



# THE LONGITUDINAL INVESTIGATION OF GENDER, HEALTH, AND TRAUMA SURVEY (LIGHT Survey)

## Time 1

Over one's lifetime, people experience a wide range of significant life events. We are specifically interested in the unique experiences Veterans have during their lives. This survey will ask you questions about life experiences, health, attitudes, and emotions, as well as how you have been supported and how you generally cope. Thank you in advance for completing this survey.

If you wish to participate PLEASE GO TO QUESTION 1.

If you do not wish to participate PLEASE MAIL BACK THE OPT-OUT FORM TO STOP FUTURE REQUESTS TO COMPLETE THE SURVEY. You may also contact our helpdesk at 1-855-462-7577.

### INSTRUCTIONS

- Choose one answer for each question unless the instructions say otherwise.
- Read each question carefully. Different questions ask about different timeframes.

Please use pen or dark pencil to mark an "X" in the answer box.

EXAMPLES: Correct  Incorrect

This number preserves your confidentiality and allows us to mail you the incentive as a thank you for your time.

Q1 What is your age?

Q2 Are you of Hispanic, Latino/a, or Spanish origin?

Yes

No

Q3 How do you describe your race? *Select all that apply.*

Native American or Alaska Native

Black

Asian

West Asian, Middle Eastern, or North African

Native Hawaiian

Other Pacific Islander

White/European

Other: (Please describe)

Q4 What is the highest degree or level of education you have completed?

Some high school but no diploma or GED

High school diploma / GED

Post-high school vocational or technical training

Some college credit, no degree

Associate's degree (*for example, AA, AS*)

Bachelor's degree (*for example, BA, BS*)

Master's, Doctorate or professional degree (*for example, MA, MSW, MBA, PhD, MD, JD*)

Q5 How many children do you have (both your biological children and other children for whom you have parenting responsibilities)?

Number of children:

I do not have any children → **Go to question 6**

Q5b If you have children, what are their ages in years?

Child 1	<input type="text"/>	<input type="text"/>
Child 2	<input type="text"/>	<input type="text"/>
Child 3	<input type="text"/>	<input type="text"/>
Child 4	<input type="text"/>	<input type="text"/>
Child 5	<input type="text"/>	<input type="text"/>
Child 6	<input type="text"/>	<input type="text"/>
Child 7	<input type="text"/>	<input type="text"/>
Child 8	<input type="text"/>	<input type="text"/>
Child 9	<input type="text"/>	<input type="text"/>
Child 10	<input type="text"/>	<input type="text"/>

Q5c Would you consider yourself the or one of the primary caregivers for your child/children?

- Yes  
 No

Q6 Do you have family members who are veterans of the armed services? *Select all that apply.*

- No, I do not have an immediate or extended family member who served/serves in the military
- Yes, my grandfather and/or grandmother served in the military
- Yes, my mother and/or father served/serves in the military
- Yes, I have a sibling that served/serves in the military
- Yes, I have a child who served/serves in the military
- Yes, I have an extended family member (e.g., aunt, uncle) who served/serves in the military

Q7 What is your current living situation?

- Rent an apartment, house, or room
- Own my house or apartment
- Live with a relative or friend and not paying rent
- Live in a car, on the street, or in a homeless shelter
- Other (Please describe)

Q8 Have you ever been homeless?

- Yes  
 No

Q9 What is your current employment status?  
*Select all the apply.*

- Working for pay full-time ( $\geq 30$  hours/week)
- Working for pay part-time ( $< 30$  hours/week)
- Not working for pay but actively looking for paid work
- Full-time care of children under the age of 18 or adult (*for example, disabled adult child/parent/spouse*)
- Full-time homemaker without full-time child or elder care responsibilities
- Retired
- Disabled

Q10 Please provide an estimate of your HOUSEHOLD'S yearly income before taxes are taken out. Include all sources of income from **all earners** in your household. If you do not know the answer, please make your best guess.

- No income
- Less than \$15,000 per year
- \$15,000 – 24,999
- \$25,000 – 34,999
- \$35,000 – 44,999
- \$45,000 - 54,999
- \$55,000 – 74,999
- \$75,000 – 99,999
- \$100,000 - \$149,999
- \$150,000 or more per year

Q11 How many people are supported by this HOUSEHOLD income, including yourself, your significant other (if you have one), and anyone else partially or fully supported by this income whether or not they live with you?

Q12 Have you ever been incarcerated for longer than 24 hours?

- Yes  
 No

**Now we will ask you about your military history and experiences**

Q13 In what component(s) have you served? *Select all that apply.*

- Active Duty  
 Reserve  
 National guard

Q14 In which branch of the military have you spent the most time?

- Army  
 Marine Corps  
 Navy  
 Air Force  
 Coast Guard

Q15 How long were you in the military?

