



29/03/96

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STUDY

PARTNER'S

QUESTIONNAIRE

This questionnaire asks about your lifestyle and the role you have in bringing up a child and any problems you have.

It asks you a number of questions. To answer please tick the box which is most accurate in your opinion.

Please answer all questions if you can, even if some are similar to those you may have answered before. If you cannot answer a question or if it does not apply to you, put a line through it. There are no good or bad answers. Just tell us what you think.

All answers are confidential

THANK YOU FOR YOUR HELP

29/03/96

Recycled paper

SECTION A: YOUR HEALTH

A1. Which of the following would you say describes your health now?

fit and well	<div>1</div>
mostly well and healthy	<div>2</div>
often feel unwell	<div>3</div>
hardly ever feel well	<div>4</div>

A2. Have you had any of the following in the past year (since your study child was 4 years old)?

In past year:	Yes and consulted doctor	Yes but did not consult doctor	No ↓
a) anxiety or 'nerves'	<div>1</div>	<div>2</div>	<div>3</div>
b) depression	<div>1</div>	<div>2</div>	<div>3</div>
c) headache or migraine	<div>1</div>	<div>2</div>	<div>3</div>
d) epilepsy	<div>1</div>	<div>2</div>	<div>3</div>
e) back pain, sciatica, slipped disc	<div>1</div>	<div>2</div>	<div>3</div>
f) indigestion	<div>1</div>	<div>2</div>	<div>3</div>
g) high blood pressure	<div>1</div>	<div>2</div>	<div>3</div>
h) cough or cold	<div>1</div>	<div>2</div>	<div>3</div>
i) diabetes	<div>1</div>	<div>2</div>	<div>3</div>
j) haemorrhoids/piles	<div>1</div>	<div>2</div>	<div>3</div>
k) schizophrenia	<div>1</div>	<div>2</div>	<div>3</div>
l) influenza	<div>1</div>	<div>2</div>	<div>3</div>

A2. (cont.)

In the past year:	Yes and consulted doctor	Yes but did not consult doctor	No ↓
m) alcohol problem	<div>1</div>	<div>2</div>	<div>3</div>
n) wheezing or asthma	<div>1</div>	<div>2</div>	<div>3</div>
o) bronchitis	<div>1</div>	<div>2</div>	<div>3</div>
p) stomach ulcer	<div>1</div>	<div>2</div>	<div>3</div>
q) eczema	<div>1</div>	<div>2</div>	<div>3</div>
r) psoriasis	<div>1</div>	<div>2</div>	<div>3</div>
s) arthritis	<div>1</div>	<div>2</div>	<div>3</div>
t) rheumatism	<div>1</div>	<div>2</div>	<div>3</div>
u) urinary infection	<div>1</div>	<div>2</div>	<div>3</div>
v) syphilis	<div>1</div>	<div>2</div>	<div>3</div>
w) gonorrhoea	<div>1</div>	<div>2</div>	<div>3</div>
x) other problems (please tick & describe)	<div>1</div>	<div>2</div>	<div>3</div>

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A3. **In the past year** how often have you taken the following?

	Every day	Often	Sometimes	Not at all
a) sleeping pills	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) vitamins	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) cannabis/marihuana	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) tranquillisers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) pills for depression	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) hormone tablets	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g) antibiotics	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) aspirin	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) paracetamol	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) other painkillers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) amphetamines or other stimulants	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l) iron	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m) heroin, methadone, crack, cocaine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n) anticonvulsants	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) steroids	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

other pill, medicine, drug or treatment (please describe each and state how frequently taken)

p)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
q)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
r)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

A4. Please list all the drugs, medicines and ointments that you have taken or used **in the past month:**

For office use

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What did you take:	About how many days did you take or use it?	How often per day?
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Check

Have you included iron tablets, laxatives, vitamins, sleeping tablets, aspirin, cough mixture, pain killers, herbal medicine, and homeopathic remedies?

A5. a) Since your study child was 4 years old have you had to go and stay in hospital?

