



Girls' experiences, thoughts and behaviour

Alert!

This questionnaire is different!

Use black or blue pen



Answer questions with a cross in the box, like this:



If you are writing words make sure they are inside the box, like this:



I EAT CARROTS

01/08/2005

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REMEMBER

!!!

Do not tick the answer boxes!!

Mark them with a cross
like this



*If you make a mistake, shade
the box in like this*



then cross the correct box.

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Section A: How you spend your time

A1. How much time on average do you spend each day:

	(i) on a school weekday				(ii) on a weekend day			
	Not at all	less than 1 hour	1-2 hours	3 or more hours	Not at all	less than 1 hour	1-2 hours	3 or more hours
a) in a car, bus or other transport	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) out of doors in summer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) out of doors in winter	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) watching TV	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) with other young people	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) drawing, making, constructing things	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) doing things by yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) school homework	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) reading books for pleasure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j) playing musical instruments	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) using a computer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l) talking on a mobile phone	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m) texting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n) talking on an ordinary phone	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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A1. How much time on average do you spend each day:

(iii)

on normal days in school holidays

	Not at all	less than 1 hour	1-2 hours	3 or more hours
a) in a car, bus or other transport	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) out of doors in summer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) out of doors in winter	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) watching TV	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) with other young people	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) drawing, making, constructing things	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) doing things by yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) school homework	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) reading books for pleasure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j) playing musical instruments	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) using a computer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l) talking on a mobile phone	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m) texting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n) talking on an ordinary phone	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>



Section B: Everyone is different !

Please answer these questions about your experiences, thoughts and behaviour **over the last year**. There are no right and wrong answers.

We want to know what **you** think attractive women look like.

B1. What do you think makes a woman look attractive?

	Strongly agree	Agree	Can't decide	Disagree	Strongly disagree
a) Very thin women are not attractive	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) Women with long legs are more attractive than those with normal length legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) Women with toned (lean) bodies are more attractive	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) Tall women are more attractive than women of normal height	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e) Shapely women are attractive	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f) Women are more attractive if they are short (petite)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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B2. How satisfied are you at the moment with your:

	Extremely satisfied	Moderately satisfied	Can't decide	Moderately dissatisfied	Extremely dissatisfied	Not an issue
a) weight	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b) figure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c) breasts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
d) stomach	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
e) waist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
f) thighs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
g) buttocks	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
h) hips	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
i) legs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
j) face	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
k) hair	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

B3. Mark **one** box in **each line** that best describes the way you might have felt pressure to change your weight.

	Not at all	A little	Quite a lot	A lot
a) I've felt pressure to lose weight:				
(i) from my friends	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(ii) from my family	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(iii) from boys I've gone out with	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(iv) from the media (e.g. TV, magazines)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) I've felt pressure to gain weight:				
(i) from my friends	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(ii) from my family	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(iii) from boys I've gone out with	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(iv) from the media (e.g. TV, magazines)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Do family members tease you about your weight or body shape?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Do people at school tease you about your weight or body shape?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Remember there are no right or wrong answers, we just want to know what you think.

B4. How do you describe your weight?

Very underweight	1 <input type="checkbox"/>	Slightly underweight	2 <input type="checkbox"/>	About the right weight	3 <input type="checkbox"/>
Slightly overweight	4 <input type="checkbox"/>	Very overweight	5 <input type="checkbox"/>		

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B5. Which of the following are you trying to do about your weight?

I am not trying to do anything about my weight 1 ☐

Stay the same 2 ☐

Gain weight 3 ☐

Lose weight 4 ☐

B6. a) During the **past year**, did you go on a diet to lose weight or keep from gaining weight?

Always on a diet 1 ☐

Often 2 ☐

Several times 3 ☐

A couple of times 4 ☐

Never 5 ☐ → If never, go to **B7a** on page 10

b) How long did you stay on the diet(s)?

Less than a week 1 ☐

1-3 weeks 2 ☐

1-3 months 3 ☐

3 or more months 4 ☐

c) What type of diet(s) did you use? (You **can** mark **more** than one answer)

Yes

i) Low calorie 1 ☐

ii) High protein 1 ☐

iii) Skipped meals 1 ☐

iv) Weight loss shakes 1 ☐

v) Low carbohydrate 1 ☐

vi) High carbohydrate 1 ☐

vii) Smaller portion size 1 ☐

viii) Weight Watchers or other programme 1 ☐

ix) Low fat 1 ☐

x) Did not eat snacks or desserts 1 ☐

xi) Other (please cross box then describe below) 1 ☐

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B6. d) Did you lose weight on the diet(s)?

