

OMB No.: xxxx
Expiration Date: xx/xx/xxxx

2013 Generation Health Study Survey

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.

This survey asks about your health. A participant in our study has recruited you to help us by completing this survey. You have agreed to participate in this one-time survey. The information you give will be used to improve the health of young adults like you.

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. Make sure you read every question. You do not have to answer any question that makes you feel uncomfortable. Answer the questions based on what you really do, think, and feel.

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How old are you? The example on left is completed for someone 19 years old. Using the columns on the right, please type in your age and select the circles for your age.

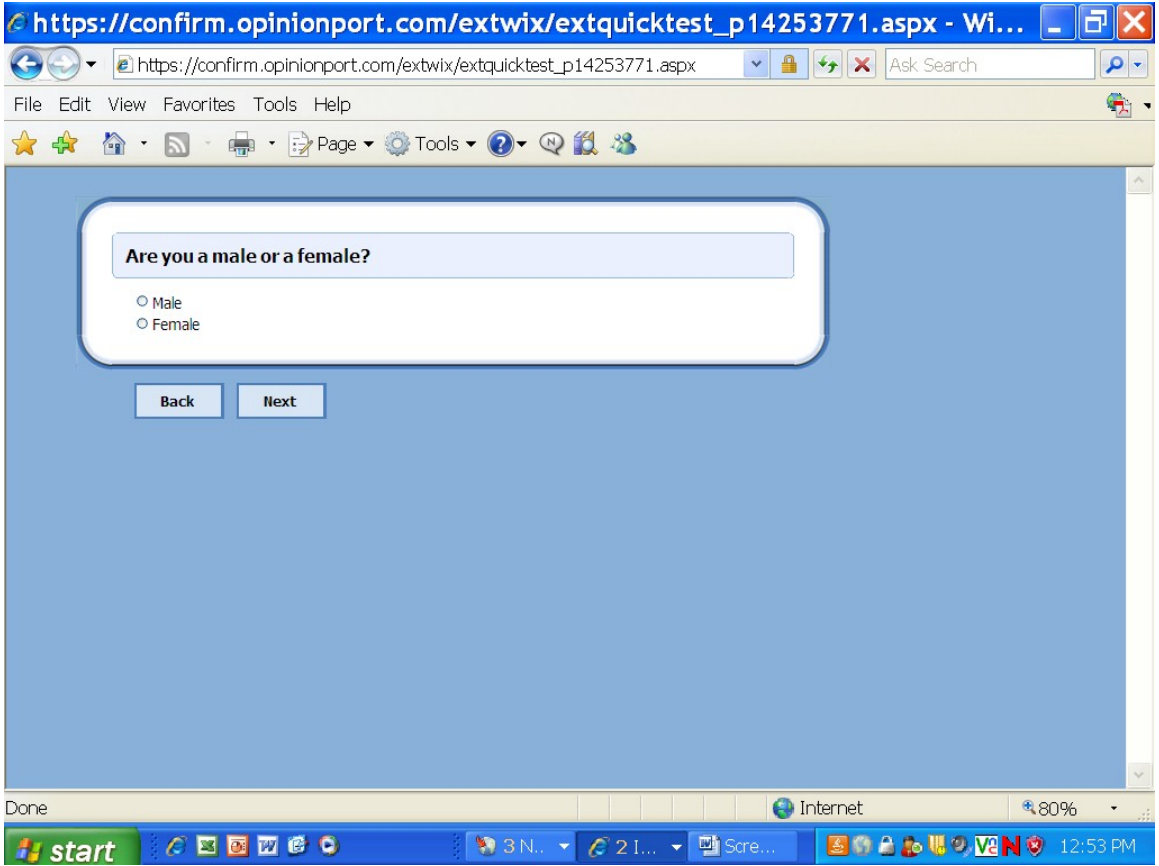
EXAMPLE Age in years

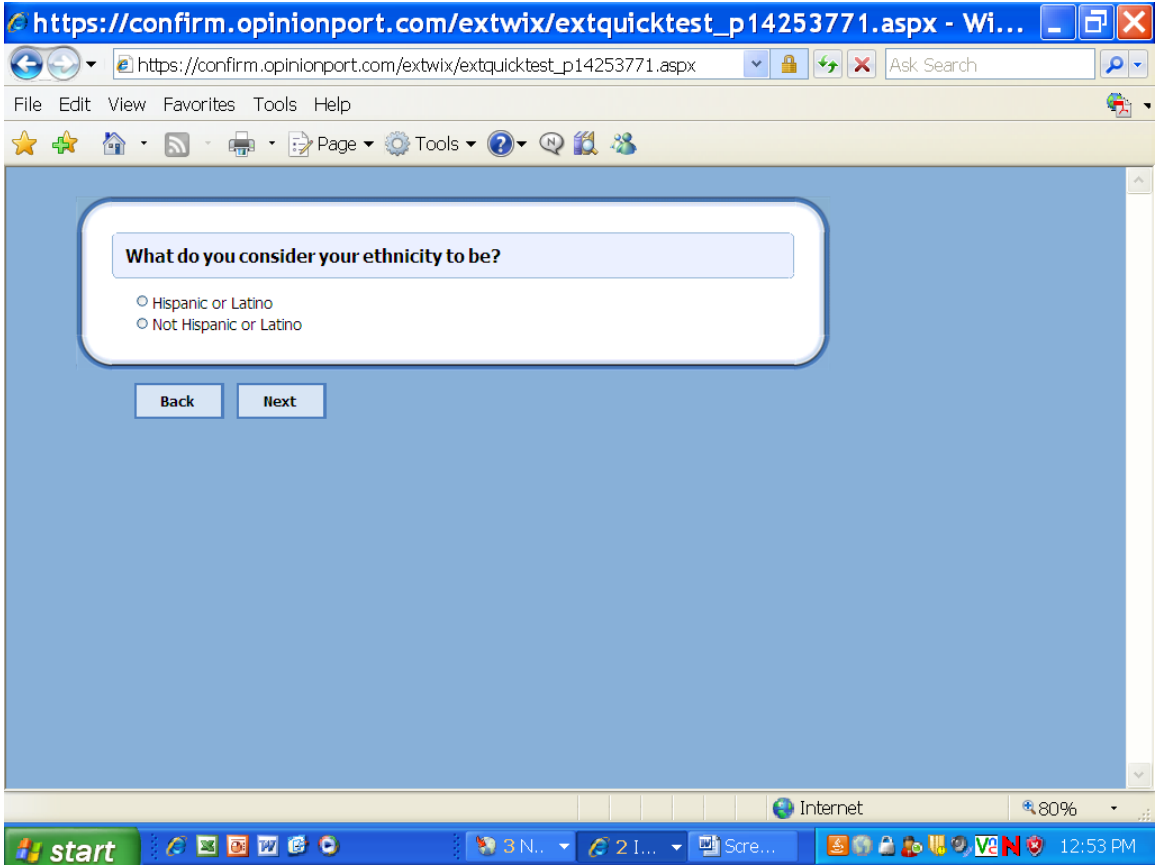
1	9
<input type="radio"/> 0	<input type="radio"/> 0
<input checked="" type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/>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