Yes No → If **no**, go to A6 below

If **yes**,

b) how many times?

c) for how many different reasons?

Reason for each hospital stay:

How long did you stay?

d)	<input type="text"/> <input type="text"/>	nights
e)	<input type="text"/> <input type="text"/>	nights
f)	<input type="text"/> <input type="text"/>	nights
g)	<input type="text"/> <input type="text"/>	nights
h)	<input type="text"/> <input type="text"/>	nights

A6. In the past month, how often have you had any of the following:

In the past month:	Almost all the time	Sometimes	Once	Not at all
a) backache	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) headache or migraine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) urinary infection	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) nausea	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) vomiting	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) diarrhoea	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g) haemorrhoids or piles	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

A6. (cont.)

In the past month:	Almost all the time	Sometimes	Once	Not at all
h) feeling weepy/tearful	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) feeling irritable	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) feeling exhausted	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) varicose veins	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l) passing urine very often	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m) problem holding urine when you jump, sneeze etc.	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n) indigestion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) feeling dizzy/fainting	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
p) flashing lights/spots before eyes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
q) shoulder ache	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
r) tingling in hands/fingers	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
s) tingling in feet/toes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
t) neck ache	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
u) feeling depressed	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
v) pain in your knee(s)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
w) other problem (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

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A7. a) Have you ever had pain in one or both of your knees lasting for at least a month?

Yes, one Yes, both No → If no, go to A8 below

If yes,

b) about how old were you when this first happened?

Less than 10 10-13 14-16 17-19 20 or more

c) Have you had pain in your knees in the past month?

Yes No

A8. a) How often are you having sexual intercourse now?

not at all	<input type="text" value="1"/>
less than once a month	<input type="text" value="2"/>
1-3 times a month	<input type="text" value="3"/>
about once a week	<input type="text" value="4"/>
2-4 times a week	<input type="text" value="5"/>
5 or more times a week	<input type="text" value="6"/>

b) In general, do you enjoy it?

yes, very much	<input type="text" value="1"/>
yes, somewhat	<input type="text" value="2"/>
no, not a lot	<input type="text" value="3"/>
no, not at all	<input type="text" value="4"/>
no sex at the moment	<input type="text" value="5"/>

SECTION B: YOUR OPINION OF YOURSELF

Below are some statements. Please say how true they are of you.

		Almost always	Often true	Sometimes true	Seldom true	Never true
B1.	I feel that I am a person of worth, at least equal to others.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B2.	I feel I have a number of good qualities.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B3.	I am able to do things as well as most other people.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B4.	I feel I do not have much to be proud of.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B5.	I take a positive attitude towards myself.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B6.	Sometimes I think I am no good at all.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B7.	I am a useful person to have around.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B8.	I feel I cannot do anything right.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B9.	When I do a job I do it well.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B10.	I feel that my life is not very useful.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
B11.	I am unlucky.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

SECTION C: YOUR FEELINGS

The questions in this section ask you about your feelings and the way you behave. You have answered these questions in other questionnaires, but you might be feeling differently now.

Please indicate the way you feel.

		Very often	Often	Not very often	Never
C1.	Do you feel upset for no obvious reason?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C2.	Do you get troubled by dizziness or shortness of breath?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C3.	Have you felt as though you might faint?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C4.	Do you feel sick or have indigestion?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C5.	Do you feel that life is too much effort?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C6.	Do you feel uneasy and restless?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C7.	Do you feel tingling or prickling sensations in your body, arms or legs?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C8.	Do you regret much of your past behaviour?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C9.	Do you sometimes feel panicky?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C10.	Do you find that you have little or no appetite?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C11.	Do you wake unusually early in the morning even when you haven't been woken by your children?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C12.	Do you worry a lot?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

		Very often	Often	Not very often	Never
C13.	Do you feel tired or exhausted?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C14.	Do you experience long periods of sadness?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C15.	Do you feel strung-up inside?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C16.	Can you go to sleep all right?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C17.	Do you ever have the feeling you are going to pieces?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C18.	Do you often have excessive sweating or fluttering of the heart?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C19.	Do you find yourself needing to cry?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C20.	Do you have bad dreams which upset you when you wake up?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C21.	Do you lose the ability to feel sympathy for others?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C22.	Can you think as quickly as you used to?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
C23.	Do you have to make a special effort to face up to a crisis or difficulty?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

Your feelings in the past week.

