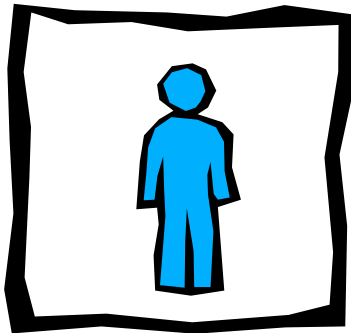


Questionnaire Number



A large empty rectangular box for writing the questionnaire number.

Life of a 16+ Teenager



02/08/2007

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ABOUT THIS QUESTIONNAIRE

- Thank you for filling in this questionnaire.
- We realise it is quite long but a lot of interesting things are happening to you!
- ALL your answers are confidential. They are kept under code numbers, not your name, so no-one can find out what you have said.
- We realise how sensitive and personal some of the questions are, but it is important for scientific research to find out what is happening to teenagers and how they really think and feel.
- You might want to talk to someone about some of the subjects in this questionnaire, so we have included details of confidential Helplines on a separate sheet.



FILLING IN THE QUESTIONNAIRE

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:



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? (On **each** line answer **one** box on **each** side)

	(i) on a typical weekday				(ii) on a typical 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 or college 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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SECTION B: FATIGUE

B1. We would like to know more about any problems you have had with feeling tired, weak or lacking in energy **in the last month**. Please answer ALL the questions by marking the answer that applies to you most closely.

If you have been feeling tired for a long while, then compare yourself to how you felt when you were last well. Please only mark *one* box on each line.

	Less than usual	No more than usual	More than usual	Much more than usual
a) Do you have problems with tiredness?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Do you need to rest more?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Do you feel sleepy or drowsy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Do you have problems starting things?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Do you lack energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Do you have less strength in your muscles?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Do you feel weak?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Do you have difficulty concentrating?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) Do you make slips of the tongue when speaking?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j) Do you have problems thinking clearly?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) How is your memory?	Better than usual	1 <input type="checkbox"/>		
	No worse than usual	2 <input type="checkbox"/>		
	Worse than usual	3 <input type="checkbox"/>		
	Much worse than usual	4 <input type="checkbox"/>		

B2. How would you describe your attendance at school or college (the percentage of your expected attendance)? Please mark **one** box only.

None	0 <input type="checkbox"/>
About 10% (e.g. one half day a week)	1 <input type="checkbox"/>
About 20% (e.g. one day a week)	2 <input type="checkbox"/>
About 40% (e.g. two days a week)	3 <input type="checkbox"/>
About 60% (e.g. three days a week)	4 <input type="checkbox"/>
About 80% (e.g. four days a week)	5 <input type="checkbox"/>
Full time (100%)	6 <input type="checkbox"/>
Not applicable (I'm not registered at school or college)	7 <input type="checkbox"/>



SECTION C: MAJOR LIFE CHANGES

Below is a list of things that sometimes happen to young people. In the first column please indicate whether that event has happened since you were age 12. If you mark "yes", please move to the second column and indicate the effect of what happened.

If you mark "no" in the first column please move on to the next question.

(i) Did this happen to you since you were aged 12?			(ii) If yes, what was the effect?				
	Yes	No	Very un-pleasant	A bit un-pleasant	No effect	A bit pleasant	Very pleasant
C1. Moving to a new neighbourhood	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C2. Birth of a new brother or sister	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C3. A new stepbrother or stepsister	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C4. Changing to new school	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C5. Serious illness or injury in a parent, brother or sister	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C6. Parents divorced or separated	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C7. Death of parent, brother or sister	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C8. Death of grandparent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C9. Death of a close friend	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C10. Brother or sister leaving home	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C11. Serious illness or injury in a close friend	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

continued over...

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**(i) Did this happen to you
since you were aged 12?**

(ii) If yes, what was the effect?

	Yes	No	Very un-pleasant	A bit un-pleasant	No effect	A bit pleasant	Very pleasant
C12. Parent getting into trouble with the police	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C13. Your parent's partner moved in	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C14. Special recognition for good schoolwork	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C15. Serious illness or injury to you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C16. Doing badly in schoolwork	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C17. Special prize or recognition for doing well in an activity (like sports, music or art)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C18. A close friend moved a long way away	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C19. Death of a pet	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C20. Either parent lost their job	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C21. Bullying by another person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C22. You became a parent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	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 D: YOUR CURRENT FEELINGS

The next set of questions is about feelings and experiences that you may have had.

D1. Some people believe that other people can read their thoughts. Have other people ever read your thoughts?

Yes, definitely ¹ ☐



Yes, maybe ² ☐



No, never ³ ☐ → **If no, go to D2 on page 10**

If yes, go to D1a) below

D1. a) How often have other people read your thoughts **since your 15th birthday?**

Once or twice

¹ ☐ → **go to D1b) below**

Less than once a month

² ☐ → **go to D1b) below**

More than once a month

³ ☐ → **go to D1b) below**

Nearly every day

⁴ ☐ → **go to D1b) below**

Not at all

⁵ ☐ → **go to D2 on page 10**

b) Were you upset by this?

No, not at all upset ¹ ☐

Yes, a bit upset ² ☐

Yes, quite upset ³ ☐

Yes, very upset ⁴ ☐

c) Do you think people sometimes used special powers to read your thoughts?

Yes, definitely ¹ ☐

Yes, maybe ² ☐

No, never ³ ☐

d) If people have read your thoughts, did this happen **only** within 24 hours of using or taking cannabis or other drugs?