Your Response - Your age in years

<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"/> 8
<input type="radio"/> 9	<input type="radio"/> 9

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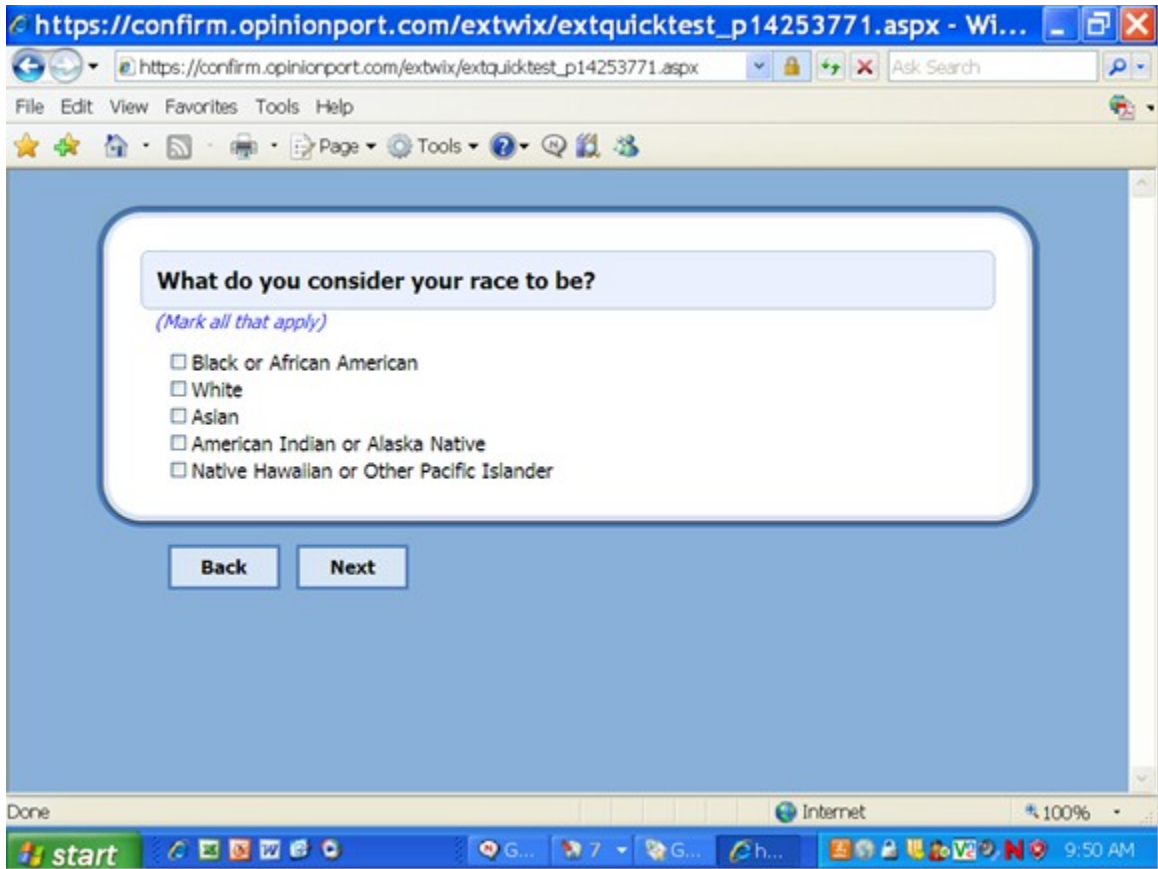
What do you consider your ethnicity to be?

- Hispanic or Latino
- Not Hispanic or Latino

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Are you currently attending school or working? If YES, please indicate the name and location (town, state) of the school and/or job. If you work and attend school, please fill in all that are appropriate

- No, I am not attending school or working
- High School (type in below)
- Technical/Vocational School (type in below)
- Community College (type in below)
- College/University (type in below)
- Graduate School or Professional School (type in below)
- Place where you work (type in below)

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The following questions are about your relationship with the person(s) who recruited you into this study. If you were recruited by more than one person currently in the NEXT study, please fill out the second set of questions for the two persons with whom you spend the most time.