Years   
Months

Q16 At what age did you enlist?

Q17 At what age did you separate from military service?

Q18 What was your paygrade on your last day of military service (*for example, E-5, O-6*)?

Q19 What was your primary military occupation during your military service?

- Combat arms  
 Combat support  
 Service support

Q20 Which of the following describes your discharge from military service?

- Honorable  
 General under honorable conditions  
 Under another category besides honorable (*for example, Other Than Honorable (OTH), Bad Conduct Discharge (BCD), Dishonorable*)  
 Medical  
 Not sure

Q21 Did you ever deploy overseas?

- Yes  
 No → **Go to question 22**

If **YES**, please answer the following questions about your deployments. If you never deployed please skip to question 22.

Q21a How many times were you deployed?

Q21b How many total months were you deployed out of country?

Q21c Did you experience a deployment in support of the following wars? *Select all that apply.*

- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND)  
 Gulf War (1990-1991)  
 Other: (Please describe)

**The statements below are about your combat experiences during your military service. Please select the response that best fits your answer.**

**Q22 During your military service...**

	Never	Once or Twice	Several times	Many times
a. You encountered land or water mines, booby traps, or roadside bombs ( <i>for example, IEDs</i> ).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. You saw refugees who had lost their homes or belongings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. You fired your weapon at enemy combatants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. You saw civilians after they had been severely wounded or disfigured.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. You were involved in searching and/or disarming potential enemy combatants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. You went on combat patrols or missions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. You personally witnessed someone from your unit or an ally unit being seriously wounded or killed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. You were exposed to hostile incoming fire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. You saw the bodies of dead enemy combatants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The statements below are about your relationships with other military personnel during your military service. As used in these statements, the term “unit” refers to those you lived and worked with on a daily basis during your military service. Please mark how much you agree or disagree with each statement.**

**Q23 While I was in the military...**

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
a. My unit was like family to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. People in my unit were trustworthy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My fellow unit members appreciated my efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt valued by my fellow unit members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Members of my unit were interested in my well-being.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My fellow unit members were interested in what I thought and how I felt about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My unit leader(s) were interested in what I thought and how I felt about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I felt like my efforts really counted to the leaders in my unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. My service was appreciated by the leaders in my unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I could go to unit leaders for help if I had a problem or concern.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. The leaders of my unit were interested in my personal welfare.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. I felt valued by the leaders of my unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next set of questions is about your relationships with others (*for example, other unit members, other unit leaders, civilians*) during your military service. Please mark how often you experienced each circumstance.

Q24 While I was in the military, the people I worked with...

	Never	Once or twice	Several times	Many times
a. Treated me in an overly critical way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Behaved in a way that was uncooperative when working with me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Treated me as if I had to work harder than others to prove myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Questioned my abilities or commitment to perform my job effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Acted as though my mistakes were worse than others'.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Tried to make my job more difficult to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. "Put me down" or treated me in a condescending way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Threatened my physical safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Made crude and offensive sexual remarks directed at me, either publicly or privately.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Spread negative rumors about my sexual activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Tried to talk me into participating in sexual acts when I didn't want to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Used a position of authority to pressure me into unwanted sexual activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Offered me a specific reward or special treatment to take part in sexual behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Threatened me with some sort of retaliation if I was not sexually cooperative ( <i>for example, the threat of a negative review or physical violence</i> ).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Touched me in a sexual way against my will.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Physically forced me to have sex.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Now we will ask you about experiences you have had starting in your childhood.**

**Q25 The sentences below refer to your relationship with your family WHEN YOU WERE GROWING UP. Please describe how much you agree or disagree with each statement by marking the response that best fits your choice. If you spent time in more than one family setting, please answer these questions about the family in which you spent the greatest part of your childhood.**

	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
a. I got along well with my family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I felt like I fit in with my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family members knew what I thought and how I felt about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt like my contributions to my family were appreciated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I shared many common interests and activities with family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My opinions were valued by other family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I was affectionate with family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I played an important role in my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I spent as much of my free time with family members as possible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Family members told me when they were having a problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. I could be myself around family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. My input was sought on important family decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following questions ask about experiences you may have had in your life. Please mark the number of times you experienced these events in each age range. If the event does not apply to you, mark “Not at all.”**

**Q26a Serious accident (for example, car/boat accident, accident at work)**

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q26b Exposure to toxic substance (for example, dangerous chemicals, radiation)**

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26c Witnessed sudden, violent death or aftermath (*for example, homicide, suicide*)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26d Sudden, unexpected death of someone close to you

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26e Serious injury, harm, or death you caused to someone else

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26f Captivity (*for example, being kidnapped, held hostage, prisoner of war*)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until End of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26g Community violence: terrorist attack, bombing, riots.