Yes, **only** within 24 hours of using cannabis or other drugs ¹ ☐

No, it happened at other times too ² ☐

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If no, go to D3 below

D2.a)

1 ☐2 ☐3 ☐4 ☐5 ☐

b)

1 2 ☐3 ☐4 ☐

c)

1 ☐2 ☐

D3. H



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D3.a) How often has this happened **since your 15th birthday?**

- Once or twice 1 ☐ → go to D3b) below
Less than once a month 2 ☐ → go to D3b) below
More than once a month 3 ☐ → go to D3b) below
Nearly every day 4 ☐ → go to D3b) below
Not at all 5 ☐ → go to D4 below

D3. b) Were you upset by this?

- No, not at all upset 1 ☐ Yes, a bit upset 2 ☐
Yes, quite upset 3 ☐ Yes, very upset 4 ☐

c) If you ever thought you were being followed or spied on, did this happen **only** within 24 hours of using or taking cannabis or other drugs?

- Yes, **only** within 24 hours of using cannabis or other drugs 1 ☐
No, it happened at other times too 2 ☐

D4. Have you ever heard voices that other people couldn't hear?

- Yes, definitely 1 ☐ Yes, maybe 2 ☐ No, never 3 ☐ → **If no, go to D5 on page 12**
↓ ↓
If yes, go to D4a) below

a) How often have you heard voices that other people couldn't hear **since your 15th birthday?**

- Once or twice 1 ☐ → go to D4b) below
Less than once a month 2 ☐ → go to D4b) below
More than once a month 3 ☐ → go to D4b) below
Nearly every day 4 ☐ → go to D4b) below
Not at all 5 ☐ → go to D5 on page 12

b) Were you upset by this?

- No, not at all upset 1 ☐ Yes, a bit upset 2 ☐
Yes, quite upset 3 ☐ Yes, very upset 4 ☐

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D4. c) If you have heard voices that other people couldn't hear, did this happen:

- | | Yes | No |
|---|----------------------------|----------------------------|
| i) Only within 24 hours of taking cannabis or other drugs? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| ii) Only when you had a high temperature because you were ill? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| iii) Only when you were falling asleep or as you were waking up? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

d) If you have heard voices that other people couldn't hear, did the voice ever:

- | | Yes | No |
|---|----------------------------|----------------------------|
| i) Call out your name? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| ii) Say something, or comment, about what you were doing or thinking? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| iii) Talk to another voice about you? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| iv) Say something nice about you? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| v) Say something horrible about you? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

D5. Have you ever felt that you were under the control of some special power?

Yes, definitely 1 ☐ Yes, maybe 2 ☐ No, never 3 ☐ → **If no, go to D6 on page 13**

↓ ↓

If yes, go to D5a) below

a) How often have you thought that you were under the control of some special power **since your 15th birthday?**

- Once or twice 1 ☐ → **go to D5b) on page 13**
- Less than once a month 2 ☐ → **go to D5b) on page 13**
- More than once a month 3 ☐ → **go to D5b) on page 13**
- Nearly every day 4 ☐ → **go to D5b) on page 13**
- Not at all 5 ☐ → **go to D6 on page 13**

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D5. b) Who did you think was controlling you?

God or another religious figure ¹ ☐

Someone or something else ² ☐

c) Were you upset by this?

No, not at all upset ¹ ☐

Yes, a bit upset ² ☐

Yes, quite upset ³ ☐

Yes, very upset ⁴ ☐

d) If you ever thought you were under the control of some special power, did this happen **only** within 24 hours of using or taking cannabis or other drugs?

Yes, **only** within 24 hours of
using cannabis or other drugs ¹ ☐

No, it happened at other times too ² ☐

D6. Have you ever seen something or someone that other people could not see?

Yes, definitely ¹ ☐

Yes, maybe ² ☐

No, never ³ ☐ → **If no, go to D7
on page 14**

↓
If yes, go to D6a) below

a) How often have you seen something or someone that other people could not see **since your 15th birthday**?

Once or twice ¹ ☐ → **go to D6b) below**

Less than once a month ² ☐ → **go to D6b) below**

More than once a month ³ ☐ → **go to D6b) below**

Nearly every day ⁴ ☐ → **go to D6b) below**

Not at all ⁵ ☐ → **go to D7 on page 14**

b) Were you upset by this?

No, not at all upset ¹ ☐

Yes, a bit upset ² ☐

Yes, quite upset ³ ☐

Yes, very upset ⁴ ☐

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D6. c) If you have seen something or someone that other people could not see, did this happen:

- | | Yes | No |
|---|----------------------------|----------------------------|
| i) Only within 24 hours of taking cannabis or other drugs? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| ii) Only when you had a high temperature because you were ill? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| iii) Only when you were falling asleep or as you were waking up? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

D7. Have you ever felt that:

- i) Your thoughts were being taken out of your head against your will?
Yes, definitely 1 ☐ Yes, maybe 2 ☐ No, never 3 ☐
- ii) Someone else's thoughts were being inserted into your head against your will?
Yes, definitely 1 ☐ Yes, maybe 2 ☐ No, never 3 ☐
- iii) Your thoughts were so loud that people around you could hear what you were thinking?

Yes, definitely 1 ☐ Yes, maybe 2 ☐ No, never 3 ☐ → **If no to all three questions, go to D8 on page 15**

↓ ↓

If yes to any of the three questions above, go to D7a) below

a) How often have any of these three experiences happened **since your 15th birthday**?

- Once or twice 1 ☐ → **go to D7b) below**
- Less than once a month 2 ☐ → **go to D7b) below**
- More than once a month 3 ☐ → **go to D7b) below**
- Nearly every day 4 ☐ → **go to D7b) below**
- Not at all 5 ☐ → **go to D8 on page 15**

b) Were you upset by this?

- No, not at all upset 1 ☐ Yes, a bit upset 2 ☐
- Yes, quite upset 3 ☐ Yes, very upset 4 ☐

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D7. c) If you did have any of these three experiences, did this happen **only** within 24 hours of using or taking cannabis or other drugs?