C24. I have been able to laugh and see the funny side of things:

As much as I always could	1
Not quite so much now	2
Definitely not so much now	3
Not at all	4

C25. I have looked forward with enjoyment to things:

As much as I ever did	1
Rather less than I used to	2
Definitely less than I used to	3
Hardly at all	4

C26. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time	1
Yes, some of the time	2
Not very often	3
Never	4

C27. I have been anxious or worried for no good reason:

No, not at all	1
Hardly ever	2
Yes, sometimes	3
Yes, often	4

In the past week:

C28. I have felt scared or panicky for no good reason:

Yes, quite a lot

1

Yes, sometimes

2

No, not much

3

No, not at all

4

C29. Things have been getting on top of me:

Yes, most of the time I haven't been able to cope

1

Yes, sometimes I haven't been coping as well as usual

2

No, most of the time I have coped quite well

3

No, I have been coping as well as ever

4

C30. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time

1

Yes, sometimes

2

Not very often

3

No, not at all

4

C31. I have felt sad or miserable:

Yes, most of the time

1

Yes, quite often

2

Not very often

3

No, not at all

4

In the past week:

C32. I have been so unhappy that I have been crying:

Yes, most of the time

1

Yes, quite often

2

Only occasionally

3

Never

4

C33. The thought of harming myself has occurred to me:

Yes, quite often

1

Sometimes

2

Hardly ever

3

Never

4

C34. On the whole are there more good days than bad?

Yes, more good days

1

About half and half

2

No, more bad days

3

SECTION D: RECENT EVENTS

Listed below are a number of events which may have brought changes in your life. Have any of the these occurred in the past year (since your study child was 4). If so, please assess how much effect it had on you.

	Yes & affected me a lot	Yes, moderately affected	Yes, mildly affected	Yes, but did not affect me at all	No did not happen
In the past year:					
D1. Your partner died	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D2. One of your children died	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D3. A friend or relative died	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D4. One of your children was ill	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D5. Your partner was ill	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D6. A friend or relative was ill	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D7. You were admitted to hospital	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D8. You were in trouble with the law	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D9. You were divorced	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D10. You found that your partner didn't want your child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D11. You were very ill	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
D12. Your partner lost her job	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

		Yes & affected me a lot	Yes, moderately affected	Yes, mildly affected	Yes, but did not affect me at all	No did not happen
In the past year:						
D13.	Your partner had problems at work	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D14.	You had problems at work	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D15.	You lost your job	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D16.	Your partner went away	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D17.	Your partner was in trouble with the law	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D18.	You and your partner separated	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D19.	Your income was reduced	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D20.	You argued with your partner	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D21.	You argued with your family and friends	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D22.	You moved house	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D23.	Your partner was physically cruel to you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D24.	You became homeless	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D25.	You had a major financial problem	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D26.	You got married	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

		Yes & affected me a lot	Yes, moderately affected	Yes, mildly affected	Yes, but did not affect me at all	No did not happen
In the past year:						
D27.	Your partner was physically cruel to your children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D28.	You were physically cruel to your children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D29.	You attempted suicide	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D30.	You were convicted of an offence	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D31.	Your partner became pregnant	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D32.	You started a new job	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D33.	Your partner had a miscarriage	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D34.	Your partner had an abortion	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D35.	You took an examination	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D36.	Your partner was emotionally cruel to you	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D37.	Your partner was emotionally cruel to your children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D38.	You were emotionally cruel to your children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D39.	Your house or car was burgled	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

		Yes & affected me a lot	Yes, moderately affected	Yes, mildly affected	Yes, but did not affect me at all	No did not happen
In the past year:						
D40.	Your partner started a new job	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D41.	A pet died	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
D42.	You had an accident (please tick & describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

.....