Yes more than 1 ☐
10 pounds
(more than 5 kilos)

Yes, 6-10 2 ☐
pounds
(3-5 kilos)

Yes, 1-5 3 ☐
pounds
(½-2½ kilos)

No 4 ☐
↓
**If no, go to
B7a below**

e) Did you gain back any of the weight you lost on the diet?

No, did not regain any of the weight 1 ☐

Gained back a little of the weight 2 ☐

Gained back most of the weight 3 ☐

Gained back all of the weight 4 ☐

Put on more than I lost 5 ☐

B7. a) During the **past year**, how often did you do any exercise?

5 or more times 1 ☐
a week

1-4 times 2 ☐
a week

1-3 times 3 ☐
a month

less than once 4 ☐
a month

never 5 ☐ → **If never go to B8 on page 11**

b) Was it difficult for you to do your work or school work because of the amount of time that you were exercising?

Yes, sometimes 1 ☐

Yes, frequently 2 ☐

No 3 ☐

c) Did you exercise in order to lose weight or avoid gaining weight?

Yes, sometimes 1 ☐

Yes, frequently 2 ☐

No 3 ☐
↓
If no, go to B8 on page 11

If yes,

d) Did you carry on exercising even if you were sick or injured?

No 1 ☐

Yes 2 ☐

Was not sick or injured 3 ☐

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B8. During the **past year**, how often did you fast (not eat for at least a day) to lose weight or avoid gaining weight?

Never 1 ☐

Less than once 2 ☐
a month

1-3 times 3 ☐
a month

Once a week 4 ☐

2 or more times a week 5 ☐

B9. During the **past year**, how often did you make yourself throw up (vomit) to lose weight or avoid gaining weight?

Never 1 ☐

Less than once 2 ☐
a month

1-3 times 3 ☐
a month

Once a week 4 ☐

2-6 times a week 5 ☐

Every day 6 ☐

B10. During the **past year**, how often did you take laxatives to lose weight or avoid gaining weight?

Never 1 ☐

Less than once 2 ☐
a month

1-3 times 3 ☐
a month

Once a week 4 ☐

2-6 times a week 5 ☐

Every day 6 ☐

B11. Sometimes people will go on an "eating binge", where they eat an amount of food that most people would consider to be very large, in a short period of time.

During the past year, how often did you go on an eating binge?

Never 1 ☐

Less than once a month 2 ☐

1-3 times a month 3 ☐

Once a week 4 ☐

More than once a week 5 ☐

→ If never, go to B14 on page 13

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B12. These questions refer to when you were on a binge.

	Yes usually	Yes sometimes	No
a) Did you feel out of control, like you couldn't stop eating even if you wanted to stop?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Did you eat very fast or faster than you normally do?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) Did you eat until your stomach hurt or you felt sick to your stomach?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) Did you eat really large amounts of food when you didn't feel hungry?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) Did you eat by yourself because you did not want anyone to see how much you ate?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) Did you feel really bad about yourself or feel guilty after eating a lot of food?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

B13. a) **In the past year**, if there was a period of time when you went on eating binges **at least once a week**, how long did you do this altogether?

1 month 1 ☐ 2 months 2 ☐ 3 or more months 3 ☐

Didn't do this at least once a week 4 ☐ —————> **Go to B14 on page 13**

b) **During that time** did you do any of the following:

(i) exercise a lot to burn off the calories you had eaten during the eating binges?

Yes 1 ☐ No 2 ☐

(ii) use laxatives to keep from gaining weight?

Yes 1 ☐ No 2 ☐

(iii) make yourself throw up to keep from gaining weight?

Yes, monthly 1 ☐ Yes, weekly 2 ☐

Yes, 2 or more times a week 3 ☐ No 4 ☐

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B14. Has anyone ever told you that they thought you had an eating disorder, such as anorexia nervosa or bulimia? (you can mark more than one answer)

a) No 1 ☐

b) Yes, a friend 1 ☐

c) Yes, a parent 1 ☐

d) Yes, a doctor, nurse, or other health care provider 1 ☐

B15. Have you ever been treated for an eating disorder by a doctor, nurse or other health care provider?

No 1 ☐

Yes, in the past 2 ☐

Yes, am being 3 ☐
treated now

Remember there are no right or wrong answers. We just want to know what you think.