Yes, **only** within 24 hours of using cannabis or other drugs ¹ ☐

No, it happened at other times too ² ☐

D8. Have you ever felt that you are somebody really very special, or that you have special powers like reading people's minds, or that you have been chosen to perform great and special tasks? (This doesn't mean that you are just clever or that you come from an important family).

Yes, definitely ¹ ☐ Yes, maybe ² ☐ No, never ³ ☐ → **If no, go to D9 on page 16**

↓ ↓

If yes, go to D8a) below

a) How often have you thought you were really very special or had special powers **since your 15th birthday**?

Once or twice ¹ ☐ → **go to D8b) below**

Less than once a month ² ☐ → **go to D8b) below**

More than once a month ³ ☐ → **go to D8b) below**

Nearly every day ⁴ ☐ → **go to D8b) below**

Not at all ⁵ ☐ → **go to D9 on page 16**

b) Were you upset by this?

No, not at all upset ¹ ☐ Yes, a bit upset ² ☐

Yes, quite upset ³ ☐ Yes, very upset ⁴ ☐

c) If you ever thought you were really very special or had special powers, did this happen **only** within 24 hours of using or taking cannabis or other drugs?

Yes, **only** within 24 hours of using cannabis or other drugs ¹ ☐

No, it happened at other times too ² ☐

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D9. For each of the following questions, please mark the box that best describes the way you have felt over the **past month**.

	Yes, nearly always	Yes, often	Yes, sometimes	No, never
a) Have you felt sad?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Have you felt pessimistic about everything?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Have you felt as if there is no future for you?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Have you cried about nothing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Have you felt that you are lacking in energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Have you felt guilty?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Have you felt like a failure?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Have you felt that you are not much of a talker when you are chatting with other people?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) Have you felt that you experience few or no emotions at important events, such as on your birthday?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j) Have you felt that you are lacking in motivation when you have to do things?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) Have you felt that you are spending all your days doing nothing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l) Have you felt that you are lacking 'get up and go'?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m) Have you felt that you have only a few hobbies or interests?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n) Have you felt that you have no interest to be with other people?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
o) Have you felt that you are not a very lively person?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
p) Have you felt that you are neglecting your appearance or personal hygiene?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
q) Have you felt that you can never get things done?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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SECTION E: HOW YOU FEEL ABOUT YOURSELF

We're interested in knowing what you usually think and feel about different things.
There are no right or wrong answers.

	Yes	No
E1. Do you feel that wishing can make good things happen?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E2. Are people nice to you no matter what you do?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E3. Do you usually do badly in your schoolwork even when you try hard?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E4. When a friend is angry with you is it hard to make that friend like you again?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E5. Are you surprised when your teacher praises you for your work in school?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E6. When bad things happen to you is it usually someone else's fault?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E7. Is doing well in your schoolwork just a matter of "luck" for you?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E8. Are you often blamed for things that just aren't your fault?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E9. When you get into an argument or fight is it usually the other person's fault?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E10. Do you think that preparing for things is a waste of time?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E11. When nice things happen to you is it usually because of "luck"?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E12. Does planning ahead make good things happen?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
E13. Are you satisfied with your body?	1 <input type="checkbox"/>	2 <input type="checkbox"/>

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SECTION F: ALCOHOL USE

The next questions are about drinking alcohol (this includes beer, wine, "alcopops", cider and spirit drinks like vodka).

F1. Have you ever drunk alcohol?

Yes ¹ ☐ → If yes, go to
F2 below

No ² ☐ → If no, go to section G
on page 22

F2. How old were you when you **first** drank alcohol **without** an adult's permission?

i) What age were you?

--	--

years

OR

ii) Mark this box if you have **never** drunk alcohol **without** an adult's permission ¹ ☐

F3. Think back over the **last 30 days**. How many full drinks (if any) of the following types of alcohol have you had? Mark **one** box for each line.

Please use the separate DRINKOGRAM sheet to help you.

	Number of full drinks						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) Beer (do not include low alcohol beer), lager, cider or "alcopops"	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"/>
b) Wine	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"/>
c) Spirits (whisky, cognac, vodka etc., also include spirits mixed with soft drinks)	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"/>

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F4. The next question refers to up to the **first 5 times** you ever had a drink of alcohol:

- a) Up to the **first 5 times** you ever had a drink of alcohol did it make you feel drunk or tipsy, or like you had a buzz?

Yes ¹ ☐

No ² ☐

Don't know ⁹ ☐

If yes,

- (i) How many drinks did it take for this to happen?

--	--

- b) Up to the **first 5 times** you ever had a drink of alcohol did it make you feel dizzy or make your speech slurred?

Yes ¹ ☐

No ² ☐

Don't know ⁹ ☐

If yes,

- (i) How many drinks did it take for this to happen?

--	--

- c) Up to **the first 5 times** you ever had a drink of alcohol did it make you stumble or fall or did you find it difficult to walk properly?

Yes ¹ ☐

No ² ☐

Don't know ⁹ ☐

If yes,

- (i) How many drinks did it take for this to happen?

--	--

- d) Up to the **first 5 times** you ever had a drink of alcohol did it make you pass out or fall asleep when you didn't want to?

Yes ¹ ☐

No ² ☐

Don't know ⁹ ☐

If yes,

- (i) How many drinks did it take for this to happen?

--	--

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F5. a) How often do you have a drink containing alcohol?

Never 1 ☐

Monthly 2 ☐
or less

2-4 times 3 ☐
a month

↓
**go to Section G
on page 22**

2-3 times 4 ☐
a week

4 or more 5 ☐
times a week

- b) How many units of alcohol do you drink on a typical day when you are drinking?
**One unit of alcohol is: ½ pint average strength beer/lager OR one glass of wine
OR one single measure of spirits. Note: a can of high strength beer or lager
contains 3-4 units. Please use the separate DRINKOGRAM sheet to help you.**

1 or 2 1 ☐

3 or 4 2 ☐

5 or 6 3 ☐

7, 8 or 9 4 ☐

10 or more 5 ☐

- c) How often do you have six or more units of alcohol on one occasion?

