** when someone else, or a group of people, say or do nasty and unpleasant things to him or her. It is also bullying when someone is teased repeatedly in a way he or she does not like or when he or she is deliberately left out of things. But it is **NOT BULLYING** when two people of about the same strength or power argue or fight. It is also not bullying when someone is teased in a friendly or playful way.

Please mark one circle for each line

	Never	Once or twice	2 or 3 times a month	About once a week	Several times a week
In the past couple of months, how often have you been bullied at school or work using a computer, e-mail messages or pictures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the past couple of months, how often have you been bullied at school or work using a cell phone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the past couple of months, how often have you bullied another student(s) or co-worker at school or work using a computer, e-mail messages or pictures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the past couple of months, how often have you bullied another student(s) or co-worker at school or work using a cell phone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Which of the following best describes your sexual orientation?

- Attracted to opposite sex
- Attracted to same sex
- Attracted to both sexes
- Questioning

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In the last 12 months, have you had a romantic relationship with anyone?

- No
- Yes. Please write the number of romantic relationships in the last 12 months:

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The following questions ask about things that might have happened in your romantic relationships over the last 12 months. Please think about your **most recent** relationship in the last **12 months**. Don't count anything you or your partner did in self-defense.

Please enter the age of the partner in your most recent romantic relationship:

Enter their gender.

- Male  
 Female

Is this a current or past relationship?

- Current  
 Past

How long have you been (or were you) together?

Years   
Months

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all and 7 means Very Much.)

	Not at all						Very Much
	1	2	3	4	5	6	7
How happy are (were) you in this relationship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is (was) this relationship to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Threatened to hurt me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would not let me do things with other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulted me in front of others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hurt my feelings on purpose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Said mean things to me to make me feel bad about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Threatened to hurt him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would not let him/her do things with other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulted him/her in front of others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hurt his/her feelings on purpose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Said mean things to him/her to make him/her feel bad about his/her self.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Slapped or scratched me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically twisted my arm or bent back my fingers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushed, grabbed, shoved, or kicked me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hit me with a fist or something else hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assaulted me with a knife or gun.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Slapped or scratched him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically twisted his/her arm or bent back fingers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushed, grabbed, shoved, or kicked him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hit him/her with a fist or something else hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assaulted him/her with a knife or gun.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Kissed me when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed me pictures of naked people that I did not want to see.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed me his/her private parts when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put his/her hand on one of my private parts when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forced me to have sex or do sexual things that I did not want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Kissed him/her when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed him/her pictures of naked people that he/she did not want to see.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed him/her my private parts when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put my hand on one of his/her private parts when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forced him/her to have sex or do sexual things that he/she did not want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The following questions ask about things done using a cell phone, e-mail, IM, text messaging, Web chat, a blog, or a networking site like MySpace or Facebook.

In the last 12 months,

**This person did this to me**

*Using one of these technologies. . .*

	Never	1 - 3 times	4 - 9 times	10 or more times
Spread rumors about me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Called me names, put me down, or said something really mean.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed private or embarrassing pictures/videos of me to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeatedly checked up on me to see where I was.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

*Using one of these technologies. . .*

	Never	1 - 3 times	4 - 9 times	10 or more times
Spread rumors about him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Called him/her names, put him/her down, or said something really mean.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed private or embarrassing pictures/videos of him/her to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeatedly checked up on him/her to see where he/she was.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next



For the next questions, think about from when you first met until now, that is, the ENTIRE TIME you have been (or were) together with this person.

*How often*

	Never	1 - 2 times	3 - 5 times	6 or more times
Has this person hit you <b>out of self-defense</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Because of things this person did to you on purpose</b>				
Have you been injured (e.g. a bruise, a cut, a burn, a broken bone)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you had an injury that had to be treated by a doctor or nurse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*How often*

	Never	1 - 2 times	3 - 5 times	6 or more times
Have you hit this romantic partner <b>out of self-defense</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Because of things you did to this person on purpose</b>				
Has he/she been injured (e.g. a bruise, a cut, a burn, a broken bone)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has he/she had an injury that had to be treated by a doctor or nurse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

Now think about your **second** most recent romantic relationship in the **last 12 months**. Remember, don't count anything you or your partner did in self-defense. If you only had ONE relationship in the last 12 months, please skip to Question 55.

Please enter the age of the partner in your second romantic relationship:

Enter their gender.

- Male  
 Female

Is this a current or past relationship?

- Current  
 Past

How long have you been (or were you) together?

Years

Months

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all and 7 means Very Much.)

	Not at all 1	2	3	4	5	6	Very Much 7
How happy are (were) you in this relationship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(Please mark one circle for each line on a scale from 1 to 7 where 1 means Not at all and 7 means Very Much.)