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This section is about violent attacks against you by someone who is NOT a romantic partner or spouse**

Q26h Sexual assault by anyone who is **NOT** an intimate partner (rape, attempted rape, made to perform any sexual act through force or threat of harm)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26i Serious physical assault by anyone who is **NOT** an intimate partner (attacked with or without a weapon, threatened with a weapon)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This section is about violence against you by someone who WAS/IS a romantic partner or spouse**

Q26j Physical assault (pushed, grabbed, shaken, hit, beat up) by a significant other/spouse

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26k Unwanted sexual experience by a significant other/spouse (pressured or forced to do sexual things you didn't want to do)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Q26l Emotional mistreatment by significant other/spouse (name-calling, criticized, not allowed to see friends/family, humiliated, or denied money)

	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26m Other traumatic event: **please specify.**

Please describe the event:

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	Not at all	Once or twice	Several times	Many times
Childhood (birth – age 17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 18 to enlistment (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After military service until end of May 2018	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q27 Think about things that may have happened to you throughout your life that are unusually or especially frightening, horrible, or traumatic. If you have had one of these experiences, which experience causes you the most distress? If you have not had an experience like this, please select “I did not have an experience like this” and proceed to question 30. *Check one only.*

- Combat/ exposure to warzone
- Physical assault
- Sexual assault
- Accident
- Natural disaster
- Seen someone killed or seriously injured
- Death of loved one through homicide or suicide
- I did not have an experience like this → **Go to question 30**
- Other: (Please describe)

Q28 How old were you when this most distressing trauma occurred?

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**Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then choose one of the responses to the right to indicate how much you have been bothered by that problem in the past month. Please base your answers on problems related to the experience you named as the worst in question 27**

**Q29 Thinking about the experience you named in question 27, in the past month, how much were you bothered by:**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Repeated, disturbing dreams of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling very upset when something reminded you of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Having strong physical reactions when something reminded you of the stressful experience ( <i>for example, heart pounding, trouble breathing, sweating</i> )?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Avoiding external reminders of the stressful experience ( <i>for example, people, places, conversations, activities, objects, or situations</i> )?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Trouble remembering important parts of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Having strong negative beliefs about yourself, other people, or the world ( <i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i> )?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Blaming yourself or someone else for the stressful experience or what happened after it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Loss of interest in activities that you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Feeling distant or cut off from other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Trouble experiencing positive feelings ( <i>for example, being unable to feel happiness or have loving feelings for people close to you</i> )?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Irritable behavior, angry outbursts, or acting aggressively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Taking too many risks or doing things that could cause you harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Being "superalert" or watchful or on guard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Feeling jumpy or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Having difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Trouble falling or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q30** The next set of items ask about potentially stressful situations you may be currently experiencing. Think about whether or not the stressful situation described happened in the last month. If the situation IS NOT occurring for you, choose "N/A" and go to the next item. If the situation IS occurring, please rate the extent to which it is NOW stressful/distressing to you on a scale from 1-10.

	N/A	Not at all distressing			Somewhat distressing			Extremely distressing			
		1	2	3	4	5	6	7	8	9	10
a. Laid off or fired from work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. At risk for losing your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Caring of seriously ill and/or disabled dependents (e.g., children, elders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Divorce or separation from romantic partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Legal problems, court proceedings, ongoing litigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Major negative change in financial status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Major problems at school/At risk of losing spot at school or Veteran subsidies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Major health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Major problem with your significant other or child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q31** Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead, or of hurting yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q32 Have you ever been diagnosed with any of the following emotional/mental health conditions? *Select all that apply.*

Post-traumatic Stress Disorder (PTSD)

Depression

Anxiety Disorder (*for example, panic disorder, generalized anxiety disorder*)

Other mental health problem (please specify):

Q33b How often have you thought about killing yourself in the past year? *Check one only.*

Never

Rarely (1 time)

Sometimes (2 times)

Often (3-4 times)

Very often (5 or more times)

Q33c Have you ever told someone that you were going to commit suicide, or that you might do it? *Check one only.*

No

Yes, at one time, but did not really want to die

Yes, at one time, and really wanted to die

Yes, more than once, but did not want to do it

Yes, more than once, and really wanted to do it

**Please check the one box beside the statement or phrase that best applies to you.**

Q33a Have you ever thought about or attempted to kill yourself? *Check one only.*

Never

It was just a brief passing thought

I have had a plan at least once to kill myself but did not try to do it

I have had a plan at least once to kill myself and really wanted to die

I have attempted to kill myself, but did not want to die

I have attempted to kill myself, and really hoped to die

Q33d How likely is it that you will attempt suicide someday? *Check one only.*

Never

No chance at all

Rather unlikely

Unlikely

Likely

Rather likely

Very likely

**Having thoughts of hurting yourself can be a common response to feeling distressed. We want you to know that help is available. We recommend that you contact your primary care provider or call the Veterans Crisis Hotline (1-800-273-8255) if you are experiencing suicidal thoughts.**

Q34 Thinking over the past month, check the option that best describes the amount of time you felt that way.

