



LIVING IN AUSTRALIA



ROY
MORGAN

Freecall: 1800 656 670
Email: hilda@roymorgan.com

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Household ID

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Person No.

First name of
respondent:

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IN-CONFIDENCE

We appreciate and thank you for the information you have already given our interviewer. This form contains some additional questions that you might find easier to answer by yourself.

All the information you give us is completely confidential. Only the survey team will have access to this form. Everyone in this team has signed a deed of confidentiality and is required to observe privacy laws when handling your information.

Your full name and address will never be linked with any of the information you provide.

Thank you!

COMPLETE AND RETURN
FOR YOUR \$25 GIFT

Pick up date and time:



You can complete
this form online too.
Just call 1800 656 670 or
email hilda@roymorgan.com
and we'll send your direct
survey link to your email.

How to fill in this form

In answering these questions, please be as honest and accurate as possible.

- Use only blue or black ink.
Put an X inside the box provided.
(Do not mark any areas outside the box.)
For example:



- If you make a mistake:
Simply colour in the whole box and
mark the correct one as shown.
For example:



If more than one answer is allowed, this will be specified under the question.

When completed, please seal this form in the envelope provided.



R11218 – W25M1

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SCQ Serial No.

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PART A: GENERAL HEALTH AND WELL-BEING
(SF-36 Health Survey)

This first set of questions seeks your views about your health, how you feel and how well you are able to do your usual activities.

Please take the time to read and answer each question carefully by crossing the box corresponding to your response. If you are unsure about how to answer a question, please give the best answer you can.

A1 In general, would you say your health is:

(Cross ONE box)

1 Excellent

2 Very good

3 Good

4 Fair

5 Poor

A2 Compared to one year ago, how would you rate your health in general now?

(Cross ONE box)

1 Much better now than a year ago

2 Somewhat better now than a year ago

3 About the same as one year ago

4 Somewhat worse now than one year ago

5 Much worse now than one year ago

A3 The following questions are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

(Cross ONE box on EACH line)

	<i>ACTIVITIES</i>	<i>Yes, limited a lot</i>	<i>Yes, limited a little</i>	<i>No, not limited at all</i>
a	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
b	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
c	Lifting or carrying groceries	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
d	Climbing several flights of stairs	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
e	Climbing one flight of stairs	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
f	Bending, kneeling, or stooping	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
g	Walking more than one kilometre	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
h	Walking half a kilometre	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
i	Walking 100 metres	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>
j	Bathing or dressing yourself	<input type="checkbox"/> <u>1</u>	<input type="checkbox"/> <u>2</u>	<input type="checkbox"/> <u>3</u>

A4 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Cross ONE box on EACH line)

		YES	NO
a	Cut down the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c	Were limited in the <u>kind</u> of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d	Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

A5 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(Cross ONE box on EACH line)

		YES	NO
a	Cut down the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c	Didn't do work or other activities <u>as carefully</u> as usual	<input type="checkbox"/>	<input type="checkbox"/>

A6 During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(Cross ONE box)

<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Slightly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Quite a bit	<input type="checkbox"/> 5 Extremely
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A7 How much bodily pain have you had during the past 4 weeks?

(Cross ONE box)

<input type="checkbox"/> 1 No bodily pain	<input type="checkbox"/> 2 Very mild	<input type="checkbox"/> 3 Mild	<input type="checkbox"/> 4 Moderate	<input type="checkbox"/> 5 Severe	<input type="checkbox"/> 6 Very severe
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A8 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(Cross ONE box)

<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Slightly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Quite a bit	<input type="checkbox"/> 5 Extremely
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- A9** These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks:

(Cross ONE box on EACH line)

	<i>All of the time</i>	<i>Most of the time</i>	<i>A good bit of the time</i>	<i>Some of the time</i>	<i>A little of the time</i>	<i>None of the time</i>
a Did you feel full of life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b Have you been a nervous person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
d Have you felt calm and peaceful?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
e Did you have a lot of energy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
f Have you felt down?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
g Did you feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
h Have you been a happy person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
i Did you feel tired?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

- A10** During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

(Cross ONE box)

<input type="checkbox"/> 1 All of the time
<input type="checkbox"/> 2 Most of the time
<input type="checkbox"/> 3 Some of the time
<input type="checkbox"/> 4 A little of the time
<input type="checkbox"/> 5 None of the time

- A11** How TRUE or FALSE is each of the following statements for you?