	Not at all 1	2	3	4	5	6	Very Much 7
How important is (was) this relationship to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Threatened to hurt me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would not let me do things with other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulted me in front of others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hurt my feelings on purpose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Said mean things to me to make me feel bad about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Threatened to hurt him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would not let him/her do things with other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulted him/her in front of others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hurt his/her feelings on purpose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Said mean things to him/her to make him/her feel bad about his/her self.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Slapped or scratched me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically twisted my arm or bent back my fingers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushed, grabbed, shoved, or kicked me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hit me with a fist or something else hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assaulted me with a knife or gun.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Slapped or scratched him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically twisted his/her arm or bent back fingers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pushed, grabbed, shoved, or kicked him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hit him/her with a fist or something else hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assaulted him/her with a knife or gun.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

In the last 12 months,

**This person did this to me**

	Never	1 - 3 times	4 - 9 times	10 or more times
Kissed me when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed me pictures of naked people that I did not want to see.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed me his/her private parts when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put his/her hand on one of my private parts when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forced me to have sex or do sexual things that I did not want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**I did this to him/her**

	Never	1 - 3 times	4 - 9 times	10 or more times
Kissed him/her when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed him/her pictures of naked people that he/she did not want to see.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed him/her my private parts when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put my hand on one of his/her private parts when he/she did not want me to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forced him/her to have sex or do sexual things that he/she did not want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

The following questions ask about things done using a cell phone, e-mail, IM, text messaging, Web chat, a blog, or a networking site like MySpace or Facebook.

In the last 12 months,

### This person did this to me

*Using one of these technologies. . .*

	Never	1 - 3 times	4 - 9 times	10 or more times
Spread rumors about me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Called me names, put me down, or said something really mean.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed private or embarrassing pictures/videos of me to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeatedly checked up on me to see where I was.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### I did this to him/her

*Using one of these technologies. . .*

	Never	1 - 3 times	4 - 9 times	10 or more times
Spread rumors about him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Called him/her names, put him/her down, or said something really mean.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showed private or embarrassing pictures/videos of him/her to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeatedly checked up on him/her to see where he/she was.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

For the next questions, think about from when you first met until now, that is, the ENTIRE TIME you have been (or were) together with this person.

*How often*

	Never	1 - 2 times	3 - 5 times	6 or more times
Has this person hit you <b>out of self-defense</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Because of things this person did to you on purpose</b>				
Have you been injured (e.g. a bruise, a cut, a burn, a broken bone)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you had an injury that had to be treated by a doctor or nurse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*How often*

	Never	1 - 2 times	3 - 5 times	6 or more times
Have you hit this romantic partner <b>out of self-defense</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Because of things you did to this person on purpose</b>				
Has he/she been injured (e.g. a bruise, a cut, a burn, a broken bone)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has he/she had an injury that had to be treated by a doctor or nurse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

Different people have different reasons for deciding whether or not to do things. We want to know how true each of these reasons is for you.

For the next question, please mark one circle for each line on a scale from 1 to 7 where 1 means **Not at all True** and 7 means **Very True**.

I treat my romantic partner the way I do because:

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits with who I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It makes me feel good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends will like me better	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel pressured to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner lets me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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At present, how often do you drink anything alcoholic, such as beer, wine, or hard liquor like vodka or rum? Throughout these questions, by a "drink," we mean a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Please do not include any time when you only had a sip or two from a drink.

(Please mark one circle for each line)

	Every day	Every week	Every month	Rarely	Never
Beer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liquor/Spirits (for example, gin, vodka)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pre-mixed drinks (for example, Smirnoff Ice, Bacardi Breezer, Mike's Hard Lemonade)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any other drink that contains alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Next

Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.

*(If there is something you have not done, choose the 'never' category)*

Never I was  years old (type in box how old you were)

Now think about the first time you drank 5 or more drinks on a single occasion.

*(If there is something you have not done, choose the 'never' category)*

Never I was  years old (type in box how old you were)

Now think about the first time you got drunk.

*(If there is something you have not done, choose the 'never' category)*

Never I was  years old (type in box how old you were)

Back

Next

On how many occasions (if any) have you done the following things in the LAST 30 DAYS?

(Please mark one circle for each line)

	Never	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
Smoked cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drunk alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been drunk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blacked out when drinking alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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FOR BOYS

Think back again over the LAST 30 DAYS. How many times (if any) have you had five or more drinks IN A ROW **ON AN OCCASION**?

FOR GIRLS

Think back again over the LAST 30 DAYS. How many times (if any) have you had four or more drinks IN A ROW **ON AN OCCASION**?