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Done

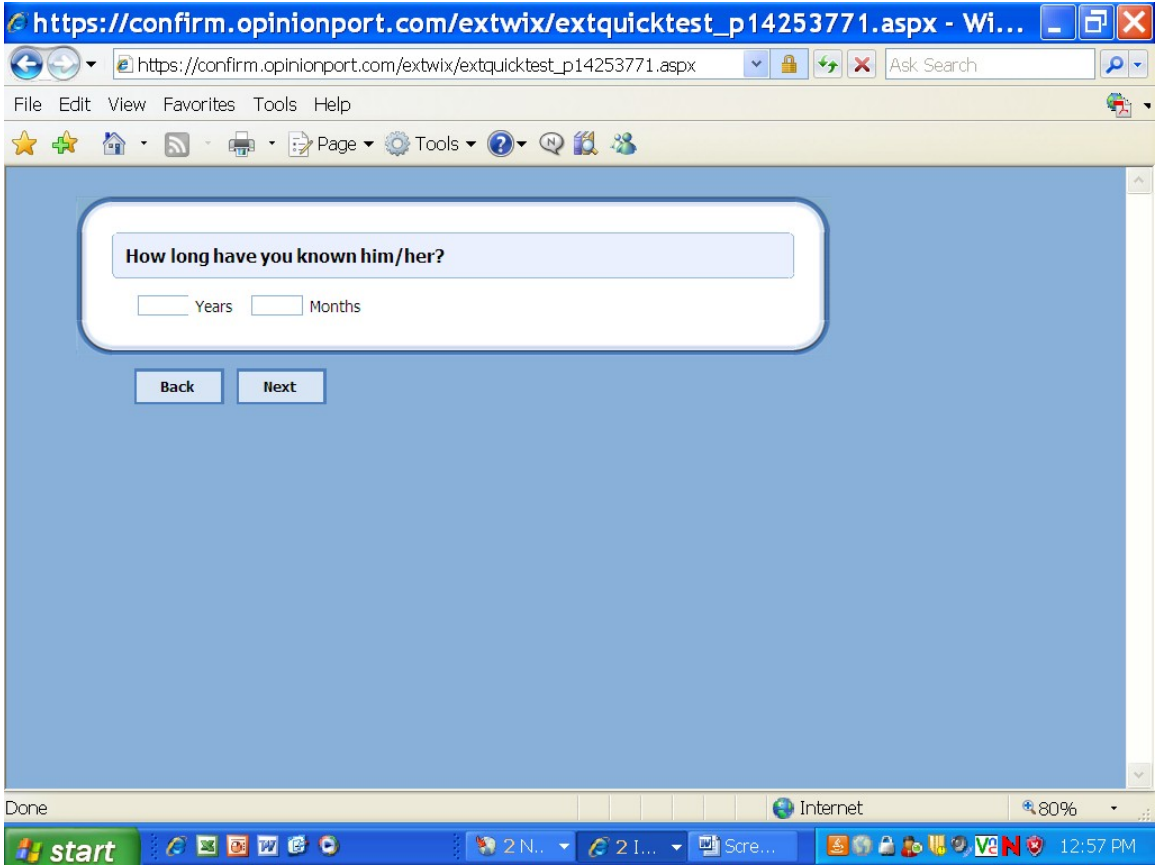
Screen Shots.doc - Microsoft Word 80%

start 2 N... 2 I... Scre... 12:56 PM

What is your current relationship to the person who recruited you into this study?

- Friend
- Romantic partner
- Spouse
- Relative; if so, please specify (e.g., brother, sister, cousin, aunt, grandparent) _____

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How happy are you with your relationship with him/her?

Not at all							Very Much
1	2	3	4	5	6	7	
<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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How important is this friendship/relationship to you?

Not at all							Very Much
1	2	3	4	5	6	7	
<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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How often do you see him/her?

- Less than once a year
- About once a year
- Every few months
- Once a month or so
- Once or twice a week
- Almost daily or daily
- You live together

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How often do you talk or communicate with him/her using a phone, e-mail, IM or text messaging?

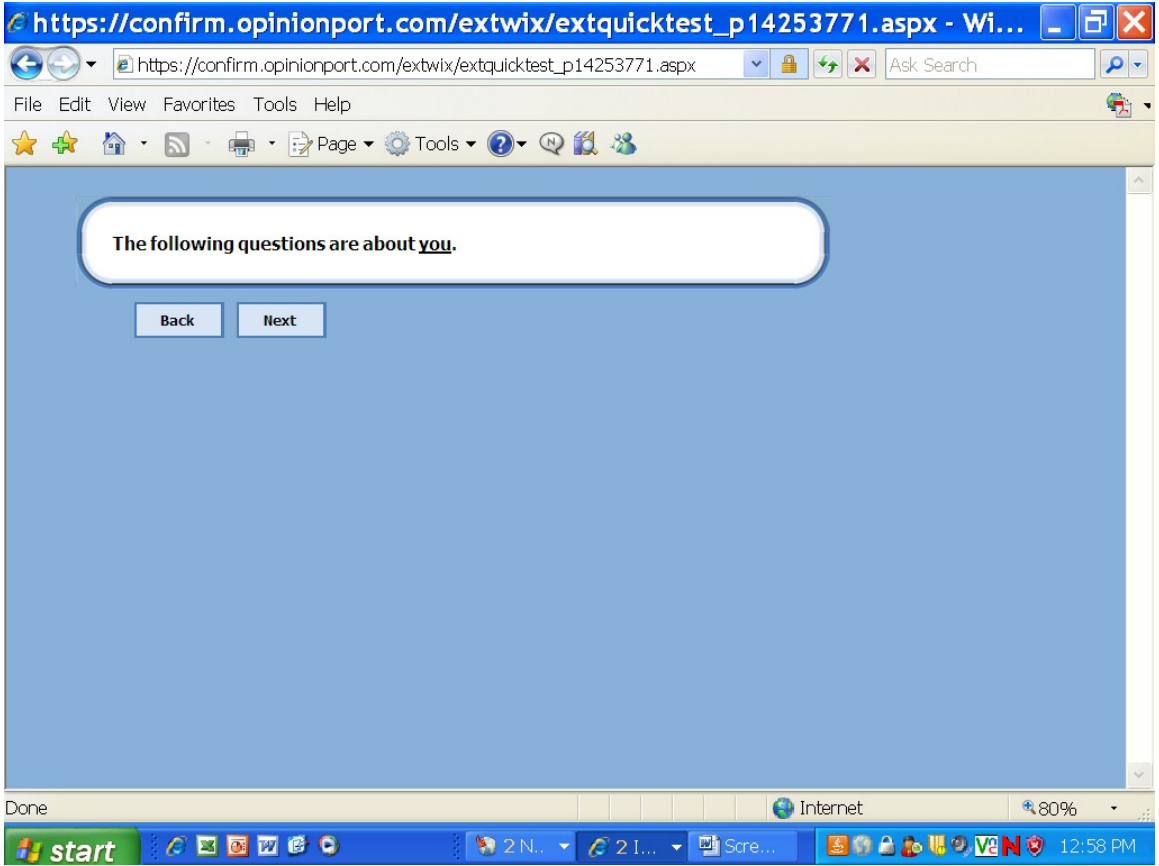
- Less than once a year
- About once a year
- Every few months
- Once a month or so
- Once or twice a week
- Almost daily or daily

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How often do you talk or communicate with him/her using a phone, e-mail, IM or text messaging?