(Cross ONE box on EACH line)

	<i>Definitely True</i>	<i>Mostly True</i>	<i>Don't know</i>	<i>Mostly False</i>	<i>Definitely False</i>
a I seem to get sick a little easier than other people	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b I am as healthy as anybody I know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c I expect my health to get worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d My health is excellent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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PART B: YOU, YOUR LIFESTYLE AND YOUR LIVING SITUATION

B1 In general, how often do you participate in moderate or intensive physical activity for at least 30 minutes?

Moderate level physical activity will cause a slight increase in breathing and heart rate, such as brisk walking.

(Cross **ONE** box)

- Not at all
- Less than once a week
- 1 to 2 times a week
- 3 times a week
- More than 3 times a week
(but not every day)
- Every day

B2 Do you smoke cigarettes or any other tobacco products?

(Cross **ONE** box)

- No, I have never smoked ➔ **Go to B4**
- No, I no longer smoke ➔ **Go to B4**
- Yes, I smoke daily ➔ **Go to B3**
- Yes, I smoke at least weekly (but not daily) ➔ **Go to B3**
- Yes, I smoke less often than weekly ➔ **Go to B3**

B3 How many cigarettes do you usually smoke each week?

Please convert cigar/pipe/loose tobacco to a number of cigarettes: per week

B4 Do you drink alcohol? (Cross **ONE** box)

- No, I have never drunk alcohol ➔ **Go to B7**
- No, I no longer drink alcohol ➔ **Go to B7**
- Yes, I drink alcohol every day
- Yes, I drink alcohol 5 or 6 days per week
- Yes, I drink alcohol 3 or 4 days per week
- Yes, I drink alcohol 1 or 2 days per week
- Yes, I drink alcohol 2 or 3 days per month
- Yes, but only rarely

B5 On a day that you have an alcoholic drink, how many standard drinks do you usually have?

A standard drink is a small glass of wine, a 285 ml glass of regular beer, a nip of spirits, or a mixed drink.

(Cross **ONE** box)

- 13 or more standard drinks
- 11 to 12 standard drinks
- 9 to 10 standard drinks
- 7 to 8 standard drinks
- 5 to 6 standard drinks
- 3 to 4 standard drinks
- 1 to 2 standard drinks

B6a How often do you have 5 or more standard drinks on one occasion?

(Cross **ONE** box)

- Not in the last year
- Less than monthly but at least once a year
- Once a month
- 2 to 3 times a month
- 1 to 2 times a week
- 3 to 4 times a week
- 5 or more times a week

B6b How often do you have 7 or more standard drinks on one occasion?

(Cross **ONE** box)

- Not in the last year
- Less than monthly but at least once a year
- Once a month
- 2 to 3 times a month
- 1 to 2 times a week
- 3 to 4 times a week
- 5 or more times a week

B7 Are you currently an active member of a sporting, hobby or community-based club or association?

(Cross **ONE** box)

- Yes
- No

B8 How often do you feel rushed or pressed for time?

(Cross **ONE** box)

- Almost always
- Often
- Sometimes
- Rarely
- Never

B9 How often do you feel you have spare time that you don't know what to do with?

(Cross **ONE** box)

- Almost always
- Often
- Sometimes
- Rarely
- Never

B10 How tall are you (without shoes)?

You only need to provide an answer in either centimetres (cms) or in feet / inches.

centimetres

OR

feet inches

(Note: There are 12 inches in a foot)

B11 What is your current weight?

You only need to provide an answer in either kilograms (kgs) or in stones / pounds.

kgs

OR

stones pounds

(Note: There are 14 pounds in a stone)

Go to B12 ➔

B12 How much do you measure around your waist?

Use the tape measure provided to measure yourself around your waist at the level of your belly button. The measure is best taken against bare skin or light clothing. Do not suck in your stomach.

Please provide an answer in centimetres.

centimetres

B13 Are you currently on a diet to lose weight?

(Cross **ONE** box)

- Yes
- No

B14 In the last 12 months, how often have you dieted in order to lose weight?

(Cross **ONE** box)

- Never
- Once
- More than once
- Always on a diet

B15 Do you consider yourself to be ...

(Cross **ONE** box)

- Acceptable weight?
- Underweight?
- Overweight?

B16 How satisfied are you with your current weight?

