

SEED Follow-Up Studies: Second Follow-up Survey of Young Adults (Self-Report)

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A. Exit from High School

1. Thank you for taking this survey today. Before starting we would like to know if you are taking the survey by yourself or if you have someone in the room with you to help answer questions.
 I am completing the survey by myself
 Someone is in the room with me to help answer questions
2. When did you graduate or leave school? (This includes traditional high school, homeschool, or another school program).

Month	Year
_____	_____

)

3. What was the highest grade level you completed when you left school? (Check 12th grade if you recently graduated high school)

<input type="radio"/> Pre-school	<input type="radio"/> 7 th grade
<input type="radio"/> Kindergarten	<input type="radio"/> 8 th grade
<input type="radio"/> 1 st grade	<input type="radio"/> 9 th grade
<input type="radio"/> 2 nd grade	<input type="radio"/> 10 th grade
<input type="radio"/> 3 rd grade	<input type="radio"/> 11 th grade
<input type="radio"/> 4 th grade	<input type="radio"/> 12 th grade
<input type="radio"/> 5 th grade	<input type="radio"/> Don't know
<input type="radio"/> 6 th grade	<input type="radio"/> Does not apply, I did not attend a typical public or private school
<input type="radio"/> Other education, specify: _____ (e.g., 18-21-year-old program for eligible high school students)	

4. When you left school, did you...

- Receive a regular high school diploma
- Receive an occupational diploma
- Receive a certificate of completion
- Take a test and receive a GED
- Drop out or stop going
- Get expelled (or suspended but did not return)
- I did not attend high school
- Other reason for leaving high school, specify: _____

5. Since leaving school, have you attended a... (Check all that apply)

	No	Yes	If yes, did you graduate with...	No	Yes
2-year community college?	<input type="checkbox"/>	<input type="checkbox"/>	a diploma, certificate, or license?	<input type="checkbox"/>	<input type="checkbox"/>

vocational, business, or technical school?	<input type="checkbox"/>	<input type="checkbox"/>	a diploma, certificate, or license?	<input type="checkbox"/>	<input type="checkbox"/>
4-year college?	<input type="checkbox"/>	<input type="checkbox"/>	degree, certificate, or license?	<input type="checkbox"/>	<input type="checkbox"/>
graduate program (e.g., master's or doctoral program)?	<input type="checkbox"/>	<input type="checkbox"/>	advanced degree (e.g., master's or doctoral degree)	<input type="checkbox"/>	<input type="checkbox"/>

6. Are you currently enrolled in college?

No
 Yes, Part-time
 Yes, Full-time
 € Yes, but unsure whether part-time or full-time

B. Living Situation

1. Where do you currently live or what is your current living situation? (Check only one)

Live alone with some assistance
 Live alone with no assistance
 Live with spouse or roommate
 Live with parent(s) or foster parent(s)
 Live with an adult family member who is not a parent (e.g., sibling, aunt, uncle, cousin, etc.)

Specify relationship: _____

Live with a legal guardian who is not a family member
 Live in a group home within the community
 Live in a residential facility separated from the community
 Other living situation, specify (please print): _____

C. Daily Activities and Social Participation

The next questions are about activities you may have participated in since leaving school.

1. Since leaving school, have you participated in:

	Yes	No	Don't know
A sports team or taken sport lessons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any clubs or organizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other organized activities or lessons, such as music, dance or language?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any type of community service or volunteer work at school, church, or in the community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any work, including regular jobs as well as babysitting, cutting grass, or other occasional work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Since leaving school, how often do you usually do the following:

	Never	At least once	Every other month	Monthly	Weekly	Daily
Get together socially with friends or neighbors?	<input type="checkbox"/>					
Call or text friends on the phone?	<input type="checkbox"/>					
Use email, instant messaging, Skype, texting, Facebook/Instagram/Snapchat messaging or taken part in chat rooms?	<input type="checkbox"/>					
Gotten together with ANY relatives, not including those who live with you?	<input type="checkbox"/>					
Gone to church, temple, or another place of worship for services or other activities?	<input type="checkbox"/>					
Gone to a show or movie, sports events, club meeting, or another group event?	<input type="checkbox"/>					
Gone out to eat at a restaurant?	<input type="checkbox"/>					

3. DURING THE PAST MONTH, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? *This may include sports, exercise, and brisk walking or cycling for recreation or to get to and from places but should not include housework or physical activity that may be part of your job.*

Number of days of exercise during the past month: _____

4. ON AN AVERAGE WEEKDAY, about how much time do you usually spend in front of a TV watching TV programs or movies, including streaming services such as Netflix, Hulu, Disney+, Apple TV, etc.?