D43. a) Is there anything else which is not on the list which has concerned you or required additional effort from you to cope in the last year?

Yes

1

 No

2

 → **If no, go to Section E on page 19**

If yes, b) please describe:

.....

c) How did this affect you?

a lot	<div>1</div>
moderately	<div>2</div>
mildly	<div>3</div>
not at all	<div>4</div>

SECTION E: YOUR OCCUPATION AND LIFESTYLE

E1. a) In the last year have you worked at all?

no

→ If **no**, go to Question E7 on page 22

yes, paid work at home

yes, paid work outside home

yes, paid work both at home and outside home

If **yes**,

b) how old was this study child when you started your most recent job?

years

months

(If started before the child was born put 0 00)

c) are you still working?

Yes

No

month

199

Now go to E7
→ on page 22

If **no**, i) when did you finish?

If **yes**, ii) how many jobs are you now doing?

d) As far as you can, please describe your actual job, occupation, trade or profession. (Use precise terms such as radio mechanic, woodworking machinist, toolroom foreman. If the occupation is known by a special name, please use that name. If in HM Forces, give the rank in addition to the actual job. Please also describe the type of industry or service given: i.e. give details of what is made, materials used, or services given).

Your present job or last main job.

i) Actual job, occupation, trade or profession

.....

.....

.....

E1d ii) Please tick which of the following apply to you:

foreman	<input type="checkbox"/>
manager	<input type="checkbox"/>
supervisor	<input type="checkbox"/>
leading hand	<input type="checkbox"/>
self-employed	<input type="checkbox"/>
none of these	<input type="checkbox"/>

iii) Type of industry or service given (main things done in job):

.....

e) How many hours a week altogether do you now work? hours

i) Does this include weekends ?

Yes ☐ No ☐ Sometimes ☐

ii) Do you work in the evenings or at night ?

Yes ☐ No ☐ Sometimes ☐

f) How would you describe the physical effort you need for your current job(s)?

very little effort, mostly sitting	<input type="checkbox"/>
some physical effort	<input type="checkbox"/>
quite a lot of physical effort	<input type="checkbox"/>
considerable physical effort	<input type="checkbox"/>

E2. Are you working at the same status as you were 5 years ago?

no, lower level

yes, same level

no, higher level

didn't work 5 years ago

E3. Do you find your job satisfying?

Yes

No

Sometimes

E4. a) How do you usually travel to work? (Tick all that apply)

Yes

No

Work at home

i) public transport (bus, train)

→ Go to E8 on page 23

ii) car

iii) cycle

iv) walk

v) other

E4. b) How long does it usually take:

**Less than
15 mins**

**15-29
mins**

**30-59
mins**

**An hour
or more**

i) to travel to work

ii) to travel home from work

E5. Below are statements about how working affects being a parent.
Please indicate which is true for you:

		Yes almost always	Yes often	Not very often	Never
a)	I enjoy seeing my child after work	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b)	After a day working I find it hard to cope with a young child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

E6. a) Do you worry about your study child when you are at work?

Yes Yes, sometimes No

b) Does he/she make a fuss when you leave him/her?

Yes No

If you are not working:

E7. a) Have you chosen not to work so that you can stay at home with your child?

No Yes → **If yes, go to E8 on page 23**

If no,

b) Have you been looking for work? Yes No → **If no, go to E8 on page 23**

c) How long have you been seeking work? months

E8. a) Please list all previous paid jobs since the day the study child was born:

Job done	Hours/ week (average)	Month started	Year started	Month finished	Year finished
1.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>
2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>
3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>
4.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>
5.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>	<input type="text"/> <input type="text"/>	199 <input type="text"/>

b) Did any of these jobs involve working at weekends?

Yes ₁ No ₂ → If **no**, go to E8d below

c) If **yes**, which ones? (Tick all that apply)

Job No.				
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d) Did any of these jobs involve working in the evenings or at nights?

