**Attachment 7 - Adolescent Follow-back Survey (AFS)**

**Content Summary**

**General health and well-being**

* Self-assessed health status **‡‡**
* Satisfaction with life **§§**

**Height and weight**

* Self-reported height **‡**
* Self-reported weight **‡**
* Perception of weight status
* Concern about weight

**Physical activity**

* (Past 12 months) Played on sports teams, took sports lesson in school/community **‡**
* (Past 12 months) Took PE or gym class **‡**
* (Typical school week) How often physically active for a total of at least 60 minutes per day **‡**
* (Typical school week) How often muscle strengthening activities **‡**
* (Typical school week) How often walks for at least 10 minutes **‡**
* (Typical school week) How often rides a bike for at least 10 minutes **‡**

**Sleep**

* (Typical school week) How often do you wake up well-rested **‡**
* (Typical school week) How often do you have difficulty getting out of bed in morning **‡**
* (Typical school week) How often do you complain about being tired **‡**
* (Typical school week) How often do you fall asleep during day **‡**
* (Typical school week) How often do you go to bed at same time **‡**
* (Typical school week) How often do you wake up at the same time **‡**

**Screen time**

* (Typical weekday) Number of hours in front of TV, computer, cellphone, or other electronic device **‡**

**Concussions**

* As a result of a blow or jolt to the head, ever knocked out or lost consciousness **‡§**

*If no:*

* + As a result of a blow or jolt to the head, ever been dazed or had a gap in your memory **‡§**
	+ As a result of a blow or jolt to the head, ever had headaches, vomiting, blurred vision, changes in mood or behavior **‡§**
* Ever been checked for a concussion or brain injury **‡§**

*If yes:*

* + Ever been diagnosed with a concussion or brain injury **‡§**

**Health care utilization**

* Time since last seen doctor or health professional **‡‡**

*If not never:*

* + Time alone with doctor or health professional at last visit **§§**
* Was most recent visit a wellness visit, physical, or general-purpose check-up **‡‡**

*If no:*

* Time since last wellness visit, physical, or general-purpose check-up **‡‡**

*If not never:*

* + - Time alone with doctor or health professional at last wellness visit **§§**
* (Ever) Had visit with doctor or health professional that parents did not know about

*If yes:*

* Type of visit (mental health, women’s health, other - specify)

**Content of care in past year (or at last wellness visit)**

* Talked about understanding the changes in health care that happen at age 18
* Talked about gaining skills to manage your health and health care
* Talked about tobacco products or smoking
* Talked about your mental or emotional health
* Talked about puberty (e.g., changes to your body) or sexual health (e.g., safe sex practices)

**Health care access**

* Has a usual place for care when sick **‡‡**

*If yes or more than one place:*

* Type of place (or type of place visited most often) **‡‡**
* Has a personal doctor or nurse **§§**

**Complementary and alternative health**

* (Past 12 months) Use of meditation **‡**
* (Past 12 months) Practice yoga **‡**
* (Past 12 months) Visit a chiropractor **‡**

**Mental health care use and unmet need**

* (Past 12 months) Any prescription medication taken to help with emotions, concentration, behavior, or mental health **§‡**
* (Past 12 months) Received counseling or therapy from a mental health professional **§‡**
* (Past 12 months) Any counseling or therapy needed but didn’t get due to cost **‡**
* (Past 12 months) Any counseling or therapy needed but didn’t get due to fear of what others would think of you
* (Past 12 months) Any counseling or therapy needed but didn’t get due to not knowing where to go or how to get help

**Social support**

* How often do you receive the social and emotional support you need **§§**
* How much can you rely on friends if you have a serious problem
* How much can you open up to friends if you need to talk about your worries
* How much can you rely on your parents/guardians if you have a serious problem
* How much can you open up to your parents/guardians if you need to talk about your worries
* Is there an adult in school, neighborhood, or community who makes a positive and meaningful difference in your life **§§**

**Cognition**

* Compared with people of same age, level of difficulty learning things **‡‡**
* Compared with people of same age, level of difficulty remembering things **‡‡**

**Behavior**

* Compared with people of same age, level of difficulty controlling behavior **‡‡**
* Level of difficulty focusing on activity you enjoy **‡‡**
* Level of difficulty accepting changes in routine **‡‡**
* Level of difficulty making friends **‡‡**

**Depression and anxiety (PHQ-2 and GAD-2)**

* (Past 2 weeks) Frequency of…little interest or pleasure in doing things
* (Past 2 weeks) Frequency of…feeling down, depressed, hopeless
* (Past 2 weeks) Frequency of…feeling nervous, anxious, or on edge
* (Past 2 weeks) Frequency of…not being able to stop or control worrying

**Stressful life events / adverse childhood experiences**

* Ever victim of violence or witness any violence in neighborhood **‡§**
* Ever been separated from a parent or guardian because they went to jail, prison, or detention center **‡§**
* Ever live with anyone who was mentally ill or severely depressed **‡§**
* Ever live with anyone who had a problem with alcohol or drugs **‡§**
* Ever had a parent or guardian die
* Ever had a parent or guardian divorce or separate
* Ever lived with parent or guardian who frequently swore at you, insulted you, or put you down **‡§**
* Ever been a time when your basic needs were not met **‡§**
* Ever been treated or judged unfairly because of your race or ethnic group **§§**
* Ever been treated or judged unfairly because of your sexual orientation or gender identity **§§**

**Bullying**

* (Past 12 months) How often were you bullied, picked on, or excluded by others **§§**
* (Past 12 months) Been electronically bullied **§§**
* (Past 12 months) How often did you bully others, pick on them, or exclude them **§§**
* (Past 12 months) Electronically bulled others

**Everyday discrimination**

* How often are you treated with less courtesy or respect than other people your age
* At restaurants or stores, how often do you receive poorer service than other people your age
* How often do people act as if they think you are not smart

**Demographics**

* Hispanic origin **‡‡**
* Race **‡‡**
* Sexual orientation
* Sex at birth
* Gender identity
* School enrollment

**Survey environment**

* Type of device used to complete the survey
* Was survey completed at home
* Did anyone help you answer questions in the survey
* Was anyone else in the room when you completed the survey

**Experience with survey**

* How burdensome was this survey
* How easy or difficult was the survey
* How sensitive were the questions
* How would you describe the length of the survey