- Less than once a year
- About once a year
- Every few months
- Once a month or so
- Once or twice a week
- Almost daily or daily

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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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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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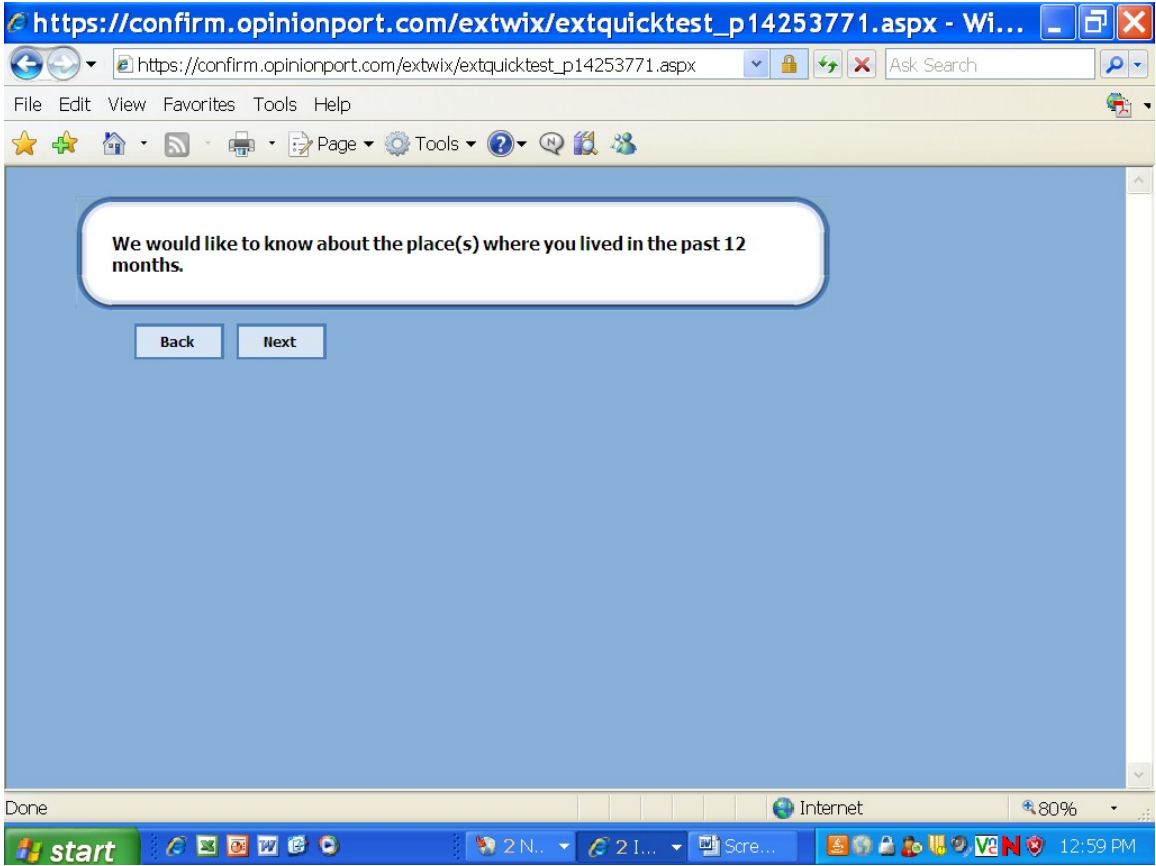
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Please indicate which of the items below best represent your current marital status:

- Married
- Divorced
- Separated
- Widow/widower
- Member of an unmarried couple
- Never married

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Please answer this question for the place where you lived all or MOST OF THE TIME in the past 12 months. Where did you live for all or most of the past 12 months?

- Your parent's home or another person's home
- Your own place (house, apartment, trailer, etc.)
- Group housing (residence hall/dorm, barracks, group home, hospital, communal home, prison or correctional facility)
- Homeless - that is, you have no regular place to stay
- Other, please specify

How many people live there?

Please mark all the people who live there.

- Parent(s), grandparent(s), or guardian(s)
- Brother(s) and/or sister(s)
- Other relatives (cousin, aunt, uncle, nephew, niece)
- Spouse or romantic partner
- Roommate(s) or housemates
- Children
- I live alone

If you live in group housing, what kind of group housing are you living

Please **mark all** the people who live there.

- Parent(s), grandparent(s), or guardian(s)
- Brother(s) and/or sister(s)
- Other relatives (cousin, aunt, uncle, nephew, niece)
- Spouse or romantic partner
- Roommate(s) or housemates
- Children
- I live alone

If you live in group housing, what kind of group housing are you living in?

- Residence hall/dorm at a school
- Fraternity or sorority house
- Barracks in the armed services
- Half-way house, social rehabilitation facility
- Prison, correctional facility
- Group home
- Hospital, nursing home, physical rehabilitation facility
- Communal home
- Other, please specify

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If you lived in more than one place in the last 12 months, please indicate the second place where you lived most often in the past 12 months.

- I live in the same place all year long
- Your parent's home or another person's home
- Your own place (house, apartment, trailer, etc.)
- Group housing (residence hall/dorm, barracks, group home, hospital, communal home, prison or correctional facility)
- Homeless - that is, you have no regular place to stay
- Other, please specify _____

How many people live there?

Please mark all the people who live there.

- Parent(s), grandparent(s), or guardian(s)
- Brother(s) and/or sister(s)
- Other relatives (cousin, aunt, uncle, nephew, niece)
- Spouse or romantic partner
- Roommate(s) or housemates
- Children
- I live alone

If you lived in more than one place in the last 12 months, please indicate the second place where you lived most often in the past 12 months.

- I live in the same place all year long
- Your parent's home or another person's home
- Your own place (house, apartment, trailer, etc.)
- Group housing (residence hall/dorm, barracks, group home, hospital, communal home, prison or correctional facility)
- Homeless - that is, you have no regular place to stay
- Other, please specify _____

How many people live there?

Please **mark all** the people who live there.

- Parent(s), grandparent(s), or guardian(s)
- Brother(s) and/or sister(s)
- Other relatives (cousin, aunt, uncle, nephew, niece)
- Spouse or romantic partner
- Roommate(s) or housemates
- Children
- I live alone

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If you live in group housing, what kind of group housing are you living in?

- Residence hall/dorm at a school
- Fraternity or sorority house
- Barracks in the armed services
- Half-way house, social rehabilitation facility
- Prison, correctional facility
- Group home
- Hospital, nursing home, physical rehabilitation facility
- Communal home
- Other, please specify

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The image shows a screenshot of a web browser window. The address bar at the top displays the URL: https://confirm.opinionport.com/extwix/extquicktest_p14253771.aspx. The browser's menu bar includes "File", "Edit", "View", "Favorites", "Tools", and "Help". Below the menu bar is a toolbar with icons for home, back, forward, print, and search. The main content area has a light blue background and contains a white rounded rectangle with a blue border. Inside this rectangle, the following text is displayed:

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.

Below the text box are two buttons: "Back" and "Next". The browser's status bar at the bottom shows "Done" on the left, "Internet" in the center, and "80%" on the right. The Windows taskbar is visible at the very bottom, showing the "start" button, several application icons, and the system clock displaying "1:06 PM".