	None or almost none of the time	A little of the time	Some of the time	Most of the time	All or almost all of the time
a. I found myself getting angry at people or situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. When I got angry, I got really mad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. When I got angry, I stayed angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. When I got angry at someone I wanted to hit them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My anger prevented me from getting along with people as well as I'd have liked to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Q35 What is your current marital status?
- Never married
  - Married - first and only marriage → **Go to question 37**
  - Married - second or later marriage → **Go to question 37**
  - Separated
  - Divorced
  - Widowed

- Q36 Are you currently in a romantic relationship?
- Currently in a relationship and living as a couple
  - Currently in a relationship but not living as a couple
  - Not currently in a relationship → **Go to question 38**

**If you are married or currently in a romantic relationship, please answer the following questions. If you are not married or in a romantic relationship, please skip to question 38:**

Q37 Over the last month, how often have you done the following in your romantic relationship:

	Never	Rarely	Sometimes	Often	Most or all of the time
a. Provided your significant other with the emotional support they sought	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Shared your intimate thoughts and feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Done your fair share of day-to-day tasks. <i>(for example, grocery shopping, errands, planning activities)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Initiated leisure time activities that both you and your significant other enjoy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Made effort to work through disagreements respectfully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Expressed interest and/or willingness to engage in regular sexual or physical intimacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you currently have parenting responsibilities for any children 18 or under please answer the following questions. If not, please skip to question 39.**

Q38 All parents have strengths and weaknesses. Over the last month, how often have you:

	Never	Rarely	Sometimes	Often	Most or all of the time
a. Provided a healthy environment for your children. <i>(for example, preparing healthy meals, caring for their health, keeping them safe)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Been a good example for your children. <i>(for example, being respectful during disagreements with others, taking good care of your own health).</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Been actively involved in your child(ren)'s activities. <i>(for example, regularly attending sporting and school events, giving your full attention during time together)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Met your children's needs for physical affection and emotional support. <i>(for example, giving them hugs, being sympathetic to their problems)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Been able to successfully manage your child(ren)'s unique challenges. <i>(for example, effectively disciplining children)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following questions ask about your neighborhood and community.**

Q39 How long have you lived in your current neighborhood (Years / Months)?

Years:

Months:

Q40 Over the course of your adult life, how often have you been involved in....

	Never	Rarely	Sometimes	Often	Most or all of the time
a. Activities that address political topics at the local, state, or national level (for example, political rallies or fundraisers, groups that focus on specific political point of views, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Volunteer activities for non-political organizations (for example, red cross, local organization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Religious or spiritual communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Culture, recreational, or leisure group activities (for example, sport, music, craft, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q41 To what extent do you think these groups or organizations above would offer you help if you request it?

- Not involved in these groups/organizations
- Very unlikely
- Unlikely
- Neither likely nor unlikely
- Likely
- Very likely

Q42 How likely are these things to happen in your neighborhood...

	Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
a. People around here are willing to help their neighbors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. This is a close-knit neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. People in this neighborhood can be trusted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. People in this neighborhood generally don't get along with each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. People in this neighborhood do not share the same values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q43 On the whole, how much do you like this neighborhood as a place to live?

- Not at all
- A little
- Somewhat
- A great deal

**Q44 We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.**

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. There is a lot of graffiti in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My neighborhood is noisy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Vandalism is common in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. There are a lot of abandoned buildings in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My neighborhood is clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. People in my neighborhood take good care of their houses and apartments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. There are too many people hanging around on the streets near my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. There is a lot of crime in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. There is too much drug use in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. There is too much alcohol use in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. I'm always having trouble with my neighbors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. In my neighborhood, people watch out for each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. My neighborhood is safe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q45** In the last year, how often have you heard gunshots associated with crime or violence in your neighborhood?

- Never
- Once or twice
- Three to five times
- More than five times

**Q46** How common would you say it is for people to belong to street gangs in your neighborhood?

- Very common
- Somewhat common
- Somewhat uncommon
- Very uncommon

**Q47** How common do you think it is for people to carry guns in the neighborhood?

- Very common
- Somewhat common
- Somewhat uncommon
- Very uncommon

**Q48** Have you ever seen someone threatened with a gun in the neighborhood?

- Yes
- No

**Q49** Have you ever seen someone shot with a gun in the neighborhood?

- Yes
- No

**Q50** If a fight were to break out near your home, how likely is it that your neighbors would attempt to break it up?

- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely

**Q51** If a fight were to break out near your home, how likely is it that the police would be called?

- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely

**Q52 How safe do you feel...**

	Very safe	Some what safe	Some what unsafe	Very unsafe
a. Alone inside your house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Outside in your neighborhood during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Outside in your neighborhood at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Walking alone toward a group of people that you don't know?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q53** In this neighborhood, it is sometimes necessary for people to carry guns to protect themselves or their family.