(Cross **ONE** box)

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

B17 How often do you usually eat each of the following food types? (Cross **X** ONE box on EACH line)

		Never	Less than once a month	1-3 times per month	Once per week	2-4 times per week	5-6 times per week	Once per day	Two or more times per day
a	Legumes / pulses (such as kidney beans, lentils, tofu).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
b	Biscuits, cakes, pies, cake-type desserts, pastries, etc.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
c	Pasta, rice, rice noodles/cakes, cornmeal or couscous.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
d	Snack foods (such as potato crisps, pretzels, popcorn, crackers, oriental snack mix, and salted nuts).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
e	Breakfast cereals (such as muesli, bran flakes, porridge, and commercial cereal brands).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
f	Confectionery (such as lollies, sweets, chocolate bars, and fudge) and ice cream.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
g	Breads (all types), crumpets and English muffins.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
h	Fried potatoes, French fries, hot chips or wedges.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
i	Red meat (for example, beef, veal, lamb, pork, and dishes where meat is the major component). <i>Do not include ham.</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
j	Processed meat products, such as cold meats, bacon, sausages, and meat pies.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
k	Poultry, such as chicken, turkey, and duck.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
l	Fresh / frozen / tinned fish or shellfish. <i>Do not include battered/crumbed fish, fish fingers or fish cakes.</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

B18 The following questions are about your feelings in the past 4 weeks.

In the last four weeks, about how often did you feel ...

(Cross **X** ONE box on EACH line)

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a	tired out for no good reason?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b	nervous?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c	so nervous that nothing could calm you down?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d	hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e	restless or fidgety?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f	so restless that you could not sit still?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g	depressed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
h	that everything was an effort?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
i	so sad that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
j	worthless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5





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B19 Now some questions about family life.

Please indicate, by crossing one box on each line, how satisfied or dissatisfied you currently are with each of the following relationships. The more satisfied you are, the higher the number of the box you should cross. The less satisfied you are, the lower the number of the box you should cross.

If the question does not apply to you, cross the “Does not apply” category.

How satisfied are you with:		Completely dissatisfied										Completely satisfied	
		0	1	2	3	4	5	6	7	8	9	10	Does not apply
a	your relationship with your partner?	<input type="checkbox"/>											
b	your relationship with your children?	<input type="checkbox"/>											
c	your partner's relationship with your children?	<input type="checkbox"/>											
d	your relationship with your stepchildren?	<input type="checkbox"/>											
e	how well the children in the household get along with each other?	<input type="checkbox"/>											
f	your relationship with your parents?	<input type="checkbox"/>											
g	your relationship with your step-parents?	<input type="checkbox"/>											
h	your relationship with your (most recent) former spouse or partner?	<input type="checkbox"/>											

B20 And how satisfied are you with the following aspects of family life?

Again, please indicate, by crossing one box on each line, how satisfied or dissatisfied you currently are.

If the question does not apply to you, cross the “Does not apply” category.

How satisfied are you with:											
											<i>Does not apply</i>
a	the way childcare tasks are divided between you and your partner?										<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
b	the way household tasks are divided between you and your partner?										<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10

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B21 Do you think you do your fair share around the house?

(Cross ONE box)

- I do much more than my fair share
- I do a bit more than my fair share
- I do my fair share
- I do a bit less than my fair share
- I do much less than my fair share

Go to B22 ➔

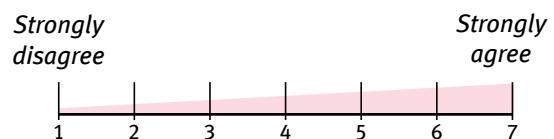
B22 In general, about how often do you get together socially with friends or relatives not living with you?

(Cross ONE box)

- Every day
- Several times a week
- About once a week
- 2 or 3 times a month
- About once a month
- Once or twice every 3 months
- Less often than once every 3 months

B23 The following statements have been used by many people to describe how much support they get from other people. How much do you agree or disagree with each?

(Please cross ONE box for EACH statement)



- a People don't come to visit me as often as I would like
- b I often need help from other people but can't get it
- c I seem to have a lot of friends
- d I don't have anyone that I can confide in
- e I have no one to lean on in times of trouble
- f There is someone who can always cheer me up when I'm down
- g I often feel very lonely
- h I enjoy the time I spend with the people who are important to me
- i When something's on my mind, just talking with the people I know can make me feel better
- j When I need someone to help me out, I can usually find someone

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

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B24 In the last 12 months, how often did you use each of the following types of drugs?