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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The screenshot shows a web browser window with the following elements:

- Address Bar:** https://confirm.opinionport.com/extwix/extquicktest_p14253771.aspx
- Search Bar:** Ask Search
- Menu Bar:** File Edit View Favorites Tools Help
- Toolbar:** Includes icons for Home, Back, Forward, Print, Page, Tools, and Help.
- Main Content Area:** A light blue background with a white rounded rectangle containing the text:

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.
- Navigation Buttons:** Two buttons labeled "Back" and "Next" are positioned below the text box.
- Status Bar:** Shows "Done" on the left, "Internet" in the center, and "80%" on the right.
- Taskbar:** Located at the bottom, it features the Windows Start button, several application icons, and a system tray with the time "1:06 PM".

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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The next questions ask about different physical activities you may do. When thinking about activities, include organized teams and leagues, pick-up games, and things you do on your own. Mark how frequently and vigorously you do the activity.

Activity	During the PAST YEAR, what was the average time PER WEEK that you engaged in the activity						How much of that time is vigorous activity (You are out of breath and sweat)		
	None	Less than 1 hour	1-2 hours	3-4 hours	5-7 hours	8+	None	Some	Most
		hour	hours	hours	hours	hours			
Walking for exercise	<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"/>
Walking to school/work	<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"/>
Baseball/softball	<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"/>
Basketball	<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"/>
Football	<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"/>
Soccer	<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"/>
Volleyball	<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"/>
Cheerleading, Gymnastics, Poms	<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"/>
Other team sports	<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"/>

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Volleyball									
Cheerleading, Gymnastics, Poms									
Other team sports: (ie. Wrestling, hockey, boxing, lacrosse, rugby)									
Biking									
Swimming/ Rowing									
Martial Arts									
Marching band, color guard, baton, drill team									
Running: track & field, jogging or running for exercise									
Dance									
Personal workout/ Fitness Training: (ie. Yoga, zumba, gym equipment, weight training)									
Skiing/ snowboarding/ skateboarding									
Tennis, squash, racquetball, paddle ball									
Work-related physical									

Done Internet 80%

start

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Running: track & field, jogging or running for exercise									
Dance									
Personal workout/ Fitness Training: (ie. Yoga, zumba, gym equipment, weight training)									
Skiing/ snowboarding/ skateboarding									
Tennis, squash, racquetball, paddle ball									
Work-related physical activity (ie. Construction, landscaping, busboy)									
Household-related physical activity (ie. Lawn mowing, yard work, vacuuming)									
Other									

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Done Internet 80%

On a typical weekday, how many hours a day do you spend sitting (Please include total sitting time; for example, during meetings, during class, during work, at mealtimes, watching television, at a computer, etc.). The example on left is completed for someone who spends 12 hours a day sitting. Using the columns on the right, please fill in the number of hours you typically spend sitting and mark the circles to show number of hours.

EXAMPLE:

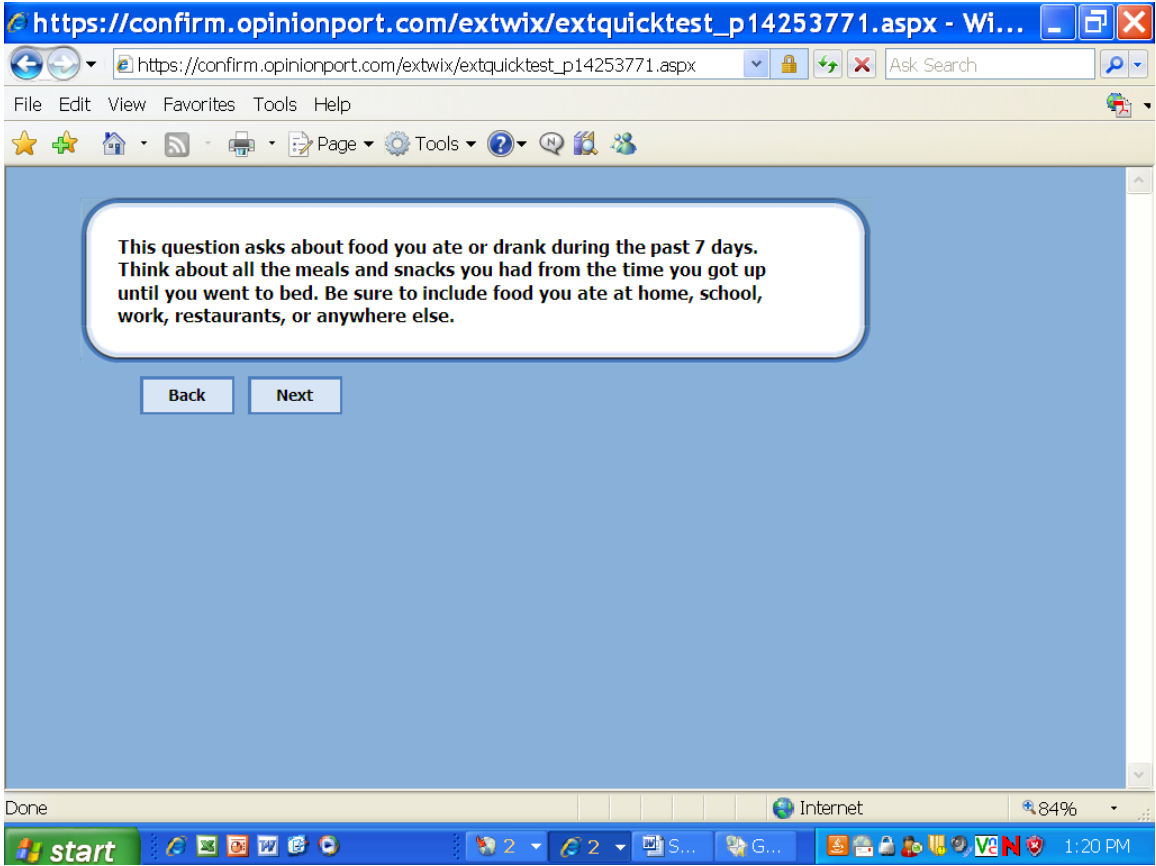
12 hours per day sitting

1	2
<input type="radio"/> 0	<input type="radio"/> 0
<input checked="" 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"/> 8
<input type="radio"/> 9	<input type="radio"/> 9

Your hours per day sitting

<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"/> 8
<input type="radio"/> 9	<input type="radio"/> 9