Never 1 ☐

Less than 2 ☐
monthly

Monthly 3 ☐

Weekly 4 ☐

Daily or 5 ☐
almost daily

- d) How often during the last year have you found that you were not able to stop drinking once you had started?

Never 1 ☐

Less than 2 ☐
monthly

Monthly 3 ☐

Weekly 4 ☐

Daily or 5 ☐
almost daily

- e) How often during the last year have you failed to do what was normally expected from you because of drinking?

Never 1 ☐

Less than 2 ☐
monthly

Monthly 3 ☐

Weekly 4 ☐

Daily or 5 ☐
almost daily

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F5. f) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never ¹ ☐

Less than ² ☐
monthly

Monthly ³ ☐

Weekly ⁴ ☐

Daily or ⁵ ☐
almost daily

g) How often during the last year have you had a feeling of guilt or remorse after drinking?

Never ¹ ☐

Less than ² ☐
monthly

Monthly ³ ☐

Weekly ⁴ ☐

Daily or ⁵ ☐
almost daily

h) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never ¹ ☐

Less than ² ☐
monthly

Monthly ³ ☐

Weekly ⁴ ☐

Daily or ⁵ ☐
almost daily

i) Have you or someone else been injured as a result of your drinking?

No ¹ ☐

Yes, but not ² ☐
in the last year

Yes, during ³ ☐
the last year

j) Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

No ¹ ☐

Yes, but not ² ☐
in the last year

Yes, during ³ ☐
the last year

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SECTION G: TOBACCO AND OTHER SUBSTANCES

The next set of questions is about cigarettes (including roll-ups).

G1. Have you ever smoked a cigarette (including roll-ups)?

Yes ¹ ☐ → **If yes, go to
G2 below**

No ² ☐ → **If no, go to G7 below**

G2. Please mark the box next to the statement that describes you the best:

I have only ever tried smoking cigarettes once or twice ¹ ☐

I used to smoke sometimes but I never smoke cigarettes now ² ☐

I sometimes smoke cigarettes but I smoke less than one a week ³ ☐

I usually smoke between one and six cigarettes a week ⁴ ☐

I usually smoke more than six cigarettes a week, but not every day ⁵ ☐

I usually smoke one or more cigarettes every day ⁶ ☐

G3. How old were you when you first smoked a cigarette?

Less than 10 ¹ ☐
years old

10-12 ² ☐
years old

13-14 ³ ☐
years old

15-16 ⁴ ☐
years old

G4. How many cigarettes have you smoked **in total** in your lifetime?

Less than 5 ¹ ☐

5-19 ² ☐

20-49 ³ ☐

50-99 ⁴ ☐

100 or more ⁵ ☐

G5. Have you smoked any cigarettes **since your 15th birthday**?

Yes ¹ ☐

No ² ☐

G6. If you smoke on a **daily** basis, how many cigarettes do you smoke per day, on average?

1-5 ¹ ☐

6-10 ² ☐

11-20 ³ ☐

More than ⁴ ☐
20 daily

Do not ⁵ ☐
smoke

G7. Have you **ever** used or taken nicotine patches or nicotine gum?

No ¹ ☐

Yes, less than ² ☐
10 times in total

Yes, more than ³ ☐
10 times in total

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The next set of questions is about cannabis.

G8. Have you ever tried **cannabis** (also called marijuana, hash, dope, pot, skunk, puff, grass, draw, ganja, spliff, joints, smoke, weed)?

Yes ¹ ☐ —▶ **If yes, go to G9 below** No ² ☐ —▶ **If no, go to G20 on page 26**

G9. Please mark the box next to the statement that describes you best:

- I have only ever tried cannabis once or twice 1 ☐
- I used to sometimes use or take cannabis but I never do now 2 ☐
- I sometimes use or take cannabis but less often than once a week 3 ☐
- I usually use or take cannabis between one and six times a week 4 ☐
- I usually use or take cannabis more than six times a week, but not every day 5 ☐
- I usually use or take cannabis every day 6 ☐

G10. How old were you when you first tried cannabis?

- | | | | |
|--|---|---|---|
| Less than 10 ¹ <input type="checkbox"/> | 10-12 ² <input type="checkbox"/> | 13-14 ³ <input type="checkbox"/> | 15-16 ⁴ <input type="checkbox"/> |
| years old | years old | years old | years old |

G11. How many times have you used or taken cannabis **in total**?

- | | | | | |
|---|--|---|--|---|
| Less than ¹ <input type="checkbox"/> | 5-20 ² <input type="checkbox"/> | 21-60 ³ <input type="checkbox"/> | 61-100 ⁴ <input type="checkbox"/> | More than ⁵ <input type="checkbox"/> |
| 5 times | times | times | times | 100 times |

G12. What type of cannabis have you **most commonly** used or taken?

- Marijuana (also called grass, green, herbal, skunk) 1 ☐
- Resin (also called solid, soap-bar, black, hash) 2 ☐
- Other 3 ☐
- Don't know 9 ☐



G13. How have you **most commonly** used or taken cannabis?

- | | |
|------------------------------|----------------------------|
| Smoking joints or spliffs | 1 <input type="checkbox"/> |
| Smoking it in pipes or bongs | 2 <input type="checkbox"/> |
| Eaten | 3 <input type="checkbox"/> |
| Other | 4 <input type="checkbox"/> |
| Don't know | 9 <input type="checkbox"/> |

G14. If you have ever smoked joints/spliffs, or used a pipe or bong, was the cannabis **most commonly** mixed with tobacco?