(Cross ONE box on EACH line)

		<i>Every day</i>	<i>Once a week or more</i>	<i>2 or 3 times a month</i>	<i>About once a month</i>	<i>Every few months</i>	<i>Once or twice a year</i>	<i>Not at all</i>
a	Marijuana/Cannabis (e.g., Pot, Grass, Weed, Hash, Ganja, Joint)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b	Meth / amphetamine (e.g., Speed, Base, Ice, Crystal, Meth, Whizz) [Do not include the use of prescription amphetamines]	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c	Cocaine (e.g., Coke, Crack, Flake, Snow, Freebase)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d	Ecstasy (e.g., XTC, E, Ex, Ecstasy, MDMA, PMA, Molly)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
e	Hallucinogens (e.g., Acid, LSD, Magic mushrooms, Angel dust)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
f	Inhalants (e.g., Chroming, Sniffing, Solvents, Glue, Petrol, Bulbs, Poppers)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
g	Any other illicit drug (e.g., Heroin, GHB, Ketamine, K2, Synthetics)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

B25 In the last 12 months, how often did you use each of the following types of prescription drugs?

Do not include medicines that can be bought over the counter without a prescription.

(Cross ONE box on EACH line)

		<i>Every day</i>	<i>Once a week or more</i>	<i>2 or 3 times a month</i>	<i>About once a month</i>	<i>Every few months</i>	<i>Once or twice a year</i>	<i>Not at all</i>
a	Strong Painkillers / Pain-relievers with Opioids in them (e.g., Tramadol, Fentanyl, Oxycodone, Morphine, Codeine products such as Panadeine Forte)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b	Tranquillisers / Sleeping pills (e.g., Serepax, Stilnox, Temazepam, Valium / Diazepam, Xanax)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

B26 How often, if at all, do you vape or use e-cigarettes?

(Cross ONE box)

<input type="checkbox"/> 1 Daily	<input type="checkbox"/> 2 At least weekly (but not daily)	<input type="checkbox"/> 3 At least monthly (but not weekly)	<input type="checkbox"/> 4 Less than monthly	<input type="checkbox"/> 5 I used to use them, but no longer use	<input type="checkbox"/> 6 Only tried them once or twice	<input type="checkbox"/> 7 Never used
-------------------------------------	---	---	---	---	---	--

Reminder:

Are you filling in the boxes correctly?

Are you shading the whole box for any mistakes?

Right



Wrong



+

+

+

+

+

B27 We now would like you to think about major events that have happened in your life over the past 12 months.

For each statement cross either the YES box or the NO box to indicate whether each event happened during the past 12 months. If you answer “YES”, then also cross one box to indicate how long ago the event happened or started.

Did any of these happen to you in the <u>past 12 months?</u>	YES	NO	If “YES” indicate how many months ago it happened			
			0 to 3 months ago	4 to 6 months ago	7 to 9 months ago	10 to 12 months ago
a Got married	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
b Separated from spouse or long-term partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
c Got back together with spouse or long-term partner after a separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
d Pregnancy / pregnancy of partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
e Partner or I gave birth to, or adopted, a new child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
f Serious personal injury or illness to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
g Serious personal injury or illness to a close relative / family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
h Death of spouse or child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
i Death of other close relative / family member (e.g., parent or sibling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
j Death of a close friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
k Victim of physical violence (e.g., assault)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
l Victim of a property crime (e.g., theft, housebreaking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
m Detained in a jail / correctional facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
n Close family member detained in a jail / correctional facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
o Retired from the workforce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
p Fired or made redundant by an employer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
q Changed jobs (i.e., employers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
r Promoted at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
s Major improvement in financial situation (e.g., won lottery, received an inheritance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
t Major worsening in financial situation (e.g., went bankrupt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
u Changed residence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12
v A weather-related disaster (e.g., flood, bushfire, cyclone) damaged or destroyed your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0 - 3	<input type="checkbox"/> 4 - 6	<input type="checkbox"/> 7 - 9	<input type="checkbox"/> 10 - 12

+

+

B28 How well do the following words describe you? For each word, cross one box to indicate how well that word describes you. There are no right or wrong answers.

(Cross **X** **ONE** box for **EACH** word.)