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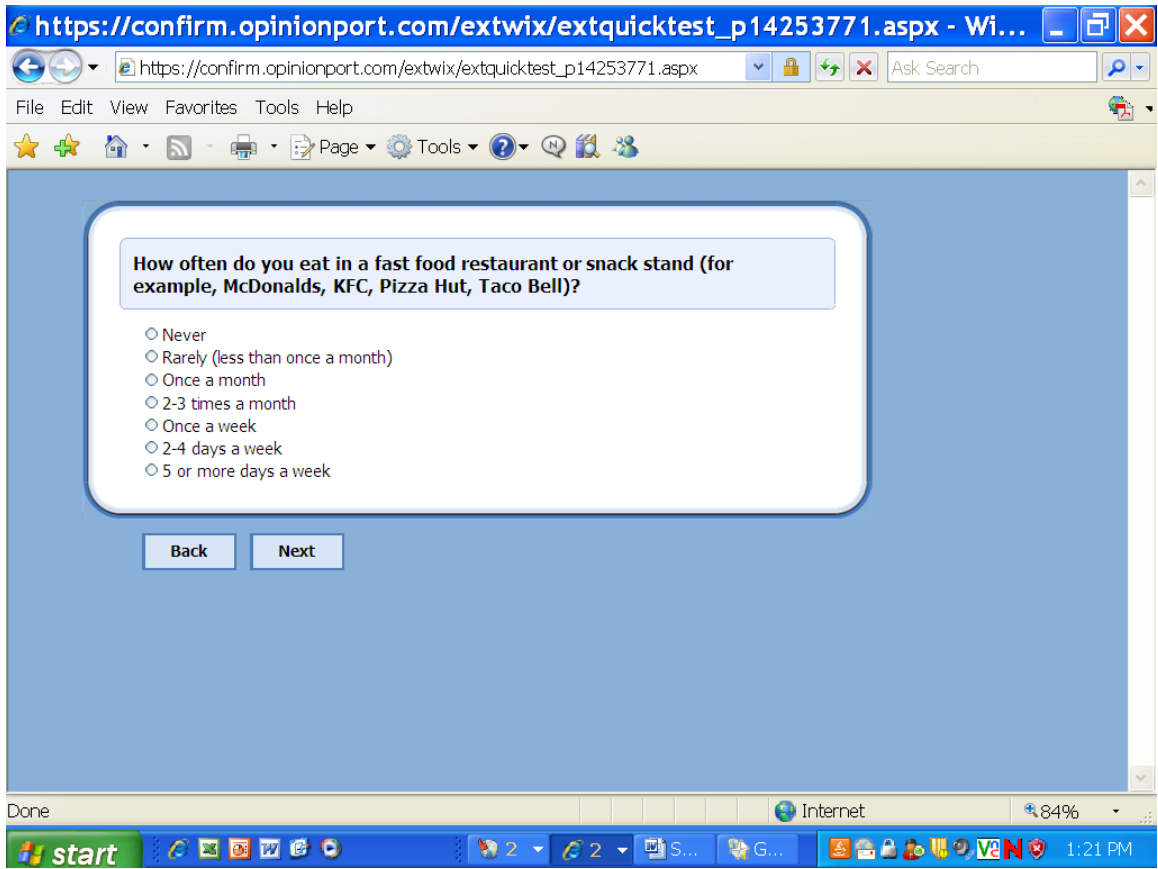
During the past 7 days, how many times did you...?

(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 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not 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 fruit ? (Do not 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 green vegetables 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 orange vegetables 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 beans like refried or baked beans.							

Eat green vegetables 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 orange vegetables 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 beans 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 whole grain foods 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 can, bottle, or glass of soda or pop , such as Coke, Pepsi, or Sprite? (Do not 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 sweet or salty snacks 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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How often do you eat in a fast food restaurant or snack stand (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:

Weight in pounds Example—152 lbs.		
1	5	2
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input checked="" type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input checked="" type="radio"/> 2
<input type="radio"/> 3	<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

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

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

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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Are you currently trying to:

- Lose weight
- Stay the same weight
- Gain weight
- I am not trying to do anything about my weight

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Would you say your health is...?
(Please mark one circle)

- Excellent
- Good
- Fair
- Poor

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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"/>
Stomache-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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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 type what they are:

No

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 important is it to your close friends that you...

On a scale from 1 to 7 where 1 means **Not at all** and 7 means **Extremely**.

(Please mark one circle for each line)

	Not at all			Somewhat		Extremely	
	1	2	3	4	5	6	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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This question is about things you do with the person who recruited you to complete this survey. For each of the items below, please indicate whether you did each of these things with this person.

Fill in one circle for each line:

You met him/her after school or work to hang out or go somewhere in the last seven days. Yes No

You spent time with him/her last weekend. Yes No

You talked with him/her about a problem in the last seven days. Yes No

You talked with him/her on the telephone in the last seven days. Yes No

You emailed, text messaged, or twittered him/her in the last seven days. Yes No

You and he are linked through your online network profile ('friend' on Facebook, 'follower' on Twitter). Yes No

You exercised or played sports with him/her in the last seven days. Yes No

You ate a meal with him/her in the last seven days. Yes No

You played computer games with him/her in the last seven days. Yes No

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seven days. Yes No

You talked with him/her on the telephone in the last seven days. Yes No

You emailed, text messaged, or twittered him/her in the last seven days. Yes No

You and he are linked through your online network profile ('friend' on Facebook, 'follower' on Twitter). Yes No

You exercised or played sports with him/her in the last seven days. Yes No

You ate a meal with him/her in the last seven days. Yes No

You played computer games with him/her in the last seven days. Yes No

You watched television or videos/DVDs with him/her in the last seven days. Yes No

You smoked tobacco with him/her in the last 30 days. Yes No

You drank alcohol with him/her in the last 30 days. Yes No

You got drunk with him/her in the last 30 days. Yes No

You used drugs with him/her in the last 30 days. Yes No

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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 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"/>

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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 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"/>

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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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Which of the following best describes your sexual orientation?