Yes ₁ No ₂

e) If **yes**, which ones? (Tick all that apply)

Job No.				
1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E9. How many cigarettes per day do you currently smoke?

30+ <input type="text"/> 30	25-29 <input type="text"/> 25	20-24 <input type="text"/> 20	15-19 <input type="text"/> 15
10-14 <input type="text"/> 10	5-9 <input type="text"/> 05	1-4 <input type="text"/> 01	none <input type="text"/> 00
pipe only <input type="text"/> 08	cigars only <input type="text"/> 09		

E10. a) How much alcohol do you drink?

never drink alcohol

very occasionally (less than once a week)

occasionally (at least once a week)

drink 1-2 glasses* nearly every day

drink 3-9 glasses* every day

drink at least 10 glasses* a day

(* by glass we mean a pub measure (1oz) of spirits, half a pint ($\frac{1}{2}$ litre) of lager or cider, a wine glass of wine, etc.)

b) How many days in the past month do you think you had the equivalent of at least 2 pints of beer, 4 glasses of wine or 4 pub measures of spirit?

every day

more than 10 days

5-10 days

3-4 days

1-2 days

none

c) Do you or your partner make your own alcoholic drinks?

Yes

No

i) wine

ii) beer

iii) spirits

E11. How difficult at the moment do you find it to afford these items:

		Very difficult	Fairly difficult	Slightly difficult	Not difficult	Paid directly by Social Security
a)	food	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<div>↓</div> <input type="text" value="5"/> <input type="text" value="5"/>
b)	clothing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
c)	heating	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
d)	rent or mortgage	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
e)	things you need for your children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
f)	costs of educational courses (e.g. music, sport, etc)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
g)	medical care	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
h)	your spare time activities	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
i)	something else (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>		

.....

E12. How many hours sleep do you get altogether now?

		None	1-3 hours	4-5 hours	6-7 hours	More than 7 hours
a)	during an average night	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
b)	during an average day	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
c)	Do you feel that you are getting enough sleep?					
	Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>		

E13. a) Do you believe in God or in some divine power?

Yes Am not sure No, not at all

b) Do you feel that God (or some divine power) has helped you at any time?

Yes Not sure No

c) Would you appeal to God for help if you were in trouble?

Yes Not sure No

d) What sort of religious faith would you say you had? (tick one only)

Church of England	<input type="text" value="01"/>	Roman Catholic	<input type="text" value="02"/>
Jehovah's Witness	<input type="text" value="03"/>	Christian Science	<input type="text" value="04"/>
Mormon	<input type="text" value="05"/>	Other Christian (please describe)	<input type="text" value="06"/>

.....

Jewish	<input type="text" value="07"/>	Buddhist	<input type="text" value="08"/>
Sikh	<input type="text" value="09"/>	Hindu	<input type="text" value="10"/>
Muslim	<input type="text" value="11"/>	Rastafarian	<input type="text" value="12"/>
None	<input type="text" value="00"/>	Other (please describe)	<input type="text" value="13"/>

.....

E13. e) How long have you had this particular faith?

all my life	<input type="text" value="1"/>
more than 5 years	<input type="text" value="2"/>
3-5 years	<input type="text" value="3"/>
1-2 years	<input type="text" value="4"/>
less than a year	<input type="text" value="5"/>

E13. f) Do you go to a place of worship?

yes, at least once a week	<input type="text" value="1"/>
yes, at least once a month	<input type="text" value="2"/>
yes, at least once a year	<input type="text" value="3"/>
no, not at all	<input type="text" value="4"/>

g) Do you obtain help and support from leaders or others members of religious groups?

Help from:	Yes	No
i) Leaders of your religious group (e.g. priests, rabbis, imams)	<input type="text" value="1"/>	<input type="text" value="2"/>
ii) Other members of <u>your</u> religious group	<input type="text" value="1"/>	<input type="text" value="2"/>
iii) Members of other religious group(s) (please describe)	<input type="text" value="1"/>	<input type="text" value="2"/>

.....

E14. a) Do you, in your spare time, belong to any organisations or groups of people (e.g. choir, gardening club, sports club, charity fund raising etc.)?

Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>
-----	--------------------------------	----	--------------------------------

i) If yes, please describe:

.....

E14. b) Are you on any committees?

Yes No

If **yes**, please describe

c) Do you do any voluntary work?

Yes No

If **yes**, please describe

E15. In the past 2 years have you taken any courses or other educational training?

	Yes	No
a) training within my job	<input type="text" value="1"/>	<input type="text" value="2"/>
b) evening classes	<input type="text" value="1"/>	<input type="text" value="2"/>
c) university	<input type="text" value="1"/>	<input type="text" value="2"/>
d) other (please describe)	<input type="text" value="1"/>	<input type="text" value="2"/>

.....

E16. What educational qualifications do you, and your partner, have?
Please tick all that apply.

	(i) Your self	(ii) Your partner
a) No qualifications	<input type="checkbox"/>	<input type="checkbox"/>
b) CSE or GCSE (D, E, F or G)	<input type="checkbox"/>	<input type="checkbox"/>
c) O-level or GCSE (A, B or C)	<input type="checkbox"/>	<input type="checkbox"/>
d) A-level	<input type="checkbox"/>	<input type="checkbox"/>
e) Qualifications in shorthand/typing/ or other skills, e.g. hairdressing	<input type="checkbox"/>	<input type="checkbox"/>
f) Apprenticeship	<input type="checkbox"/>	<input type="checkbox"/>
g) State enrolled nurse	<input type="checkbox"/>	<input type="checkbox"/>
h) State registered nurse	<input type="checkbox"/>	<input type="checkbox"/>
i) City & Guilds intermediate technical	<input type="checkbox"/>	<input type="checkbox"/>
j) City & Guilds final technical	<input type="checkbox"/>	<input type="checkbox"/>
k) City & Guilds full technical	<input type="checkbox"/>	<input type="checkbox"/>
l) Teaching qualification	<input type="checkbox"/>	<input type="checkbox"/>
m) University degree	<input type="checkbox"/>	<input type="checkbox"/>
n) Qualifications not known	<input type="checkbox"/>	<input type="checkbox"/>
o) Not applicable, no such person		<input type="checkbox"/>
p) Other (please tick & describe)	<input type="checkbox"/>	<input type="checkbox"/>

.....

.....

SECTION F: YOUR HOME AND NEIGHBOURHOOD

F1. Here is a list of some things that can be a problem in people's homes or in the neighbourhood. How much of a problem are the following for you and your family?

		Serious problem	Minor problem	Not a problem	No opinion
a)	Badly fitted doors and windows	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b)	Poor ventilation	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c)	Noise travelling between the rooms of your home	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	Noise from other homes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	Noise from outside in the street	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f)	Rubbish or litter dumped around your neighbourhood	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g)	Dog dirt on pavement/walkways	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
h)	Worry about vandalism	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
i)	Worry about burglaries	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
j)	Worry about muggings or attacks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k)	Disturbance from teenagers or youths	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l)	Other problems (please tick & describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

.....

.....

F2. a) How would you rate your home in relation to that of other families?

much cleaner	<input type="text" value="1"/>
a bit cleaner	<input type="text" value="2"/>
about the same	<input type="text" value="3"/>
less clean	<input type="text" value="4"/>
much less clean	<input type="text" value="5"/>
don't know	<input type="text" value="9"/>

b) much tidier	<input type="text" value="1"/>
a bit tidier	<input type="text" value="2"/>
about the same	<input type="text" value="3"/>
less tidy	<input type="text" value="4"/>
much less tidy	<input type="text" value="5"/>
don't know	<input type="text" value="9"/>

F3. How many people living in your household
(including yourself) are smokers ?

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

F4. a) What is your present marital status?

never married	<input type="text" value="1"/>
widowed	<input type="text" value="2"/>
divorced	<input type="text" value="3"/>
separated	<input type="text" value="4"/>
married (once only)	<input type="text" value="5"/>
married for second or third time	<input type="text" value="6"/>

F4. b) If married, what was the date
of the most recent marriage?