- None
- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours
- I don't know

5. ON AN AVERAGE WEEKDAY, about how much time do you usually spend with computers, tablets, cell phones, handheld video games, and other electronic devices, doing things other than schoolwork or watching videos on YouTube/TikTok, TV shows, or movies?

- None
- Less than 1 hour
- 1 hour
- 2 hours

- 3 hours
- 4 or more hours
- I don't know

D. Vocational Support and Training

The next questions are about services or training you may have received after leaving school to help you find and/or keep a job.

1. After you exited school, did you receive any of the following services? (Check all that apply)

	Service	Yes	No	Don't know
a.	Testing to find out your work interests or abilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Training in specific job skills, for example food services, computer skills, or training for another kind of job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Training in basic skills needed for work, like counting change, telling time, or using transportation to get to work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Career counseling, like help in figuring out jobs that might best suit you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Help in learning how to search for available job positions online, write a resume, or prepare for a job interview.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Job shadowing, such as visiting a workplace and watching the way a job is done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Apprenticeships or internships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Other services or training? Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you think you need job training or additional training that is not being provided now?

- € Yes
- € No (Skip to Section E)
- € Don't know (Skip to Section E)

3. Do you think you are getting enough job or career training?

- Yes
- No
- Don't know

4. How useful do you think job or career training is in helping you get a job?

- Very useful
- Somewhat useful
- Not very useful
- Not at all useful

Don't know

5. What other kinds of job training or help do you think you need? (Check all that apply)

<input type="checkbox"/>	Testing to find out your work interests or abilities
<input type="checkbox"/>	Training in specific job skills, for example food services, computer skills, or training for another kind of job
<input type="checkbox"/>	Training in basic skills needed for work like counting change, telling time, or using transportation to get to work
<input type="checkbox"/>	Career counseling like help in figuring out jobs you might be suited to
<input type="checkbox"/>	Help in finding or applying for a job such as learning how to search for available job positions online, write a resume, or prepare for a job interview
<input type="checkbox"/>	Job shadowing, visiting a workplace and watching the way the job is done
<input type="checkbox"/>	Apprenticeships or internships
<input type="checkbox"/>	Other training, specify: _____
<input type="checkbox"/>	Don't know

E. Job and Work Experience

The next questions are about work you were paid for since leaving school.

1. At any time since leaving school have you worked for pay other than work around the house?
 Yes (**Skip to question 3**)
 No
2. You have told us you are not currently working for pay. Please help us understand your situation.
Check all that apply then skip to question 1 in Section F.

<input type="checkbox"/>	Want to work but can't find work
<input type="checkbox"/>	Have tried to work but faced discrimination or other difficulties with employers because of a disability
<input type="checkbox"/>	Do not wish to work at present (taking care of family members, a stay-at-home parent, etc.)
<input type="checkbox"/>	Not able to work because it would interfere with federal or state benefits (such as disability payments)
<input type="checkbox"/>	Not able to work because the workplace would be too challenging (because of ASD or other health or mental health issues)
<input type="checkbox"/>	Have an unpaid internship or volunteer position
<input type="checkbox"/>	Full-time or part-time college student
<input type="checkbox"/>	Other reason for not currently working for pay, specify: _____

3. What is the longest time you have worked at a particular job since leaving school?
4. For your current or most recent job, how many hours per week do/did you work on average?
 1 - 9 hours
 10 - 19 hours
 20 - 29 hours
 30 - 39 hours
 40 or more hours
5. If you work(ed) part-time, or less than 40 hours per week at your current or most recent job, do you work part-time because you want to, or would you rather work full-time?
 Does not apply, I work(ed) full time
 I want to work part-time
 I would rather work full-time
 Other reason for working part-time, specify: _____

6. For your current or most recent job, about how much are/were you paid per hour, per month, or per year at this job?

\$ _____ per hour OR \$ _____ per month OR \$ _____ per year

7. Did you receive benefits from this job? (Check all that apply)

- Health Insurance
- Vacation/Sick leave
- Retirement account
- Other insurance (e.g., disability, life, dental, vision)
- Tuition assistance
- Other, specify: _____
- None

8. For your current or most recent job, what was the work situation? (Check one situation that best describes your current or most recent job)

<input type="checkbox"/>	_____
<input type="checkbox"/>	Regular paid employment (with no help or support)
<input type="checkbox"/>	Supported employment (you may have a job coach or other special help at work)
<input type="checkbox"/>	Work in a business with a group of other people with special needs, all under supervision of an agency serving people with disabilities
<input type="checkbox"/>	Day program that includes paid work
<input type="checkbox"/>	Paid internship or work study program
<input type="checkbox"/>	Other work situation, specify: _____

9. How satisfied are you with the work situation at your current or most recent job?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

10. For your current or most recent job, what is the job title?

Job Title: _____

11. Did you find your current or most recent job yourself or did you have help?

- Found the job on my own
- Found the job with help from an agency (e.g., a job coach or vocational rehab)

Found the job with help from a family member or friend?