- | | |
|--|----------------------------|
| Most commonly smoked cannabis mixed with tobacco | 1 <input type="checkbox"/> |
| Most commonly smoked cannabis by itself | 2 <input type="checkbox"/> |
| Never smoked cannabis | 3 <input type="checkbox"/> |
| Don't know | 9 <input type="checkbox"/> |

G15. What is the **most** number of joints/spliffs, pipes or bongs that you smoked in a single day?

- | | |
|-----------------------------|----------------------------|
| Less than 3 in a single day | 1 <input type="checkbox"/> |
| 3 or more in a single day | 2 <input type="checkbox"/> |
| Never smoked cannabis | 3 <input type="checkbox"/> |

G16. Over the past **three months** how much cannabis have you **personally** used?

- | | |
|---|----------------------------|
| None | 0 <input type="checkbox"/> |
| Less than a £10 bag (around 16th of an ounce) | 1 <input type="checkbox"/> |
| A £10 bag | 2 <input type="checkbox"/> |
| Between a £10 bag and an 8th of an ounce | 3 <input type="checkbox"/> |
| Between an 8th and a quarter of an ounce | 4 <input type="checkbox"/> |
| Between a quarter and a half of an ounce | 5 <input type="checkbox"/> |
| Between a half ounce and an ounce | 6 <input type="checkbox"/> |
| More than an ounce | 7 <input type="checkbox"/> |

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G17. Have you ever had any of the following experiences **within 1 hour** of using or taking cannabis? (You can mark **more than one** answer)

- i) Feeling sick and sweaty 1 ☐
- ii) Feeling calm and relaxed 1 ☐
- iii) Feeling very anxious or panicky 1 ☐
- iv) Feeling that people are spying on you, or trying to harm you 1 ☐
- v) Feeling that you want to laugh at everything around you 1 ☐
- vi) Hearing voices that other people couldn't hear 1 ☐
- vii) Seeing things that other people couldn't see 1 ☐
- viii) Feeling more sociable and friendly 1 ☐

G18. Have you used or taken cannabis **since your 15th birthday**?

Yes 1 ☐ No 2 ☐ —► If no, go to G20 on page 26

G19. The next questions are about your use of cannabis **since your 15th birthday**.

	Never	Rarely	From time to time	Fairly often	Very often
a) Have you ever used cannabis <u>before midday</u> ?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Have you ever used cannabis <u>when you were alone</u> ?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Have you ever had <u>memory problems</u> when you used cannabis?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Have <u>friends or members of your family</u> ever told you that you ought to reduce your cannabis use?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Have you ever tried to reduce or stop your cannabis use <u>without succeeding</u> ?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Have you ever had problems <u>because of your use</u> of cannabis (argument, fight, accident, bad result at school, other problems)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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The next questions are about other drugs that people sometimes take.

G20. Have you ever tried inhaling or sniffing any of the following **since your 15th birthday?**
(Mark **one** box on each line)

	No	Yes, less than 5 times	Yes, more than 5 times
a) Aerosols	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Gas (butane and lighter refills)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) Glue	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) Solvents (including petrol and paint thinners)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) Poppers (also called amyl nitrates, liquid gold, rush)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

G21. Have you tried, taken or used any of the following drugs **since your 15th birthday?**
(Mark **one** box on each line)

	No	Yes, less than 5 times	Yes, more than 5 times
a) Amphetamines (also called speed, uppers, whizz, sulphate, billy, crystal meth)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) Ecstasy (also called 'E' pills, MDMA)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) LSD (also called acid, tabs, trips, dots)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) Magic mushrooms (also called shrooms)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) Spanglers (also called spangs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) Cocaine (also called Charlie, 'C', coke)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g) Crack (also called rock, stone)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h) Heroin (also called brown, smack, gear, junk, 'H')	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i) Ketamine (also called Green, K, special K, super K, vitamin K)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j) Steroids (not prescribed by a doctor)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
k) White widows	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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SECTION H: MOODS AND FEELINGS

These questions are about how you may have been feeling or acting recently. For each question, please say how much you think you have felt or acted this way in the **past two WEEKS**.

	In the past 2 weeks:	True	Sometimes true	Not true
H1.	I felt miserable or unhappy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H2.	I have been having fun	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H3.	I didn't enjoy anything at all	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H4.	I felt so tired that I just sat around and did nothing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H5.	I was very restless	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H6.	I felt I was no good any more	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H7.	I cried a lot	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H8.	I felt happy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H9.	I found it hard to think properly or concentrate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H10.	I hated myself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H11.	I enjoyed doing lots of things	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H12.	I felt I was a bad person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H13.	I felt lonely	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H14.	I thought nobody really loved me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H15.	I thought I could never be as good as other kids	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H16.	I felt I did everything wrong	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H17.	I have had a good time	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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SECTION I: ASTHMA & ALLERGIES

11. **In general**, would you say your health is (please mark **one** box):

Excellent 1 ☐

Very good 2 ☐

Good 3 ☐

Fair 4 ☐

Poor 5 ☐

12. Have you or your parent ever been told by a doctor that you have asthma?

Yes 1 ☐

No 2 ☐

13. **In the past 12 months**, have you had any of the following conditions?

	Yes & saw doctor	Yes - no doctor	No
a) wheezing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) breathlessness	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) asthma	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) eczema	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) hay fever	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

14. **In the last 12 months**, have you been prescribed any asthma medication, e.g. inhalers, tablets, nebulisers?

Yes 1 ☐

No 2 ☐

If yes, please write the names of the medications in the box below:

15. a) **In the past 12 months**, have you had any periods when there was wheezing with whistling on your chest when you breathed?