--	--

--	--

1	9		
---	---	--	--

F5. What do you think of your neighbourhood as a place to live?

a very good place to live	<table border="1" style="text-align: center; width: 40px;"><tr><td>1</td></tr></table>	1
1		
a fairly good place to live	<table border="1" style="text-align: center; width: 40px;"><tr><td>2</td></tr></table>	2
2		
not a very good place to live	<table border="1" style="text-align: center; width: 40px;"><tr><td>3</td></tr></table>	3
3		
not at all a good place to live	<table border="1" style="text-align: center; width: 40px;"><tr><td>4</td></tr></table>	4
4		

F6. Taking everything into account, which of the following best describes your feeling
about your home?

satisfied	<table border="1" style="text-align: center; width: 40px;"><tr><td>1</td></tr></table>	1
1		
fairly satisfied	<table border="1" style="text-align: center; width: 40px;"><tr><td>2</td></tr></table>	2
2		
dissatisfied	<table border="1" style="text-align: center; width: 40px;"><tr><td>3</td></tr></table>	3
3		
very dissatisfied	<table border="1" style="text-align: center; width: 40px;"><tr><td>4</td></tr></table>	4
4		

SECTION G: YOUR FAMILY AND FRIENDS

G1. Excluding your partner and children, how many of your relatives and your partner's relatives do you see at least twice a year?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G2. About how many friends do you have (people you know more than just casually)?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G3. Overall, would you say you belong to a close circle of friends?

Yes	<input type="text"/>	No	<input type="text"/>
	1		2

G4. How many people are there, including your partner, that you can talk to about personal problems?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G5. How many people, including your partner, talk to you about their personal problems or their private feelings?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G6. If you have to make an important decision, how many people, including your partner are there with whom you can discuss it?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G7. How many people are there among your family and friends from whom you could borrow £100 if you needed to?

None	1	2-4	more than 4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1	2	3	4

G8. How many of your family and friends would help you in times of trouble?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

G9. During the last month, how many times did you get together with one or more friends?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

G10. During the last month, how many times did you get together with one or more of your relatives or your partner's relatives?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

The following statements are about the help and support you have.

	This is exactly how I feel	This is often how I feel	This is how I sometimes feel	I never feel this way
G11. I have no one to share my feelings with	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
G12. My partner provides the emotional support I need	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
				no partner <input type="text" value="7"/>
G13. I believe in moments of difficulty my neighbours would help me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
G14. I'm worried that my partner might leave me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
				no partner <input type="text" value="7"/>
G15. There is always someone with whom I can share my happiness and excitement about my child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

		This is exactly how I feel	This is often how I feel	This is how I sometimes feel	I never feel this way	
G16.	If I feel tired I can rely on my partner to take over	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	no partner <div>7</div>
G17.	If I was in financial difficulty I know my family would help if they could	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	
G18.	If I was in financial difficulty I know my friends would help if they could	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	
G19.	If all else fails I know the state will support and assist me	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	

G20. How often during the day are you in a room or enclosed place where people are smoking?

	(i) weekdays	(ii) weekends
all the time	<div>1</div>	<div>1</div>
more than 5 hours	<div>2</div>	<div>2</div>
3-5 hours	<div>3</div>	<div>3</div>
1-2 hours	<div>4</div>	<div>4</div>
less than 1 hour	<div>5</div>	<div>5</div>
not at all	<div>6</div>	<div>6</div>

H1. This questionnaire was completed by:

a) mother

b) father

c) other (please
(describe)

.....

H2. Please give the date on which you completed this questionnaire

day

month

year

H3. Please give the date of birth of your child:

day

month

year

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comments you would like to make.

NB. Please remember we cannot reply personally to your comments unless they are signed.

When completed, please return the questionnaire to:

**Professor Jean Golding
Children of the Nineties - ALSPAC
Institute of Child Health
24 Tyndall Avenue
Bristol
BS8 1BR Tel: Bristol (0117) 928 5007**

For Office use only

Coder