In the past year:

Never

Sometimes

Often

Always

B16. How often have you thought about wanting to have toned or defined muscles?

1 ☐

2 ☐

3 ☐

4 ☐

**Don't
know**

B17. How often has your **mother** tried to lose weight?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

B18. How often has your mother or father made a comment to you about your weight or the amount you are eating, that made you feel bad?

1 ☐

2 ☐

3 ☐

4 ☐

B19. **In the past year** how **happy** have you been with the way your body looks?

Very unhappy 1 ☐

A little unhappy 2 ☐

Quite happy 3 ☐

Very happy 4 ☐

B20. **In the past year**, how much has your weight made a difference to how you feel about yourself?

Not at all 1 ☐

A little 2 ☐

Quite a lot 3 ☐

A lot 4 ☐

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B21. **In the past year**, how much have you worried about gaining a little weight (as little as one kilo)?

Not at all 1 ☐

A little 2 ☐

A lot 3 ☐

All the time 4 ☐

B22. a) **In the past year**, how much have you tried to look like some of the girls or women you see on television, in movies, or in magazines?

Not at all 1 ☐ —► **Go to B23 below**

A little 2 ☐

Sometimes 3 ☐

Frequently 4 ☐

A lot 5 ☐

b) To look like them I have changed or I'm trying to change my:
(You can mark more than one box)

(i) hair colour 1 ☐

(vi) muscle definition 1 ☐

(ii) hair style 1 ☐

(vii) tan/skin colour 1 ☐

(iii) makeup 1 ☐

(viii) weight (trying to gain) 1 ☐

(iv) clothing 1 ☐

(ix) weight (trying to lose) 1 ☐

(v) body shape 1 ☐

(x) other (please cross box 1 ☐
then describe below)

B23. Do you try to eat less at mealtimes than you would like to eat?

Yes, usually 1 ☐

Yes, sometimes 2 ☐

No 3 ☐

B24. How often do you refuse food or drink offered because you are concerned about your weight?

Never 1 ☐

Occasionally 2 ☐

Sometimes 3 ☐

Frequently 4 ☐

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B25. Do you feel that you want to eat more than usual at the following times:

	Yes, usually want to eat more	Sometimes want to eat more	No, not at all
a) when you are irritated or cross?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) when you have nothing to do?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) when you are depressed or discouraged?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) when you are feeling lonely?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) when somebody lets you down?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) when you are happy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g) when something unpleasant is due to happen?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h) when you are anxious, worried or tense?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i) when things have gone wrong?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j) when you are frightened?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
k) when you are disappointed?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
l) when you are emotionally upset?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
m) when you are bored or restless?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
n) when you are excited?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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B26. If food tastes good do you eat more than usual?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B27. If food smells and looks good do you eat more than usual?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B28. If you see or smell something delicious do you have the desire to eat it?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B29. If you see others eating do you also have the desire to eat?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B30. Can you resist eating delicious foods?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B31. Do you eat more than usual when you see others eating?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

B32. When preparing a meal are you inclined to eat something while you are preparing it?

Never ¹ ☐

Occasionally ² ☐

Sometimes ³ ☐

Always ⁴ ☐

Never prepare a meal ⁵ ☐



Section C: Behaviour

C1. How often **in the last year** have you done any of the following:

Have you:	Not at all	Just once	2-5 times	6 or more times
a) skipped or bunked off school	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) broken into a car or van with intention of stealing something out of it	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) hit, kicked or punched someone on purpose	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) deliberately set fire or tried to set fire to somebody's property or a building	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) taken money or something else that did not belong to you from home without permission	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) used force, threats or a weapon to get money or something else from somebody	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) written things or sprayed paint on property that did not belong to you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) gone into or broken into a house or building with the aim of stealing something	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) deliberately damaged or destroyed property that did not belong to you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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C1. cont.

Have you <u>in the last year</u> :	Not at all	Just once	2-5 times	6 or more times
j) carried a knife or weapon with you for protection or in case it was needed in a fight	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) taken money or something else that did not belong to you from school	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l) stolen or ridden in a stolen car or van or on a stolen motorbike	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m) been rowdy or rude in a public place so that people complained or you got into trouble	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n) taken something from a shop without paying for it	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
o) not paid the correct fare or not paid at all on a bus or train	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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Section D: Accidents

D1. In the last year, have you ever been involved in a road accident?