Yes 1 ☐

No 2 ☐ → **If no**, go to question 16 on page 30



If yes, go to I5b) on page 29

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15. b) How many separate times has it happened **in the past 12 months?**

once ¹ ☐ twice ² ☐ 3-4 times ³ ☐
5 or more times ⁴ ☐ don't know ⁹ ☐

c) How many days altogether would you say that you had wheezed **in the past 12 months?**

1 day ¹ ☐ 2-3 days ² ☐ 4-9 days ³ ☐
10-19 days ⁴ ☐ 20 or more days ⁵ ☐ don't know ⁹ ☐

d) Were the episodes of wheezing associated with being breathless?

Yes, for all ¹ ☐ Yes, for some ² ☐ No, not at all ³ ☐

e) How many times **in the past 12 months,** has your sleep been disturbed because of wheezing on your chest?

Never woken with wheezing ¹ ☐ Less than one night per week ² ☐ One or more nights per week ³ ☐

f) How many days school have you missed **in the past 12 months** due to wheezing on your chest? (If you can't remember, make a guess and **mark the guess box as well**)

Number of days off school

--	--

Was this a guess? ¹ ☐

Yes

g) Has the wheezing been bad enough to limit your speech to a few words at a time (less than a complete sentence)?

Yes No

i) Ever ¹ ☐ ² ☐

ii) In the past 12 months ¹ ☐ ² ☐

h) Is your wheezing worse at any particular time of year?

Yes ¹ ☐ No ² ☐ → If no, go to I5j) on

page 30

If **yes**, go to I5i) on page 30

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15. i) What particular time? (You can tick **more** than **one** box)

Spring 1 ☐

Summer 1 ☐

Autumn 1 ☐

Winter 1 ☐

j) Which (if any) of the following do you think brings on your episodes of wheezing?

- | | Yes | No |
|-------------------------------------|----------------------------|----------------------------|
| (i) Colds/infections | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (ii) Running/exercise | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (iii) Exposure to smoky atmospheres | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (iv) Cold weather | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (v) Pets/animals | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

If so, any particular one? (please mark box & write in space below):

-
- (vi) Other, 1 ☐ 2 ☐
(please mark box & write in space below):
-

k) Do any of your brothers or sisters have wheezing with whistling on their chest?

Yes 1 ☐

No 2 ☐

Have no other 7 ☐
brothers or sisters

16. a) **In the past 12 months**, have you suffered from an itchy, dry rash in the creases of your body (such as behind your knees, or in your elbow or wrist joints)?

Yes 1 ☐

No 2 ☐ → **If no, go to I7 on page 32**

If yes,

b) How bad was it?

Very bad 1 ☐

Quite bad 2 ☐

Mild 3 ☐

No problem 4 ☐

c) Does it become sore and oozy?

Yes 1 ☐

No 2 ☐

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15. d) Is it made worse by irritants such as bubble bath, soap, wool or nylon clothing?

Yes ¹ ☐

No ² ☐

e) Have you had an itchy, dry rash on your hands in the past 12 months?

Yes ¹ ☐

No ² ☐

16. f) Have you had an itchy, dry rash on your feet in the past 12 months?

Yes ¹ ☐

No ² ☐

g) **In the past 12 months**, how often would you say on average, that you were kept awake at night by the rash?

Never in the
past 12 months ¹ ☐

Less than one
night per week ² ☐

One or more
nights per week ³ ☐

h) Does the rash get worse when you become sweaty, for example with sports or exercise, or when you are in a hot room?

Yes ¹ ☐

No ² ☐

i) Have you had a skin reaction **in the past 12 months** that you thought was due to some food that you had eaten?

Yes ¹ ☐

No ² ☐ —► **If no, go to I7 on page 32**

If yes,

j) Please describe the food(s):

k) How long after the food was eaten did the rash appear?

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16. 1) Where was the reaction? (You can mark **both** boxes).

(i) Mouth 1 ☐

(ii) Other part, (please describe): 1 ☐

17. This question is about when you do **NOT** have a cold or "flu".

a) Have you ever had sneezing, or a runny or blocked nose when you did not have a cold or flu?

Yes 1 ☐

No 2 ☐ —► If no, go to Section J on page 33

b) **In the past 12 months**, have you had sneezing, or a runny or blocked nose when you did not have a cold or flu?

Yes 1 ☐

No 2 ☐ —► If no, go to Section J on page 33

c) **In the past 12 months**, have you had itchy or watery eyes?

Yes 1 ☐

No 2 ☐

d) **In which of the past 12 months**, did the nose and/or eye problems occur? (Please mark **all** that apply).

January 1 ☐

May 1 ☐

September 1 ☐

February 1 ☐

June 1 ☐

October 1 ☐

March 1 ☐

July 1 ☐

November 1 ☐

April 1 ☐

August 1 ☐

December 1 ☐

e) **In the past 12 months**, did these nose and/or eye problems interfere with your activity?

Not at all 1 ☐

A little 2 ☐

A moderate amount 3 ☐

A lot 4 ☐

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SECTION J: EATING PATTERNS

J1. 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 J2 below**

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

Less than ¹ ☐
a week

1-3 ² ☐
weeks

1-3 months ³ ☐

3-6 months ⁴ ☐

6-12 ⁵ ☐
months

c) Did you lose weight on the diet(s)?

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

Yes, 6-10 pounds
(3-5 kilos) ² ☐

Yes, 1-5 pounds (½-2½ kilos) ³ ☐

No ⁴ ☐ → **If no, go to J2 below**

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

No, did not regain ¹ ☐
any of the weight

Gained back a ² ☐
little of the weight

Gained back ³ ☐
most of the weight

Put on more ⁴ ☐
than I lost

J2. a) During the **past year**, how often did you do any exercise (going to the gym, brisk walking or any sports activity)?

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 J3 on page 34**

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 ☐

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J2. c) Did you exercise in order to lose weight or avoid gaining weight?

Yes, sometimes 1 ☐

Yes, frequently 2 ☐

No 3 ☐



If yes, go to J2d below

If no, go to J3 below

d) Do you feel guilty after missing an exercise session?