*Does not describe
me at all*

*Describes
me very well*



*Does not describe
me at all*

*Describes
me very well*



talkative

<input type="checkbox"/>						
1	2	3	4	5	6	7

sympathetic

<input type="checkbox"/>						
1	2	3	4	5	6	7

orderly

<input type="checkbox"/>						
1	2	3	4	5	6	7

envious

<input type="checkbox"/>						
1	2	3	4	5	6	7

deep

<input type="checkbox"/>						
1	2	3	4	5	6	7

withdrawn

<input type="checkbox"/>						
1	2	3	4	5	6	7

harsh

<input type="checkbox"/>						
1	2	3	4	5	6	7

systematic

<input type="checkbox"/>						
1	2	3	4	5	6	7

moody

<input type="checkbox"/>						
1	2	3	4	5	6	7

philosophical

<input type="checkbox"/>						
1	2	3	4	5	6	7

bashful

<input type="checkbox"/>						
1	2	3	4	5	6	7

kind

<input type="checkbox"/>						
1	2	3	4	5	6	7

inefficient

<input type="checkbox"/>						
1	2	3	4	5	6	7

touchy

<input type="checkbox"/>						
1	2	3	4	5	6	7

creative

<input type="checkbox"/>						
1	2	3	4	5	6	7

quiet

<input type="checkbox"/>						
1	2	3	4	5	6	7

cooperative

<input type="checkbox"/>						
1	2	3	4	5	6	7

sloppy

<input type="checkbox"/>						
1	2	3	4	5	6	7

jealous

<input type="checkbox"/>						
1	2	3	4	5	6	7

intellectual

<input type="checkbox"/>						
1	2	3	4	5	6	7

extroverted

<input type="checkbox"/>						
1	2	3	4	5	6	7

cold

<input type="checkbox"/>						
1	2	3	4	5	6	7

disorganised

<input type="checkbox"/>						
1	2	3	4	5	6	7

temperamental

<input type="checkbox"/>						
1	2	3	4	5	6	7

complex

<input type="checkbox"/>						
1	2	3	4	5	6	7

shy

<input type="checkbox"/>						
1	2	3	4	5	6	7

warm

<input type="checkbox"/>						
1	2	3	4	5	6	7

efficient

<input type="checkbox"/>						
1	2	3	4	5	6	7

fretful

<input type="checkbox"/>						
1	2	3	4	5	6	7

imaginative

<input type="checkbox"/>						
1	2	3	4	5	6	7

enthusiastic

<input type="checkbox"/>						
1	2	3	4	5	6	7

selfish

<input type="checkbox"/>						
1	2	3	4	5	6	7

careless

<input type="checkbox"/>						
1	2	3	4	5	6	7

calm

<input type="checkbox"/>						
1	2	3	4	5	6	7

traditional

<input type="checkbox"/>						
1	2	3	4	5	6	7

lively

<input type="checkbox"/>						
1	2	3	4	5	6	7



B29 How much time would you spend on each of the following activities in a typical week?

IMPORTANT: • Please do not count any activity twice
 • If you do not do an activity, write “0” in the hours box

		Hours per week	Minutes (if applicable)
a	Paid employment	<input type="text"/>	<input type="text"/>
b	Travelling to and from a place of paid employment	<input type="text"/>	<input type="text"/>
c	Household errands, such as shopping, banking, paying bills, and keeping financial records (but do not include driving children to school and to other activities)	<input type="text"/>	<input type="text"/>
d	Housework, such as preparing meals, washing dishes, cleaning house, washing clothes, ironing and sewing	<input type="text"/>	<input type="text"/>
e	Outdoor tasks, including home maintenance (repairs, improvements, painting, etc.), car maintenance or repairs and gardening	<input type="text"/>	<input type="text"/>
f	Playing with your children, helping them with personal care, teaching, coaching or actively supervising them, or getting them to child care, school and other activities	<input type="text"/>	<input type="text"/>
g	Looking after other people's children (aged under 12 years) on a regular, unpaid basis	<input type="text"/>	<input type="text"/>
h	Volunteer or charity work (for example, canteen work at the local school, unpaid work for a community club or organisation)	<input type="text"/>	<input type="text"/>
i	Caring for a disabled spouse or disabled adult relative, or caring for elderly parents or parents-in-law	<input type="text"/>	<input type="text"/>
TOTAL: This cannot exceed 168 hours and typically will not be greater than 120. If it is, please re-think your answers.		<input type="text"/>	Add total hours (whole hours only)

B30 During the past month, how often have you ...