Other person, specify: _____

12. Have you ever applied for any accommodations or supports to help you keep a job?

Yes, applied and received job accommodations and/or supports

Yes, applied but did NOT receive job accommodations and/or supports (**Skip to question 1 in Section F**)

No, never applied for job accommodations or supports (**Skip to question 1 in Section F**)

13. If you have ever received accommodations or supports to help maintain employment, how useful were these services?

Not useful at all (i.e., did not provide any additional advantage keeping job)

Slightly useful (i.e., helped a little for keeping job)

Useful (i.e., helped a good deal for keeping job)

Very useful (i.e., made the difference between keeping or losing a job)

F. Financial Support

1. How much do you rely on your family (such as parents and siblings) for financial support such as paying your bills, housing, transportation, spending money for entertainment, or other financial?
 My family **does not provide** any financial support for me at all.
 My family provides **less than half** of my financial support. They help me financially sometimes.
 My family provides **about half** of my financial support.
 My family provides **more than half** (but not all) of my financial support.
 My family provides **all** my financial support.
2. What federal or state benefits do you currently receive? (Check all that apply or "none" if none apply)

Social Security Disability Insurance (SSDI)	<input type="checkbox"/>
Supplemental Security Income (SSI)	<input type="checkbox"/>
State disability programs that use only state and/or local funds	<input type="checkbox"/>
Medicaid (for health insurance)	<input type="checkbox"/>
Medicare	<input type="checkbox"/>
Medicaid HCBS (Home and Community Based Services) waiver or Developmental Disability waiver	<input type="checkbox"/>
Employment assistance or job support (sometimes called "Vocational Rehabilitation" or "VR")	<input type="checkbox"/>
Section 8 Housing	<input type="checkbox"/>
Transportation services for people with disabilities	<input type="checkbox"/>
Other federal or state benefits, specify: _____	<input type="checkbox"/>
None	<input type="checkbox"/>

G. Health, Mental Health, & Health Care Service Use and Need

The next questions ask you for information about your mental health, suicide and sexual activity, along with other health care services you may have used or needed. You can skip any questions that make you feel uncomfortable. Your responses will be kept private and will not be shared with anyone.

1. Which of the following best describes your general health? Please mark ONE Box.

- Excellent
- Very good
- Good
- Fair
- Poor

2. OVER THE LAST 2 WEEKS, how often have you been bothered by the following problems?

Feeling anxious, nervous, or on-edge.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days	<input type="checkbox"/> Nearly every day
Not being able to stop or control worrying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. OVER THE LAST 2 WEEKS, how often have you been bothered by the following problems?

	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days	<input type="checkbox"/> Nearly every day
Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you ever seriously thought about committing suicide?

- Yes
- No

5. Have you ever made a plan for committing suicide?

- Yes
- No

6. Have you ever attempted suicide?

- Yes
- No

If you are having thoughts about suicide, please contact the National Suicide Prevention Lifeline by calling 1-800-273-8255 or texting 988

7. Since leaving school, was there any time when you needed health care, but you did not receive it? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.

Yes

No (**Skip to question 10**)

8. If yes, which types of care were NOT received? (Check *ALL that apply*)

Dental Care

Hearing Care

Medical care, routine preventative

Medical care, sick or urgent care

Medical care, hospital emergency

Medical care, specialist

Medical services for diagnosis or evaluation related to a disability

Mental Health Services, counseling, or psychological services

Vision Care

Other healthcare needed, specify: _____

9. Which of the following contributed to you not receiving needed health care services:

	Yes	No
I did not have health insurance that covered the services needed	<input type="checkbox"/>	<input type="checkbox"/>
I was not eligible for the services	<input type="checkbox"/>	<input type="checkbox"/>
The services I needed were not available in my area	<input type="checkbox"/>	<input type="checkbox"/>
There were problems getting an appointment when I needed one	<input type="checkbox"/>	<input type="checkbox"/>
There were problems with getting transportation	<input type="checkbox"/>	<input type="checkbox"/>
The (clinic/doctor's) office wasn't open when I needed care	<input type="checkbox"/>	<input type="checkbox"/>
There were issues related to cost	<input type="checkbox"/>	<input type="checkbox"/>
There were issues related to COVID-19 (e.g., concerned about being around others at doctor's office who may have been exposed to COVID-19)	<input type="checkbox"/>	<input type="checkbox"/>
Other reasons, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

10. DURING THE PAST 12 MONTHS, have you had a chance to visit or speak with a doctor or other health care provider alone or privately, without your parents or another adult in the room?