Yes, sometimes 1 ☐

Yes, frequently 2 ☐

Do not miss any 3 ☐
exercise sessions

J3. 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 ☐

J4. 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 ☐

J5. a) During the **past year**, did you take laxatives or other tablets or medicines (diet pills or water tablets) to lose weight or avoid gaining weight?

Yes, laxative 1 ☐

Yes, other 2 ☐

Never 3 ☐

→ If never, go to
J6 on page 35



If yes, go to J5b) on page 35

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J5. b) How often?

- | | | | | | |
|-------------|----------------------------|------------------------|----------------------------|-------------------|----------------------------|
| Never | 1 <input type="checkbox"/> | Less than once a month | 2 <input type="checkbox"/> | 1-3 times a month | 3 <input type="checkbox"/> |
| Once a week | 4 <input type="checkbox"/> | 2-6 times a week | 5 <input type="checkbox"/> | Every day | 6 <input type="checkbox"/> |

J6. 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?

- | | | | | | |
|------------------------|----------------------------|-------------------|----------------------------|---------------------------------|----------------------------|
| Less than once a month | 1 <input type="checkbox"/> | 1-3 times a month | 2 <input type="checkbox"/> | once a week | 3 <input type="checkbox"/> |
| More than once a week | 4 <input type="checkbox"/> | Never | 5 <input type="checkbox"/> | → If never, go to J9 on page 36 | |

J7. 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"/> |



J8. 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 ☐ 2 months ☐ 3 or more months ☐

Didn't do this at least once a week ☐ —————> **Go to J9 below**

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 ☐ No ☐

(ii) use laxatives to keep from gaining weight?

Yes ☐ No ☐

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

Yes, monthly ☐ Yes, weekly ☐

Yes, 2 or more times a week ☐ No ☐

J9. 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 ☐

b) Yes, a friend ☐

c) Yes, a parent ☐

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

J10. Have you ever been **treated** for an eating disorder by a doctor, nurse or other health care provider?

No ☐ Yes, in the past ☐ Yes, am being treated now ☐

J11. Do you ever have strong cravings for food, or find food difficult to resist?

Never ☐ Occasionally ☐ Sometimes ☐ Always ☐

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SECTION K: DIFFERENT EXPERIENCES

For each item, please indicate which response best applies to you:

	Describes me very well	Describes me a bit	Does not describe me very well	Does not describe me at all
K1. I can see how it would be interesting to marry someone from a foreign country.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K2. When the water is very cold, I prefer not to swim even if it is a hot day.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K3. If I have to wait in a long line, I'm usually patient about it.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K4. When I listen to music, I like it to be loud.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K5. When taking a trip, I think it is best to make as few plans as possible and just take it as it comes.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K6. I stay away from movies that are said to be frightening or highly suspenseful.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K7. I think it's fun and exciting to perform or speak in front of a group.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K8. If I were to go to an amusement park, I would prefer to ride the rollercoaster or other fast rides.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K9. I would like to travel to places that are strange and far away.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K10. I would never like to gamble with money, even if I could afford it.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>



For each item, please indicate which response best applies to you:

	Describes me very well	Describes me a bit	Does not describe me very well	Does not describe me at all
K11. I would have enjoyed being one of the first explorers of an unknown land.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K12. I like a movie where there are a lot of explosions and car chases.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K13. I don't like extremely hot and spicy foods	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K14. In general, I work better when I'm under pressure.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K15. I often like to have the radio or TV on while I'm doing something else, such as reading or cleaning up.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K16. It would be interesting to see a car accident happen.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K17. I think it's best to order something familiar when eating in a restaurant.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K18. I like the feeling of standing next to the edge on a high place and looking down.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K19. If it were possible to visit another planet or the moon for free, I would be among the first in line to sign up.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
K20. I can see how it must be exciting to be in a battle during a war.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>



SECTION L: DELIBERATE SELF-HARM

Life has many ups and downs. Sometimes people feel very upset. These feelings can be so bad that people may feel suicidal or want to self-harm. The following questions ask you about your feelings and the feelings of people close to you. We know this is a sensitive subject, but it is important to ask about it now, as it is not uncommon. By finding out about self-harm we can find ways of helping people.

- L1. a) Has **anyone** in your family (not including yourself) **ever** hurt themselves on purpose (e.g. by taking an overdose of pills, or by cutting themselves)?

Yes 1 ☐

No 2 ☐ → If no, go to L2a) below

If **yes**,

- b) Who in your family has done this? Please mark **all** boxes that apply.

i) Mum 1 ☐

ii) Dad 1 ☐

iii) Brother 1 ☐

iv) Sister 1 ☐

v) Someone else, please say who: 1 ☐

- c) Which of these actions best describes what they did? Please mark **all** boxes that apply.

i) Swallowed pills or something poisonous 1 ☐

ii) Cut themselves 1 ☐

iii) Burnt themselves, e.g. with cigarette 1 ☐

iv) Something else, please say what: 1 ☐

- L2. a) Have **any** of your close friends **ever** hurt themselves on purpose?

Yes 1 ☐

No 2 ☐ → If no, go to L3a) on page 40



If yes, go to L2b) on page 40

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L2. b) Which of these actions best describes what they did? Please mark **all** boxes that apply.

- i) Swallowed pills or something poisonous 1 ☐
 - ii) Cut themselves 1 ☐
 - iii) Burnt themselves, e.g. with cigarette 1 ☐
 - iv) Something else, please say what: 1 ☐
-

L3. a) Have you **ever** hurt yourself on purpose **in any way** (e.g. by taking an overdose of pills, or by cutting yourself)?

Yes 1 ☐

No 2 ☐

→ **If no, go to L6a) on page 42**

If yes,

b) How many times have you done this in the last year? Please mark **one** box only.