(Cross **X** ONE box on EACH line)

		Not during the past month	Less than once a week	Once or twice a week	Three or four times a week	Five or more times a week
a	had trouble sleeping because you cannot get to sleep within 30 minutes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b	had trouble sleeping because you wake up in the middle of the night or early in the morning?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c	had trouble sleeping because you cough or snore loudly?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d	taken medicine (prescribed or "over the counter") to help you sleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e	had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

B31 During the past month, how would you rate your sleep quality overall?

(Cross ONE box)

1 Very good

2 Fairly good

3 Fairly bad

4 Very bad

PART C: PERSONAL AND HOUSEHOLD FINANCES

C1 Given your current needs and financial responsibilities, would you say that you and your family are ...

(Cross ONE box)

- Prosperous
- Very comfortable
- Reasonably comfortable
- Just getting along
- Poor
- Very poor

Go to C2 ➔

C2 Since January 2025 did any of the following happen to you because of a shortage of money?

(Cross ONE box on EACH line)

		YES	NO
a	Could not pay electricity, gas or telephone bills on time	<input type="checkbox"/>	<input type="checkbox"/>
b	Could not pay the mortgage or rent on time	<input type="checkbox"/>	<input type="checkbox"/>
c	Pawned or sold something	<input type="checkbox"/>	<input type="checkbox"/>
d	Went without meals	<input type="checkbox"/>	<input type="checkbox"/>
e	Was unable to heat home	<input type="checkbox"/>	<input type="checkbox"/>
f	Asked for financial help from friends or family	<input type="checkbox"/>	<input type="checkbox"/>
g	Asked for help from welfare / community organisations	<input type="checkbox"/>	<input type="checkbox"/>

C3a Suppose you had only one week to raise \$4000 for an emergency. Which of the following best describes how hard it would be for you to get that money?

(Cross ONE box)

- I could easily raise the money ➔ Go to C3b
- I could raise the money, but it would involve some sacrifices (e.g., reduced spending, selling a possession) ➔ Go to C3b
- I would have to do something drastic to raise the money (e.g., selling an important possession) ➔ Go to C3b
- I don't think I could raise the money ➔ Go to C4a ON PAGE 15

C3b And how would you obtain that money?

(Cross ALL boxes that apply)

- Use savings
- Borrow from a relative who lives with you
- Borrow from a relative who lives elsewhere
- Borrow from a friend
- Borrow from a financial institution or use credit
- Sell an asset
- Use some other method to find the money



C4a Which of the following statements comes closest to describing the amount of financial risk that you are willing to take with your spare cash? That is, cash used for savings or investment.

(Cross **ONE** box)

- I take substantial financial risks expecting to earn substantial returns ➡ Go to C5
- I take above-average financial risks expecting to earn above-average returns ➡ Go to C5
- I take average financial risks expecting to earn average returns ➡ Go to C5
- I am not willing to take any financial risks ➡ Go to C5
- I never have any spare cash ➡ Go to C4b

C4b Assume you had some spare cash that could be used for savings or investment. Which of the following statements comes closest to describing the amount of financial risk that you would be willing to take with this money?

(Cross **ONE** box)

- I would take substantial financial risks expecting to earn substantial returns
- I would take above-average financial risks expecting to earn above-average returns
- I would take average financial risks expecting to earn average returns
- I would not be willing to take any financial risks

HOUSEHOLD SPENDING

C5 Do you have any responsibility for the payment of household bills (such as household groceries and electricity, gas and water)?

(Cross **ONE** box)

- Yes ➡ Please continue
- No ➡ Go to D1 ON PAGE 17

C6 For each type of expenditure below, write in your best estimate of the total amount spent on that item by all people in the household.

If you are unsure please make your best guess.

Do not include expenses associated with any businesses you may own.