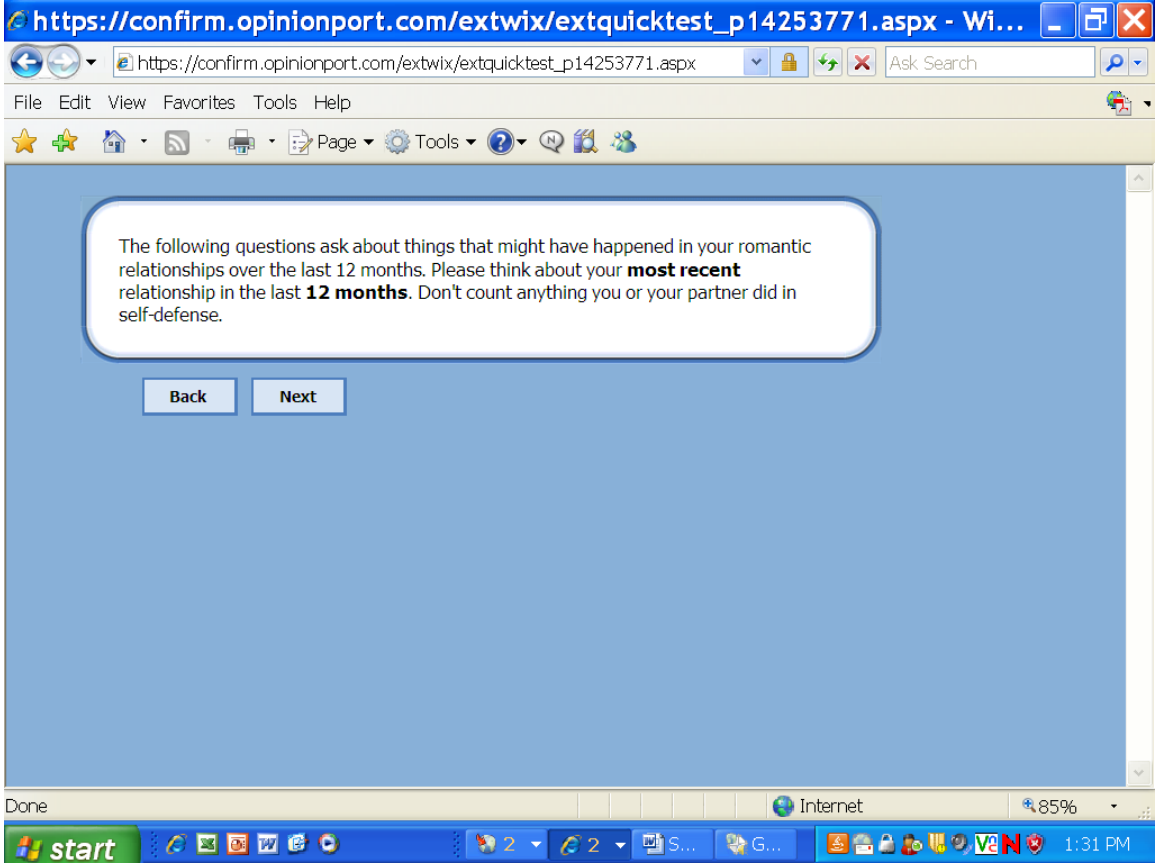
- Attracted to opposite sex
- Attracted to same sex
- Attracted to both sexes
- Questioning

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

- No
- Yes, Please type the number of romantic relationships in the last 12 months.

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

Enter their gender

Male	Female
<input type="radio"/>	<input type="radio"/>

Is this a current or past relationship?

Current	Past
<input type="radio"/>	<input type="radio"/>

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

years	months
<input type="text"/>	<input type="text"/>

(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"/>	<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"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the last 12 months, I did this to him/her:

	Never	1-3 Times	4-9 Times	10 or more times
Threatened to hurt	<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"/>
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"/>

In the last 12 months, 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"/>
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"/>

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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.

Never 1-2 times 3-5 times 6 or more times

How often	Never	1-2 times	3-5 times	6 or more times
Has this person hit you out of self defense ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Because of things this person did to you on purpose				
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 out of self-defense ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Because of things you did to this person on purpose				
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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Now think about your **second** most recent romantic relationship in the **last 12 months**. Remember, don't count anything you or your partner did it in self defense.

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

Enter their gender	Male	Female
	<input type="radio"/>	<input type="radio"/>

Is this a current or past relationship?	Current	Past
	<input type="radio"/>	<input type="radio"/>

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"/>	<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"/>	<input type="radio"/>	<input type="radio"/>

In the last 12 months, This person did this to me:

In the last 12 months, I did this to him/her:

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Hit me with a fist or something else hard.	<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 me with a knife or gun.	<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"/>
Kissed me when I did not want him/her to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kissed him/her when he/she did not want me 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 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 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"/>	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 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"/>	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 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"/>	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"/>

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:

In the last 12 months, I did this to him/her:

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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:

Never 1-3 Times 4-9 Times 10 or more times

Using one of these technologies...

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"/>

In the last 12 months, I did this to him/her:

Never 1-3 Times 4-9 Times 10 or more times

Using one of these technologies...

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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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.

Never 1-2 times 3-5 times 6 or more times

How often

Has this person hit you **out of self defense**?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------

Because of things this person did to you on purpose

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"/>
-----------------------	-----------------------	-----------------------	-----------------------

Never 1-2 times 3-5 times 6 or more times

How often

Have you hit this romantic partner **out of self-defense**?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------

Because of things you did to this person on purpose

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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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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Done Internet 84%

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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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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?

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

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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

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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="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.).

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

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For questions 66, 68, 69 and 70, please fill in the number of days from 0 to 30. For question 67, please fill in the number of miles in whole numbers.

Done Internet 84%

start 2 2 S... G... 1:41 PM

A screenshot of a web browser window. The address bar shows the URL 'https://confirm.opinionport.com/extwix/extquicktest_p14253771.aspx'. The browser's menu bar includes 'File', 'Edit', 'View', 'Favorites', 'Tools', and 'Help'. Below the menu bar is a toolbar with icons for home, back, forward, print, and search. The main content area has a light blue background and a white rounded rectangle containing the text: 'For questions 66, 68, 69 and 70, please fill in the number of days from 0 to 30. For question 67, please fill in the number of miles in whole numbers.' Below this text are two buttons labeled 'Back' and 'Next'. The status bar at the bottom shows 'Done', 'Internet', and '84%' zoom level. The Windows taskbar is visible at the very bottom with the 'start' button and several application icons.