- None
- 1
- 2
- 3-5
- 6-9
- 10 or more times

FOR BOYS

Think back again over the LAST 30 DAYS. How many times (if any) have you had five or more drinks IN A ROW **WITHIN TWO HOURS**?

FOR GIRLS

Think back again over the LAST 30 DAYS. How many times (if any) have you had four or more drinks IN A ROW **WITHIN TWO HOURS**?

- None
- 1
- 2
- 3-5
- 6-9
- 10 or more times

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Next

Think of the last time you drank alcohol. Where were you when you drank?

- I never drink alcohol
- At home
- At someone else's home
- Out on the street, in a park, beach or other open area
- At a bar or a pub
- In a club
- In a restaurant
- Other places (please describe)

Back

Next

Different people have different reasons for deciding whether or not to do things. We want to know how true each of these reasons is for you. For the next question, please mark one circle for each line on a scale from 1 to 7 where 1 means **Not at all True** and 7 means **Very True**.

I decide whether or not to smoke tobacco, drink alcohol, or smoke marijuana because:

	Not at all True 1	2	3	Somewhat True 4	5	6	Very True 7
It fits with who I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It makes me feel good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends will like me better	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel like I have to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is personally important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It depends on how easily I can get it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Have you ever taken one or several of these drugs in the last 12 months?

(Please mark one circle for each line)

	Never	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
Marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amphetamines (meth, ice, glass, speed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opiates (heroin, morphine, smack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication to get high	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine/crack cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glue or solvents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Baltok	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LSD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anabolic steroids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other drug. Which one? <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Do you have a driver's license?

- No license of any sort.
- Permit to take the classroom component of driver education only.
- Permit allowing supervised practice driving with an instructor or licensed adult.
- License allowing independent, unsupervised driving (with or without temporary restrictions on late night driving, teen passengers, etc.).

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How much of the time during the last 30 days have you had access to a vehicle that you can drive?

- None
- Some
- Most
- All

**Back**

**Next**

On how many of the last 30 days did you drive a vehicle?

(Please fill in the number of days from 0 to 30)

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Next

On average, about how many miles did you drive each day you drove?

(Please fill in the number of miles as a number that does not contain a decimal or fraction)

Back

Next

On how many days in the last 30 days have you driven with 2 or more passengers in the vehicle?

(Please fill in the number of days from 0 to 30)

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Next

On how many DAYS in the last 30 days have you done the following while driving?

Please fill in the number of days from 0 to 30.

Please note: To get to the next box please click into the box or use <Tab>. Pressing <Enter> will take you to the next question.

	Number of Days
Answered a call on your cell phone?	<input type="text"/>
Made a call on your cell phone?	<input type="text"/>
Changed radio station?	<input type="text"/>
Changed music on an MP3, CD or other device?	<input type="text"/>
Read text messages?	<input type="text"/>
Sent text messages?	<input type="text"/>
Drank or eaten?	<input type="text"/>
Programmed a navigation system?	<input type="text"/>
Looked at maps or directions while driving?	<input type="text"/>

Back

Next

On how many DAYS in the last 30 days have you done the following while driving?

Please fill in the number of days from 0 to 30.

Please note: pressing <Enter> will take you to the next question. To get to the next box please click into the box or use <Tab>.

	Number of Days
Exceeded the speed limit in residential or school zones?	<input type="text"/>
Gone 10 -19 miles per hour over the speed limit?	<input type="text"/>
Gone 20 or more miles per hour over the speed limit?	<input type="text"/>
Purposely tailgated or followed another vehicle very closely?	<input type="text"/>
Switched lanes to weave through slower traffic?	<input type="text"/>
Changed lanes with very little room between vehicles?	<input type="text"/>
Cut in front of a vehicle to turn?	<input type="text"/>
Pulled out into traffic without waiting for a large space between vehicles?	<input type="text"/>
Made an illegal U-turn?	<input type="text"/>
Gone through an intersection when the light was yellow or just turning yellow?	<input type="text"/>
Gone through an intersection when the light was red or just turning red?	<input type="text"/>
Gone through a stop sign without stopping completely?	<input type="text"/>
Changed lanes without signaling?	<input type="text"/>
Played the radio very loudly?	<input type="text"/>
Raced another vehicle, even just for a short distance?	<input type="text"/>
Read, groomed, ate, or engaged in similar activities?	<input type="text"/>
Drove in a way to show off to other people?	<input type="text"/>
Not worn a seat belt?	<input type="text"/>
Drove when sleepy or drowsy?	<input type="text"/>
Drove after midnight?	<input type="text"/>
Drove after drinking alcohol or using illegal drugs?	<input type="text"/>

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Next

How often in the last 12 months have you driven a vehicle (motorcycle, car, truck, or SUV) in a street race?