- Strongly agree
- Agree
- Disagree
- Strongly Disagree

**Q54** In this neighborhood, it is sometimes necessary for people to join a gang to protect themselves or their family.

- Strongly agree
- Agree
- Disagree
- Strongly disagree

**The following questions ask about your health.**

**Q55** During the past month, what time have you usually gone to bed at night (hh:mm)?

<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
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**Q56** During the past month, how long, has it usually taken you to fall asleep each night?

Number of Hours:

Number of minutes:

**Q57** During the past month, what time have you usually gotten up in the morning (hh:mm)?

<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
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**Q58** During the past month, how many hours of actual sleep did you get at night? (This may be different from the number of hours you spent in bed.)

Hours of sleep per night:

**Q59** How often do you exercise for 30 minutes or more?

- Daily or almost daily
- 3 to 4 times per week
- 2 to 3 times per week
- 1 to 2 times per week
- Fewer than once per week

**Please answer the following questions related to your current and history of substance use. Skip any questions that are irrelevant to you.**

**Q60** How many cigarettes did you smoke on an average day in the last month (if you do not smoke write 0)?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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For alcohol, one drink equals:

- 4 oz. wine
- 1 wine cooler
- 12 oz. beer
- 1 cocktail with 1 oz. hard liquor

**Q61** How often do you currently have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

**Q62** How many standard drinks containing alcohol do you have on a typical day?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more



Q63 On average, how often do you have 5 or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

Q64 Have you ever been diagnosed with alcohol abuse or dependence in the past?

- No
- Yes

Q65 In the past month, did you use marijuana? If **YES**, how many times in a typical week?

- No → **Go to question 66**
- Yes

Times in a week:

Q65a Does your marijuana use cause any problems?

- Yes
- No
- N/A, I do not use marijuana

Q65b Did anyone else think your marijuana use caused a problem?

- Yes
- No
- N/A, I do not use marijuana

Q66 In the past month, did you use other drugs, other than alcohol or marijuana? If **YES**, how many times in a typical week did you use, if at all? This includes cocaine, crack, heroin, acid, speed, ecstasy, methamphetamines, steroids, and medicines prescribed for someone else.

- No
- Yes

Times in a week:

Q66a Does your use of drugs other than alcohol or marijuana cause any problems?

- Yes
- No
- N/A, I do not use drugs, not including alcohol or marijuana

Q66b Did anyone else think your use of drugs other than alcohol or marijuana cause a problem?

- Yes
- No
- N/A, I do not use drugs, not including alcohol or marijuana

Q67 Have you ever been diagnosed with drug (including prescription drugs) abuse or dependence in the past?

- No
- Yes

**If you are prescribed pain medication please answer the following questions, otherwise skip to item 69.**

Q68 In the past 3 months...

	Never	Rarely	Sometimes	Often	Almost Always
a. I abused prescription pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I ran out of my prescription pain medication early	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I got prescription pain medication from someone other than my healthcare provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I used more of my prescription pain medication than I was supposed to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I experienced cravings for pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I used more pain medication before the effects wore off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q68a In the past 3 months...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
When my prescription for pain medication ran out, I felt anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following questions are about food and eating behavior**

Q69 Please answer yes or no to the following questions:

	No	Yes
a. Do you make yourself sick because you feel uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you worry that you have lost control over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you recently lost more than 14 lbs in a 3-month period?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you believe yourself to be fat when others say you are too thin?	<input type="checkbox"/>	<input type="checkbox"/>
e. Would you say that food dominates your life?	<input type="checkbox"/>	<input type="checkbox"/>

Q70 What is your current height not wearing shoes?

		'			"
--	--	---	--	--	---

Q71 What is your current weight (if you are currently pregnant please put your pre-pregnancy weight)?

--	--	--

 lbs

Q72 Please indicate whether you are currently diagnosed with any of the following conditions:

	No	Yes
a. Sleep problem or disorder (for example, insomnia, sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>
b. Chronic pain or pain related disorder (for example, knee, back, migraines)	<input type="checkbox"/>	<input type="checkbox"/>
c. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
d. Other chronic physical problem (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

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Q73 Have you ever experienced any of the following events? *Select all that apply.*

- Blast or explosion (IED, RPG, Landmine, Grenade, etc)
- Vehicular accident/crash (any vehicle including aircraft)
- Fragment wound or bullet wound above the shoulders
- Fall
- Blow to the head (head hit by falling/flying object, head hit by another person, head hit against something, etc)
- Strangulation
- Shaken violently
- None of the above → **Go to question 77**

Q74 Did you have any of these immediately after any of the events in Q73? *Select all that apply.*

- Losing consciousness/"knocked out"
- Being dazed, confused, or "seeing stars"
- Not remembering the event
- Concussion
- Head injury that resulted in broken bones in head, neck, face, damaged teeth, or ruptured eardrum
- None of the above

Q75 Did any of the following problems begin or get worse afterwards? *Select all that apply.*

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
- Headaches
- Sleep problems
- None of the above

Q76 In the past week, have you had any of the symptoms from question 73? *Select all that apply.*

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
- Headaches
- Sleep problems
- None of the above

Q77 Have you ever tried, for a period of 12 months or longer, to become pregnant?