	# of days
On how many of the last 30 days did you drive a vehicle?	<input type="text"/>
On average, about how many miles did you drive each day you drove?	<input type="text"/>
On how many days in the last 30 days have you driven with 2 or more passengers in the vehicle?	<input type="text"/>

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

(Please enter a number between 0 and 30 in the lines below)

	# of days
Talked on a cell phone?	<input type="text"/>
Changed music on an MP3, CD, radio or other device?	<input type="text"/>
Read text messages?	<input type="text"/>
Wrote text messages?	<input type="text"/>
Read (other than text messages)?	<input type="text"/>
Wrote (other than text messages)?	<input type="text"/>
Used an iPad or computer (except for listening to music)?	<input type="text"/>
Ate food?	<input type="text"/>
Looked in the mirror to put on makeup or fix hair?	<input type="text"/>
Looked at maps or directions?	<input type="text"/>
Took my eyes off the road while reaching for a phone?	<input type="text"/>
Took my eyes off the road while reaching for an object other than a phone	<input type="text"/>
Horsed around with passengers or other such activities?	<input type="text"/>

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

(Please enter a number between 0 and 30 in the lines below)

	# of days
Exceeded the speed limit in residential or school zones?	<input type="text"/>
Drove 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"/>
Went through an intersection when the light was yellow or just turning yellow?	<input type="text"/>
Went through an intersection when the light was red or just turning red?	<input type="text"/>
Went through a stop sign without stopping completely?	<input type="text"/>
Changed lanes without signaling?	<input type="text"/>
Drove after drinking alcohol?	<input type="text"/>
Raced another vehicle, even just for a short distance?	<input type="text"/>
Drove after using illegal drugs?	<input type="text"/>
Drove in a way to show off to other people?	<input type="text"/>
Drove without wearing a seat belt?	<input type="text"/>
Drove 10 MPH over the speed limit?	<input type="text"/>

(Please enter a number between 0 and 30 in the lines below)

	# of days
Exceeded the speed limit in residential or school zones?	<input type="text"/>
Drove 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"/>
Went through an intersection when the light was yellow or just turning yellow?	<input type="text"/>
Went through an intersection when the light was red or just turning red?	<input type="text"/>
Went through a stop sign without stopping completely?	<input type="text"/>
Changed lanes without signaling?	<input type="text"/>
Drove after drinking alcohol?	<input type="text"/>
Raced another vehicle, even just for a short distance?	<input type="text"/>
Drove after using illegal drugs?	<input type="text"/>
Drove in a way to show off to other people?	<input type="text"/>
Drove without wearing a seat belt?	<input type="text"/>
Drove 10 MPH over the speed limit?	<input type="text"/>
Drove when sleepy or drowsy?	<input type="text"/>

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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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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

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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

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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

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

- 0 times
- 1 time
- 2 or more times

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

- Not in an accident in the past year
- 0 times
- 1 time
- 2 or more times

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?

- Not in an accident in the past year
- 0 times
- 1 time
- 2 or more times

- Not in an accident in the past year
- 0 times
- 1 time
- 2 or more times

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?

- Not in an accident in the past year
- 0 times
- 1 time
- 2 or more times

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

- Not in an accident in the past year
- 0 times
- 1 time
- 2 or more times

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	Yes	No
Are you employed?	<input type="radio"/>	<input type="radio"/>

Where do you work?

(For example, at a hospital, bank, or restaurant or in the military)

Please type out exactly what job you do there

(for example, are you a teacher, bus driver, or doctor, etc.)

How many hours a week do you usually work?

Where do you work?

(For example, at a hospital, bank, or restaurant or in the military)

Please type out exactly what job you do there

(for example, are you a teacher, bus driver, or doctor, etc.)

How many hours a week do you usually work?

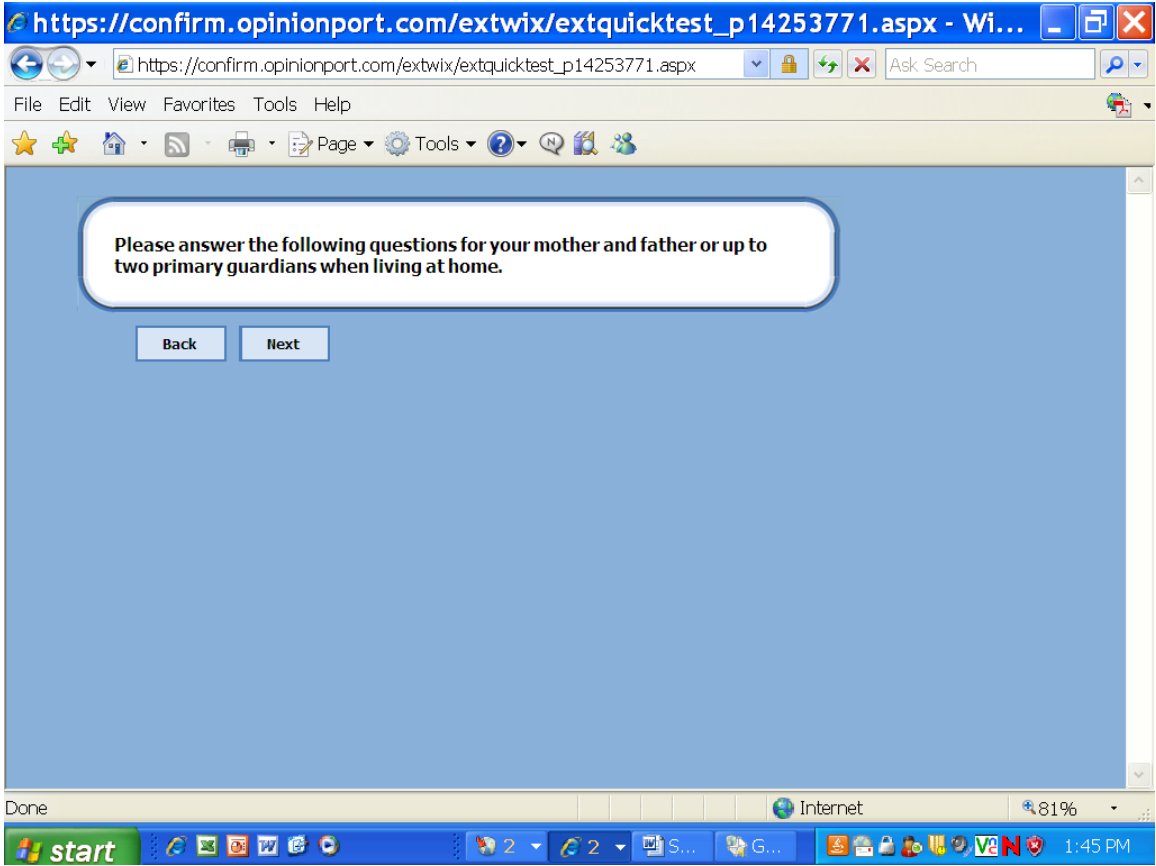
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What is the highest grade of regular school you have completed?

- Less than high school diploma
- High school diploma
- GED
- Some college or technical school
- Associate's degree
- Bachelor's degree
- Graduate degree

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What is the highest grade of regular school your mother has completed?

- Less than high school diploma
- High school diploma
- GED
- Some college or technical school
- Associate's degree
- Bachelor's degree
- Graduate degree

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What is the highest grade of regular school your father has completed?

- Less than high school diploma
- High school diploma
- GED
- Some college or technical school
- Associate's degree
- Bachelor's degree
- Graduate degree

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