- 0 times
- 1 time
- 2 or more times

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The last time you were a driver in a street race, how many passengers were in your vehicle?

- Not in a street race in the past year
- 0
- 1
- 2
- 3 or more

**Back**

**Next**



How often do you wear a seat belt when riding in a vehicle driven by someone else?

- Never
- Rarely
- Sometimes
- Most of the time
- Always

**Back**

**Next**

During the last 12 months, how many times did you ride in a car or other vehicle driven by someone else who had been drinking alcohol or using illegal drugs?

- 0 times
- 1 time
- 2 or 3 times
- 4 or 5 times
- 6 or more times

**Back**

**Next**

How often in the last 12 months have you been a passenger in a vehicle in a street race?

- 0 times
- 1 time
- 2 or more times

Back

Next

In the last 12 months, how often have you been involved in a motor vehicle accident?

- 0 times
- 1 time
- 2 or more times

Back

Next

How often did the motor vehicle accident(s) result in an injury?

- 0 times
- 1 time
- 2 or more times

Back

Next

When the accident(s) occurred, how often were you riding in a vehicle driven by someone who had been drinking alcohol or using illegal drugs?

- 0 times
- 1 time
- 2 or more times

Back

Next

When the accident(s) occurred, how often were you driving a vehicle when you had been drinking alcohol or using illegal drugs?

- 0 times
- 1 time
- 2 or more times

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Next

Which of the following best describes your current health insurance situation?

*(Mark all that apply)*

- I have no health insurance
- I am covered by my parent's insurance
- I get insurance through school or work
- I do not know what my health insurance is
- Other

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Next



Where do you usually go when you are sick or need health care?

*(Mark all that apply)*

- Never get sick or need health care
- Hospital-based clinic
- Hospital emergency room
- Community health center or clinic
- Health maintenance organization (HMO)
- Private doctor's office
- School or college clinic
- Military hospital or clinic
- Clinic at work
- Some other place

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Has there been any time in the past 12 months when you thought you should get medical care, but you did not?

- Yes
- No

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What kept you from seeing a health professional when you really needed to?

(Mark all that apply)

- Didn't know whom to go see
- Had no transportation
- No one available to go along
- Parent or guardian would not go
- Didn't want parents to know
- Difficult to make appointment
- Afraid of what the doctor would say or do
- Thought the problem would go away
- Couldn't pay
- Other

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In the past 12 months, did a health problem get worse because you did not get care when you thought you should?

- Yes
- No

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How long ago did you last see your pediatrician, primary care doctor, or family physician to have a routine check-up?

- Within the past 3 months
- 4 to 6 months ago
- 7 to 9 months ago
- 10 to 12 months ago
- Longer than 1 year ago but less than 2 years ago
- 2 years ago or longer
- Never

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At your last physical examination by a doctor or nurse...

	Yes	No
<b>Were you asked:</b>		
-whether you drink alcohol?	<input type="radio"/>	<input type="radio"/>
-whether you smoke?	<input type="radio"/>	<input type="radio"/>
-whether you use drugs?	<input type="radio"/>	<input type="radio"/>
-whether you exercise?	<input type="radio"/>	<input type="radio"/>
-nutrition questions?	<input type="radio"/>	<input type="radio"/>
-whether you are sexually active?	<input type="radio"/>	<input type="radio"/>
<b>Were you given advice about the risks associated with:</b>		
-drinking?	<input type="radio"/>	<input type="radio"/>
-smoking?	<input type="radio"/>	<input type="radio"/>
-using drugs?	<input type="radio"/>	<input type="radio"/>
-not exercising?	<input type="radio"/>	<input type="radio"/>
-a poor diet?	<input type="radio"/>	<input type="radio"/>
-sexual behavior?	<input type="radio"/>	<input type="radio"/>
<b>Were you given advice about:</b>		
-reducing or stopping drinking?	<input type="radio"/>	<input type="radio"/>
-reducing or stopping smoking?	<input type="radio"/>	<input type="radio"/>
-reducing or stopping drug use?	<input type="radio"/>	<input type="radio"/>
-increasing physical activity?	<input type="radio"/>	<input type="radio"/>
-improving your diet?	<input type="radio"/>	<input type="radio"/>
-avoiding pregnancy?	<input type="radio"/>	<input type="radio"/>
-avoiding sexually transmitted diseases?	<input type="radio"/>	<input type="radio"/>

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In the past 12 months have you had a dental examination by a dentist or dental hygienist?

- Yes
- No

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How long ago did you last have a dental examination by a dentist or hygienist?

- Longer than 1 year ago but less than 2 years ago
- 2 years ago or longer
- Never

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What do you think are the chances that you will live to age 35?

- Almost no chance
- Some chance, probably not
- A 50-50 chance
- A good chance
- Almost certain

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