Weekly Expenses		Any expenditure? NO YES	HOW MUCH PER WEEK? (on average)	
a	Groceries <i>(Include food, cleaning products, pet food and personal care products. Do <u>not</u> include alcohol or tobacco.)</i>	<input type="checkbox"/> <input type="checkbox"/> ➡ \$ <input type="text"/> · <input type="checkbox"/>		DO NOT SHOW CENTS
b	Alcohol <i>(Include alcohol consumed with meals eaten out.)</i>	<input type="checkbox"/> <input type="checkbox"/> ➡ \$ <input type="text"/> · <input type="checkbox"/>		
c	Cigarettes and other tobacco products	<input type="checkbox"/> <input type="checkbox"/> ➡ \$ <input type="text"/> · <input type="checkbox"/>		
d	Public transport, taxis and ride-sharing services <i>(e.g., Uber)</i>	<input type="checkbox"/> <input type="checkbox"/> ➡ \$ <input type="text"/> · <input type="checkbox"/>		
e	Meals eaten out <i>(Include restaurants, take-away food, and bought lunches and snacks. Do <u>not</u> include alcohol.)</i>	<input type="checkbox"/> <input type="checkbox"/> ➡ \$ <input type="text"/> · <input type="checkbox"/>		

<u>Monthly Expenses</u>		Any expenditure? NO YES		HOW MUCH PER MONTH? (on average)	
f	Motor vehicle fuel and electric charging away from home	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00
g	Men's clothing and footwear	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00
h	Women's clothing and footwear	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00
i	Children's clothing and footwear	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00
j	Phone and internet charges (Including on mobile phones.)	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00
k	Online subscriptions for recreation activities, such as for media streaming (e.g., Netflix, Spotify), news, home fitness and video games	<input type="checkbox"/>	<input type="checkbox"/>	→ \$	_____ · 00

DO NOT SHOW CENTS

<u>Annual Expenses</u>	Any expenditure?		HOW MUCH IN THE LAST 12 MONTHS?		
	NO	YES	\$		
l Private health insurance	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
m Home and contents insurance	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
n Other insurance such as motor vehicle insurance	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
o Fees paid to doctors, dentists, opticians, physiotherapists, chiropractors and any other health practitioner	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
p Medicines, prescriptions and pharmaceuticals <i>(Include alternative medicines.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
q Electricity bills, gas bills and other heating fuel <i>(such as firewood and heating oil)</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
r Repairs, renovations and maintenance to your home	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
s Motor vehicle repairs and maintenance <i>(Include regular servicing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
t Education fees paid to schools, universities and other education providers <i>(Include private tuition fees.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
u Money donated to charities or other organisations	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
v Local council rates for your home	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		
w Owners corporation or strata fees for your home	<input type="checkbox"/>	<input type="checkbox"/>	→ \$		

DO NOT SHOW CENIS

PART D: YOUR JOB AND THE WORKPLACE

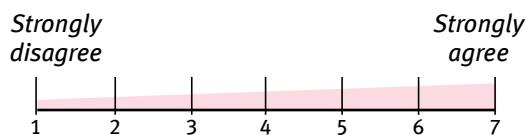
D1 Are you currently in paid work? (This includes anyone on paid leave or who is self-employed.)

Yes ➡ PLEASE GO TO D2 AND COMPLETE THE REST OF PART D

No ➡ Go to PART E ON PAGE 18

D2 The following statements are about your current (main) job. Please indicate, by crossing one box on each line, how strongly you agree or disagree with each. The more you agree, the higher the number of the box you should cross. The more you disagree, the lower the number of the box you should cross.

(Please cross ONE box for EACH statement)



a	My job is more stressful than I had ever imagined	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b	I fear that the amount of stress in my job will make me physically ill	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c	I get paid fairly for the things I do in my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d	I have a secure future in my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
e	The company I work for will still be in business 5 years from now	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
f	I worry about the future of my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
g	My job is complex and difficult	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
h	My job often requires me to learn new skills	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
i	I <u>use</u> many of my skills and abilities in my current job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
j	I have a lot of freedom to decide <u>how</u> I do my own work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
k	I have a lot of say about what happens on my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
l	I have a lot of freedom to decide <u>when</u> I do my work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
m	I have a lot of choice in deciding what I do at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
n	My working times can be flexible	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
o	I can decide when to take a break	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
p	My job requires me to do the same things over and over again	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
q	My job provides me with a variety of interesting things to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
r	My job requires me to take initiative	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
s	I have to work fast in my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
t	I have to work very intensely in my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
u	I don't have enough time to do everything in my job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

D3 Following is a list of conditions and entitlements that employers sometimes provide their employees. For each, please indicate whether you, or other employees working at a similar level to you at your workplace, would be able to use these if needed.