- Yes, I have tried for 12 months or longer to become pregnant
- No → **Go to question 78**
- N/A → **Go to question 78**

Q77a If **YES**, Did a doctor identify any of the following reasons for your difficulties in becoming pregnant? *Select all that apply.*

- I did not see a doctor for this problem
- No reason identified
- Cervical factor
- Tubal factor
- Ovulation factor
- Semen or sperm factor
- Hormonal factor
- Other (please specify)

Q77b Did you become pregnant eventually?

- No, and I have stopped trying
- No, but I am still trying
- Yes, I became pregnant naturally
- Yes, I became pregnant with medical intervention (i.e. IVF)

Q78 Are you currently pregnant?

- No
- Yes

Q78a If **YES**, how many weeks pregnant are you?

Q78b If **NO**, are you currently trying to get pregnant?

- No → **Go to question 79**
- Yes

Q78c If **YES**, how many months have you been trying to become pregnant?

Q79 Have you ever been pregnant? Please include live births, stillbirths, miscarriages, induced abortions, and tubal and other ectopic pregnancies.

- No → **Go to question 81**
- Yes

Q79a If **YES**, how many times have you been pregnant? Please include live births, stillbirths, miscarriages, induced abortions, and tubal and other ectopic pregnancies.

Q79b If **YES**, how many live or stillborn births have you had?

Q79c Have you had any pregnancies that did NOT lead to a birth, either live or stillborn, such as an abortion or miscarriage? If **YES**, how many?

- No
- Yes

Number of Abortions:

Number of miscarriages:

Age at first miscarriage:

Q79d Have you ever had an ectopic/tubal pregnancy?

- No
- Yes

**Please answer the following questions about your pregnancy history, thinking about pregnancies that led to either a LIVE or STILLBORN birth, including any current pregnancy.**

Q80a Did your pregnancy lead to (Select all that apply):

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live Birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stillborn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twins/Triples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80b Was this pregnancy planned?

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80c If planned, how long did it take you to get pregnant?

1st Pregnancy	<input type="text"/> <input type="text"/> Months	5th	<input type="text"/> <input type="text"/> Months
2nd	<input type="text"/> <input type="text"/> Months	6th	<input type="text"/> <input type="text"/> Months
3rd	<input type="text"/> <input type="text"/> Months	7th	<input type="text"/> <input type="text"/> Months
4th	<input type="text"/> <input type="text"/> Months	8th Pregnancy	<input type="text"/> <input type="text"/> Months

Q80d How old were you when you got pregnant?

1st Pregnancy	Age <input type="text"/> <input type="text"/>	5th	Age <input type="text"/> <input type="text"/>
2nd	Age <input type="text"/> <input type="text"/>	6th	Age <input type="text"/> <input type="text"/>
3rd	Age <input type="text"/> <input type="text"/>	7th	Age <input type="text"/> <input type="text"/>
4th	Age <input type="text"/> <input type="text"/>	8th Pregnancy	Age <input type="text"/> <input type="text"/>

Q80e Did you see a doctor regularly during your pregnancy?

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80f Did you have any of the following medical conditions during your pregnancy? (*Select all that apply*)

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
No conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression and/or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80g Did you use any of the following substances and/or medications during this pregnancy? (*Select all that apply*)

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioid pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other non-prescribed substance(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other prescribed substance(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80h What kind of delivery did you have? Do not include current pregnancies.

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Vaginal (spontaneous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal (induced)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planned c-section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency c-section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-emergency c-section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80i How many weeks did the pregnancy last? Do not include current pregnancies.

	Weeks			Weeks	
1st Pregnancy	<input type="text"/>	<input type="text"/>	5th	<input type="text"/>	<input type="text"/>
2nd	<input type="text"/>	<input type="text"/>	6th	<input type="text"/>	<input type="text"/>
3rd	<input type="text"/>	<input type="text"/>	7th	<input type="text"/>	<input type="text"/>
4th	<input type="text"/>	<input type="text"/>	8th Pregnancy	<input type="text"/>	<input type="text"/>

Q80j What was the birth weight of the baby? Do not include current pregnancies.