Yes 1 ☐

No 2 ☐

—► If no, please go to section E on page 21

D2. Thinking about the last accident you had, how were you travelling?

(Mark one box only)

In a car or van 1 ☐

Walking in or across a road 2 ☐

Cycling 3 ☐

Something else e.g. bus 4 ☐

(please cross box then describe below)

D3. Who was with you at the time of the accident? (You can mark more than one box)

a) On my own 1 ☐

b) Parent or other adult 1 ☐

c) Brother(s) or sister(s) 1 ☐

d) With friends 1 ☐

D4. What were you doing at the time of the accident? (Mark one box only)

Going to or from school 1 ☐

Playing or hanging out in the street 2 ☐

Going to or from a particular place
e.g. club, disco, sports field, church etc. 3 ☐

Other journey e.g. on holiday 4 ☐

(Please cross box then describe below)

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D5. When did the accident happen? (Mark one box only)

Before school	1 <input type="checkbox"/>
After school	2 <input type="checkbox"/>
At the weekend	3 <input type="checkbox"/>
During school holidays	4 <input type="checkbox"/>

	Yes	No
D6. Were you hurt?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
D7. Did you see a family doctor?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
D8. Did you go to the casualty ("A & E") department at hospital?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
D9. If you went to the casualty department, did you stay overnight in hospital?	1 <input type="checkbox"/>	2 <input type="checkbox"/>

D10. Space for you to tell what happened and what your injuries were:



Section E: Feelings and experiences

E1. Do you enjoy many different kinds of games and activity?

Yes ¹ ☐

No ² ☐

E2. Do your thoughts sometimes seem as real as actual events?

Yes ¹ ☐

No ² ☐

E3. Has dancing or the idea of it always seemed dull to you?

Yes ¹ ☐

No ² ☐

E4. Does nearly every thought you have immediately suggest a lot of ideas?

Yes ¹ ☐

No ² ☐

E5. Is trying new foods something you have always enjoyed?

Yes ¹ ☐

No ² ☐

E6. Do you sometimes feel that your accidents are caused by mysterious forces?

Yes ¹ ☐

No ² ☐

E7. Are there only very few things that you have ever really enjoyed doing?

Yes, very few I enjoyed ¹ ☐

No, have enjoyed lots of things ² ☐

E8. Does your voice ever seem distant or far away?

Yes ¹ ☐

No ² ☐

E9. Are you too independent to get involved with other people?

Yes ¹ ☐

No ² ☐

E10. Have you sometimes had the feeling of gaining or losing energy when certain people look at you or touch you?

Yes ¹ ☐

No ² ☐

E11. Do you think having close friends is important?

Yes, ¹ ☐

No ² ☐

E12. Does a passing thought ever seem so real it frightens you?

Yes ¹ ☐

No ² ☐

E13. Are you rather lively?

Yes ¹ ☐

No ² ☐

E14. When you look into the mirror does your face sometimes seem quite different from usual?

Yes ¹ ☐

No ² ☐

E15. Are people usually better off if they stay away from emotional involvements?

Yes ¹ ☐

No ² ☐



Section F: Your attitudes to health issues

What kind of effect do you think the following have:

	Very harmful	Harmful	No effect	Helpful	Very helpful
F1. Regularly smoking cigarettes on someone's physical health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F2. Regularly smoking cigarettes on someone's mental or emotional health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F3. Binge drinking alcohol on someone's physical health [By "binge" drinking we mean a large amount in a session]	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F4. Binge drinking alcohol on someone's mental or emotional health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F5. Regularly (every day) drinking a lot of alcohol on someone's physical health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F6. Regularly (every day) drinking a lot of alcohol on someone's mental or emotional health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F7. Regularly using or taking cannabis on someone's physical health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
F8. Regularly using or taking cannabis on someone's mental or emotional health	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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Section G:

G1. Did you have any help to fill this in?

No 1 ☐

Yes 2 ☐



If **yes**, please say who helped you:

a) A parent helped 1 ☐

b) Someone else helped 1 ☐

G2. What is your date of birth?

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

 /

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

 /

Year			
1	9	9	<input type="text"/>

G3. What is today's date?

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

 /

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

 /

Year			
2	0	0	<input type="text"/>

Thank you VERY much for your help

When completed, please send this back to:

**Professor Jean Golding
Children of the Nineties - ALSPAC
24 Tyndall Avenue
Bristol
BS8 1BR**

coder

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

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