(Cross ONE box on EACH line)

		Yes	No	Don't know
a	Employer-funded paid <u>maternity</u> leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Employer-funded paid <u>paternity</u> leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Permanent part-time work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Home-based work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Flexible start and finish times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Child care facilities or subsidised child care expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

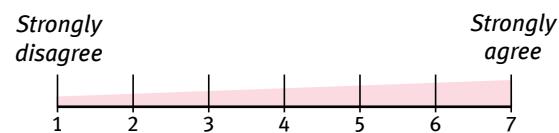
PART E: PARENTING

E1 Do you have parenting responsibilities for any children aged 17 years or less?

Yes ➔ PLEASE GO TO E2 AND COMPLETE THE REST OF PART E

No ➔ Go to PART F ON PAGE 20

E2 The following statements are about raising children. Thinking about the children aged 17 years or less that you have parenting responsibility for, please indicate, by crossing one box on each line, how strongly you agree or disagree with each statement. The more you agree, the higher the number of the box you should cross. The more you disagree, the lower the number of the box you should cross.



a	Being a parent is harder than I thought it would be	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b	I often feel tired, worn out, or exhausted from meeting the needs of my children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c	I feel trapped by my responsibilities as a parent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d	I find that taking care of my child/children is much more work than pleasure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

E3 Do you think you do your fair share of looking after the children?

(Cross ONE box)

- I do much more than my fair share
- I do a bit more than my fair share
- I do my fair share
- I do a bit less than my fair share
- I do much less than my fair share



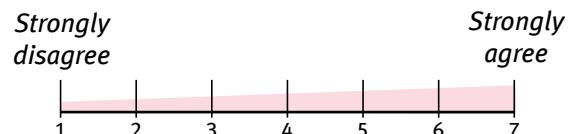
This question is for parents who are in paid work.

If you are not in paid work, skip this question and

→ Go to PART F ON PAGE 20

E4 The following statements are about combining work with family responsibilities. Please indicate, by crossing one box on each line, how strongly you agree or disagree with each. The more you agree, the higher the number of the box you should cross. The more you disagree, the lower the number of the box you should cross.

(Please cross **ONE** box for **EACH** statement)



a	Having both work and family responsibilities makes me a more well-rounded person	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b	Having both work and family responsibilities gives my life more variety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c	Managing work and family responsibilities as well as I do makes me feel competent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d	Because of my family responsibilities, I have to turn down work activities or opportunities that I would prefer to take on	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
e	Having both work and family responsibilities challenges me to be the best I can be	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
f	Because of my family responsibilities, the time I spend working is less enjoyable and more pressured	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
g	Because of the requirements of my job, I miss out on home or family activities that I would prefer to participate in	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
h	Because of the requirements of my job, my family time is less enjoyable and more pressured	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
i	Working makes me feel good about myself, which is good for my children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
j	My work has a positive effect on my children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
k	Working helps me to better appreciate the time I spend with my children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
l	The fact that I am working makes me a better parent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
m	I worry about what goes on with my children while I'm at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
n	Working leaves me with too little time or energy to be the kind of parent I want to be	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
o	Working causes me to miss out on some of the rewarding aspects of being a parent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
p	Thinking about the children interferes with my performance at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

PART F

F1 What was your sex recorded at birth? (Cross ONE box)

Male

Female

Another term (please specify)

F2 How do you describe your gender?

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

(Cross ONE box)

Man or male

I use a different term (please specify)

Woman or female

Prefer not to answer

Non-binary

F3 Which age group do you belong to?

(Cross ONE box)

15 – 17 years

22 – 24 years

45 – 54 years

75 years or over

18 – 19 years

25 – 34 years

55 – 64 years

20 – 21 years

35 – 44 years

65 – 74 years

F4 What is today's date?

day month year

 / /

F5 Is there anything else that you would like to tell us about life in Australia?

If so, please write on the lines below. (To ensure your privacy remains protected at all times, please do not write any personal contact details here such as your name, address or phone number.)

RETURNING YOUR COMPLETED QUESTIONNAIRE

- The thank you gift of \$25 may not be paid if the form is returned blank or returned late.
- Please seal the completed questionnaire in the envelope provided and have it ready when the interviewer returns to collect it.
- If the interviewer cannot come back, they will phone you and ask you to post it using the reply-paid envelope provided.

Once again, Thank You for your cooperation and participation.



ROY
MORGAN