Yes

No

11. During any visit in the past 12 months did a doctor or other health care provider ask you if you were sexually active?

Yes

No

Don't remember

If you were born female, please answer the next two questions, then **skip to question 1 in Section H**.

If you were born male, **skip to question 14**.

12. DURING THE PAST 12 MONTHS, did you receive any of the following services from a doctor or health care provider?

- Information or advice about birth control
- A method of birth control or a prescription for birth control
- Information or advice about other sexually transmitted diseases (STDs), such as gonorrhea, chlamydia, syphilis, herpes, HIV, AIDS, or HPV
- Testing for STDs
- Treatment for STDs
- Information or advice about using condoms to prevent STDs
- None of the above

13. Have you ever received:

- A Pap test - where a doctor or nurse put an instrument in the vagina and took a sample to check for abnormal cells that could turn into cervical cancer?
- An HPV test - where a doctor or nurse put an instrument in the vagina and took a sample to test for the HPV virus?
- The cervical cancer vaccine, also known as the HPV shot, Cervarix, or Gardasil?
- None of the above

If you were born male, please answer the question below, then **skip to question 1 in Section H.**

14. DURING THE PAST 12 MONTHS, did you receive any of the following services from a doctor or health care provider?

- Information or advice about your partner using methods of birth control
- Information or advice about HIV or AIDS
- Information or advice about other sexually transmitted diseases (STDs), such as gonorrhea, chlamydia, syphilis, herpes or AIDS, HPV
- Testing for STDs
- Treatment for STDs
- Information or advice about using condoms to prevent STDs
- Information or advice about using condoms to prevent pregnancy
- None of the above

H. Educational & Developmental Services

The next questions are about educational and developmental services you may have received since leaving school.

1. Since leaving school, have you received any of the services listed in the table below? Do not include services/help received from family or friends.

	Yes, received after leaving school	No, did not receive after leaving school	If no, did you <u>need</u> this service?
Financial aid, like paying for college classes or training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Educational assistance or tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reader or interpreter, such as a sign language interpreter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independent living or occupational therapy (like help with doing things such as managing money, cooking, or housekeeping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Childcare services or parenting skills training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social work services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Devices or assistive technology services (like a special calculator, reading machine, or communication device)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other services, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Overall, how satisfied have you been with all services you have received since leaving school?
 Very dissatisfied
 Dissatisfied
 Neither satisfied nor dissatisfied
 Satisfied
 Very Satisfied

I. Romantic Relationships and Sexual Orientation

The next questions are about romantic relationships and sexual orientation. You can skip any questions that make you feel uncomfortable. Your responses will be kept private and will not be shared with anyone.

1. Which of the following best describes how you think of yourself?
 Heterosexual or straight (attracted to people of the opposite sex)
 Gay or lesbian (attracted to people of the same sex)
 Bisexual (attracted to people of both sexes)
 Asexual (not sexually attracted to other people)
 I describe my sexual identity some other way
 I am not sure about my sexual identity (questioning)
 I do not know what this question is asking

2. Have you ever been in a relationship with a romantic partner?
 Yes
 No

3. Are you currently dating or in a relationship with a romantic partner?
 Yes (Skip to question 1 in Section J)
 No

4. How much would you like to have a romantic relationship in the next year?
 Not at all
 Very little
 Somewhat
 Quite a bit
 Very much

J. Sex Education and Behavior

The next few questions are about your sexual education and behavior. You can skip any questions that make you feel uncomfortable. Your responses to these questions will be kept private and will not be shared with anyone.