	Lbs	Oz		Lbs	Oz
1st Pregnancy	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
2nd	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
3rd	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
4th	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
5th	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
6th	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
7th	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
8th Pregnancy	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>

Q80k Were you prescribed pain medication after this pregnancy? Do not include current pregnancies.

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80l Did you suffer from postpartum depression and/or anxiety after this pregnancy? Do not include current pregnancies.

	1st Pregnancy	2nd	3rd	4th	5th	6th	7th	8th Pregnancy
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q80m Have you had more than 8 pregnancies leading to a live or stillborn birth?

- Yes  
 No

Additional number of births:

Additional number of stillbirths:

Q81 Within the past couple of years, has your menstrual period been regular? Please think about those times you were not using hormonal contraceptives.

- Yes  
 No  
 Cannot say because I was taking hormonal contraceptives most of the time.  
 N/A, I no longer have menstrual periods

Q82 Thinking about the time(s) when you have not used hormonal contraceptives, what is the average number of days from the first day of one period to the first day of your next period? For example, if you cycle ranges from 26-28 days, you would write 27 days.

Q83 How would you classify the total amount of your menstrual flow?

- Light (10 or fewer pads or tampons per period)
- Moderate (11 to 20 pads or tampons per period)
- Moderate/heavy (21-30 pads or tampons per period)
- Heavy (more than 30 pads or tampons per period)

Q84 How much pain do you usually have with your menstrual period? Please focus on the times when you were not using hormonal contraceptives.

- None
- Mild cramps, with medication seldom needed
- Moderate cramps, with medication usually needed
- Severe cramps, with medications and bed rest required

Q85 Have you ever used hormonal birth control (for example, the pill, hormonal IUD)?

- Yes
- No → **Go to question 86**

Q85a At what age did you first use hormonal birth control?

Q85b How many years have you been on hormonal birth control over your lifetime (If less than one year, write 0)?

Q85c Are you on hormonal birth control now?

- Yes
- No → **Go to question 86**

Q85d If **YES**, what type of hormonal birth control are you on?

- The pill
- The patch
- The shot
- Vaginal ring
- IUD/Implant

Q86 Have you ever been diagnosed or do you suffer with (Select all that apply):

- Fibroids in womb
- Chronic pelvic pain
- Polycystic Ovary Syndrome or PCO/PCOS
- Pelvic Inflammatory Disease

Q86a At what age did this begin or were you diagnosed?

- Fibroids in womb
- Chronic pelvic pain
- Polycystic Ovary Syndrome or PCO/PCOS
- Pelvic Inflammatory Disease

Q87 Have you had a hysterectomy (surgical removal of your uterus)?

- No → **Go to question 88**
- Yes, and kept ovaries
- Yes, both ovaries removed
- Yes, one ovary removed

Q87a If **YES**, why did you have a hysterectomy?

- Abdominal bleeding
- Pain
- Cancer
- Other:

Q88 During the past three years, have you had a Pap smear?

- Yes
- No

Q89 Has a doctor ever told you that you had an abnormal Pap smear?

- Yes
 No -> Go to question 90

Q89a If YES, did you have a colposcopy with cervical biopsies or a procedure to remove cervical tissue known as LEEP?

- Yes
 No
 Not sure

Q90 Did you see an OB/GYN or gynecologist during the past three years?

- Yes
 No

Q90a If YES, did you use a VA provider for this care?

- Yes
 No

Q91 Please place an 'x' in the box that best describes your feelings about pelvic exams (the internal physical exam performed by your doctor):

Table with 5 columns: Not at all, Minimally, Mildly, Moderately, Extremely. Rows: a. Do you experience emotional distress during pelvic exams? b. Do you experience physical discomfort during pelvic exams? c. Are you afraid of the examiner? d. How much does it matter to you if the doctor is male or female?

The following questions ask about your use of healthcare and thoughts about mental health treatment.

Q92 Do you get any healthcare (physical and/or mental health) at Veterans' Administration (VA) hospitals or clinics?

- Yes -> Go to question 93
 No

Q92a If NO, why not?

- Not eligible
 Distance to VA facilities/transportation concerns
 My VA does not provide the services I need.
 I don't feel comfortable seeking services at the VA.
 Preference for my current healthcare providers
 Other (please specify):

Empty rectangular box for specifying other reasons.

Q93 I think that I am suffering from mental health problems (for example, feeling anxious, depressed, or too angry).

- True
 False

Q94 I think that I might benefit from mental health treatment.

- True
 False

Q95 Are you currently receiving mental health services (for example, seeing a therapist, counselor, or medications) to help with distress?

- Yes -> Go to question 96
 No

Q95a If NO, what prevents you from seeking mental health treatment? Select all that apply.

- Concern for job security
 Judgment from others
 Distance/transportation to mental healthcare providers
 Don't think it will help me
 No insurance coverage
 I don't need mental health treatment
 Other (please specify):

Empty rectangular box for specifying other reasons.



Q96 If I thought that I were suffering from serious depression, anxiety, anger, or fear, I would seek assistance from *(Select all that apply)*:

- Good female friends
- Good male friends
- Spouse or intimate partner
- Family member (brother, sister, mother, father, etc.)
- Coworker

- Religious leader (e.g. pastor, priest, rabbi)
- Medical doctor (primary care doctor)
- Therapist or counselor
- Information on the internet
- Self-help books or magazine articles
- Other (please specify):

Q97 We are interested in your use of mental health services in the past 12 months. If you received any help (even if it was only once or for a little while), please mark where you received this help. Mark the no column only if you did not receive any of that type of help in the past 12 months.

	No, I did not get this kind of help	Yes, from a VA provider	Yes, from a community (non-VA) provider	Yes, from both a VA and a community provider
a. Medication for a mental health problem (e.g., an antidepressant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Individual counseling or therapy for a mental health program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Group counseling or therapy for a mental health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Family therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Inpatient or partial hospitalization program for a mental health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Another type of mental health treatment (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q98 If you felt as though you needed mental health treatment, do you feel your health care provider could get it for you?

- Yes
- No
- N/A

Q99 If you have received any mental health treatments, how satisfied were you with the care you received?

- Not at all satisfied
- Slightly satisfied
- Moderately satisfied
- Very satisfied
- Extremely satisfied
- N/A

Q100 If you have received any mental health treatments, how helpful was this care in reducing your distress?

- Not at all helpful
- Slightly helpful
- Moderately helpful
- Very helpful
- Extremely helpful
- N/A

Q101 If you have received any mental health treatments, how difficult was it to find a therapist and schedule your mental health appointments?

- Very difficult
- Difficult
- Moderately difficult
- Neutral
- Easy
- Very easy
- N/A

Q102 How likely would you be to use the following services if they were offered by the VA?

	Not at all likely	Slightly likely	Moderately likely	Very likely	Extremely likely
a. Family Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Help with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Help with marriage/relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q103 Were you aware that the VA offers services to support the family, including marital, couples, and family therapy?

- Yes
- No

**The next set of questions ask you about your current support system and coping strategies.**

Q104 We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
a. There is a special person who is around when I am in need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. There is a special person with whom I can share my joys and sorrows.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My family really tries to help me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I get the emotional help and support I need from my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I have a special person who is a real source of comfort to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My friends really try to help me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I can count on my friends when things go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I can talk about my problems with my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I have friends with whom I can share my joys and sorrows.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. There is a special person in my life who cares about my feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. My family is willing to help me make decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. I can talk about my problems with my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q105 Please indicate how many times you have done each of these things to someone else in the past six months.

	Once	Twice	3-5 times	6-10 times	11-20 times	More than 20 times	Not in the past 6 months, but it did happen before	This has never happened
a. I insulted, swore, shouted or yelled at someone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I pushed, shoved, or slapped someone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I punched, kicked, or beat-up someone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I destroyed something belonging to someone else or threatened to hit someone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q106 Please indicate the extent to which you agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. You tend to bounce back quickly after hard times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. You have a hard time making it through stressful events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. It does not take you long to recover from a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. It is hard for you to snap back when something bad happens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. You usually come through difficult times with little trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. You tend to take a long time to get over set-backs in your life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q107 In your day-to-day life, how often do any of the following things happen to you?

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
a. You are treated with less courtesy than other people are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. You are treated with less respect than other people are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. You receive poorer service than other people at restaurants or stores.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. People act as if they think you are not smart.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. People act as if they are afraid of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. People act as if they think you are dishonest.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. People act as if they're better than you are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. You are called names or insulted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. You are threatened or harassed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following question if you answered “a few times a year” or more frequently to any of the above questions.

Q108 What do you think is the main reason for these experiences? *Select all that apply.*

- Your Ancestry or National Origins
- Your Gender
- Your Race
- Your Age
- Your Religion
- Your Height
- Your Weight
- Some other Aspect of Your Physical Appearance
- Your Sexual Orientation
- Your Education or Income Level

Q109 What is your biological sex?

- Male
- Female

Q111 How would you describe your current sexual orientation?

- Heterosexual/straight
- Homosexual/gay or lesbian
- Bisexual
- Uncertain
- Other (please specify):

Q110 What is your gender identity?

- Male
- Female
- Transgender
- Other (please specify):

Q112 There may be opportunities for you to participate in other studies. May we use your contact information to inform you about these opportunities?

- Yes
- No, not at this time

**THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY.  
PLEASE RETURN YOUR SURVEY IN THE ENCLOSED ENVELOPE.  
ONCE WE RECEIVE THE SURVEY, \$20 WILL BE MAILED TO YOU.**