1. Please tell me where you received any sex education or information on the following topics (check all that apply).

	School	Church	Community Center	Doctor's office	Health Center	Friends	Parents /Family	Online, Internet	Never have received instruction or information on this topic
How to say no to sex	<input type="checkbox"/>								
Methods of birth control	<input type="checkbox"/>								

Where to get birth control	<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 diseases (STDs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to prevent HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to use a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some other type of education or information	Please specify type of education/information and place received:							

2. Have you ever had sex, either with a same or opposite sex partner (this includes having oral, anal, or vaginal sex)?

Yes
 No (**Skip to question 7**)

3. The **last time** you had sex with a partner, what method or methods did you or your partner use to prevent pregnancy and/or sexually transmitted diseases (STDs)? (*Check all that apply*)

No method was used to prevent pregnancy or STDs
 Birth control pills (Do **not** count emergency contraception such as Plan B or the "morning after" pill.)
 Condoms
 An intrauterine device (IUD, such as Mirena or ParaGard) or implant (such as Implanon or Nexplanon)
 A shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing)
 Withdrawal
 Some other method
 Not sure
 Other methods, specify: _____

4. Did you drink alcohol or use drugs before you had sex the last time with any partner (same or opposite sex)?

Yes
 No

5. How old were you when you had sex for the first time with any partner (same or opposite sex)?

Less than 15 years old
 15 to 17 years old
 18 years old or older

6. DURING THE LAST 12 MONTHS, with how many people did you have sex (same or opposite sex)?

I have had sex, but not during the past 12 months
 1 person
 2 to 3 people

4 or more people

1. Has anyone ever forced you to do sexual things that you did not want to do? *Examples might include unwanted kissing or touching, physical pressure (being hit, slammed into something, or injured with an object or weapon) or non-physical pressure (verbal pressure, threats of harm, or by being given alcohol or drugs)*

Yes

No

Prefer not to say

Please contact the National Sexual Assault Hotline by calling 800-656-4673 if you are experiencing sexual assault or sexual harassment.

K. Substance Use and Behaviors

The next question asks about substance use. You can skip any questions that make you feel uncomfortable. Your responses to these questions will be kept private and will not be shared with anyone.

1. Think about the statement, "**I did too much.**" IN THE LAST 12 MONTHS, how often did this apply to your...

<input type="checkbox"/>	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Never used or N/A
Alcohol use	<input type="checkbox"/>					
Tobacco or Nicotine use	<input type="checkbox"/>					
Cannabis/marijuana use	<input type="checkbox"/>					
Cocaine use	<input type="checkbox"/>					
Opioid use	<input type="checkbox"/>					
Gambling	<input type="checkbox"/>					
Shopping	<input type="checkbox"/>					
Video gaming	<input type="checkbox"/>					
Over-eating	<input type="checkbox"/>					
Sexual activity	<input type="checkbox"/>					
Over-working	<input type="checkbox"/>					

L. Beliefs & Interests

1. While some of these questions will use words such as "spirituality" please answer them in terms of your own personal belief system, whether it be religious, spiritual or personal.

	Not at all	A little	A moderate amount	A lot	An extreme amount
<input type="checkbox"/> To what extent does any connection to a spiritual being or force help you to get through hard times?	<input type="checkbox"/>				
To what extent does any connection to a spiritual being or force help you to tolerate stress?	<input type="checkbox"/>				
To what extent does any connection to a spiritual being or force help you to understand others?	<input type="checkbox"/>				
To what extent does any connection to a spiritual being or force provide you with comfort / reassurance?	<input type="checkbox"/>				

2. What particular abilities or strengths do you have? *Check all that apply or "none of the above" if none apply.*

An ability to think in unusual, creative ways
 An ability to focus intensely on certain topics
 Honesty
 A sense of justice
 A different way of experiencing the world
 Ability in mathematics or science
 An ability using technology or computers
 Ability in art or music
 A very good memory for certain topics
 An ability to focus on small details
 An incredible imagination
 Kindness
 Other abilities or strengths, specify: _____
 None of the above

3. Do you have an intense area of interest or focus? (Sometimes this is referred to as a "special interest")

No (**If no, skip questions 4 and 5**)
 Yes

4. What type of special interest or topic do you have? *Check all that apply if you have more than one.*

- Modes of transportation (such as trains, automobiles, aircraft)
- History
- Science (such as astronomy, geology)
- Science fiction or fantasy (in books, films, video games)
- Computers
- Mathematics or numbers
- Animals (such as dogs, fish, horses)
- Movies
- Cartoons or anime
- Maps, calendars, or dates
- Timetables or schedules
- Dinosaurs, monsters, or fictional creatures
- Music
- Art
- Sports
- Sewing or crafts
- Other interests, specify: _____

5. How does your special interest affect your life? *Check all that apply or "none of the above" if none apply.*

- My job or career involves my special interest.
- My studies in school or college are (or were) related to my special interest.
- I have relationships based on my special interest. I make friends or join groups focused on the same interest.
- I enjoy activities and hobbies relating to my special interest.
- My special interest sometimes gets in the way of success at work, school, or in relationships.
- The special interest has gotten me in trouble. (For example, it may have led to addictive behavior or breaking the law.)
- Other affects, specify: _____
- None of the above