Once 1 ☐

2-5 times 2 ☐

6-10 times 3 ☐

More than 10 times 4 ☐

c) When was the **last time** you hurt yourself on purpose? Please mark **one** box only.

In the last week 1 ☐

More than a week ago 2 ☐

More than a year ago 3 ☐

but in the last year

d) The **last time** you hurt yourself on purpose, which of the actions below best describes what you did? Please mark **all** boxes that apply.

- i) Swallowed pills or something poisonous 1 ☐
 - ii) Cut yourself 1 ☐
 - iii) Burnt yourself, e.g. with cigarette 1 ☐
 - iv) Something else, please say what: 1 ☐
-

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L3. e) Do **any** of the following reasons help to explain why you hurt yourself on that occasion? Please mark **all** boxes that apply.

i) I wanted to show how desperate I was feeling 1 ☐

ii) I wanted to die 1 ☐

iii) I wanted to punish myself 1 ☐

iv) I wanted to frighten someone 1 ☐

v) I wanted to get relief from a terrible state of mind 1 ☐

vi) Some other reason, please say what: 1 ☐

f) After you had hurt yourself on that occasion, how did you feel? Please mark **one** box only.

Better than before 1 ☐

The same as before 2 ☐

Worse than before 3 ☐

g) The last time you hurt yourself in any way (e.g. by taking an overdose of pills, or by cutting yourself) did you seek medical help / first aid from any of the following? Please mark **all** boxes that apply.

i) GP (Family doctor) 1 ☐

ii) Hospital casualty / emergency department 1 ☐

iii) Other health professional, 1 ☐
please say what their job was:

L4. On **any** of the occasions when you have hurt yourself on purpose, have you **ever** seriously wanted to kill yourself?

Yes 1 ☐

No 2 ☐

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L5. a) Have you ever tried to get help from someone or somewhere about hurting yourself on purpose, or about wanting to kill yourself?

Yes 1 ☐ No 2 ☐ —► If no, go to L6a) below

If yes,

b) Who have you been to for help? Please mark all boxes that apply.

- | | |
|--|----------------------------|
| i) Mum or Dad | 1 <input type="checkbox"/> |
| ii) Brother or sister | 1 <input type="checkbox"/> |
| iii) Someone else in your family | 1 <input type="checkbox"/> |
| iv) A friend | 1 <input type="checkbox"/> |
| v) A teacher | 1 <input type="checkbox"/> |
| vi) A school counsellor | 1 <input type="checkbox"/> |
| vii) Peer supporter/mediator at school | 1 <input type="checkbox"/> |
| viii) A GP (family doctor) | 1 <input type="checkbox"/> |
| ix) A social worker | 1 <input type="checkbox"/> |
| x) A psychologist or psychiatrist | 1 <input type="checkbox"/> |
| xi) A telephone help line | 1 <input type="checkbox"/> |
| xii) Somewhere else (e.g. internet, book, magazine, other person, etc.), please say what or who: | 1 <input type="checkbox"/> |

L6. a) Have you ever felt that life was not worth living?

Yes 1 ☐ No 2 ☐ —► If no, go to Section M on page 44



If yes, go to L6b on page 43

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L6. b) When was the **last time** you felt like this? Please mark **one** box only.

In the last week ¹ ☐

More than a week ² ☐

More than a year ago ³ ☐
ago but in the last year

L7. a) Have you **ever** found yourself wishing you were dead and away from it all?

Yes ¹ ☐

No ² ☐

→ **If no, go to Section M on page 44**

If yes,

b) When was the last time you felt like this? Please mark one box only.

In the last week ¹ ☐

More than a week ² ☐

More than a year ago ³ ☐
ago but in the last year

L8. a) Have you **ever** thought of killing yourself, even if you would not really do it?

Yes ¹ ☐

No ² ☐

→ **If no, go to Section M on page 44**

If yes,

b) When was the **last time** you felt like this? Please mark **one** box only.

In the last week ¹ ☐

More than a week ² ☐

More than a year ago ³ ☐
ago but in the last year

L9. Have you **ever** made plans to kill yourself?

Yes ¹ ☐

No ² ☐

You can get information and advice relating to any of the questions by contacting the organisations on the enclosed Helpline information sheet.

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SECTION M: TRANSPORT & ACCIDENTS

Your trip *to* school/college/work (this morning, or the last time you went to school/college/work)

M1.How long did your trip take? (Mark **one** box only)

- | | | | | | |
|---------------------|--------------------------|---------------|--------------------------|----------------------|--------------------------|
| Less than 5 minutes | <input type="checkbox"/> | 5-10 minutes | <input type="checkbox"/> | 11-20 minutes | <input type="checkbox"/> |
| 21-30 minutes | <input type="checkbox"/> | 31-45 minutes | <input type="checkbox"/> | More than 45 minutes | <input type="checkbox"/> |

M2.How did you get to school/college/work? (You can mark **more** than **one** answer)

- | | | | |
|-----------------------|--------------------------|---------------------------|--------------------------|
| a) Walked all the way | <input type="checkbox"/> | b) Walked part of the way | <input type="checkbox"/> |
| c) By public bus | <input type="checkbox"/> | d) By school bus | <input type="checkbox"/> |
| e) By car/taxi | <input type="checkbox"/> | f) By bicycle | <input type="checkbox"/> |
| g) By train | <input type="checkbox"/> | | |

M3.If you could change the way you travelled to and from school/college/work, would you prefer to travel: (Mark **one** box only)

- | | | | | | | | |
|---------------|--------------------------|---------------|--------------------------|--|--------------------------|----------|--------------------------|
| On foot | <input type="checkbox"/> | By bicycle | <input type="checkbox"/> | By car | <input type="checkbox"/> | By train | <input type="checkbox"/> |
| By school bus | <input type="checkbox"/> | By public bus | <input type="checkbox"/> | Do not wish to change the way I travel | <input type="checkbox"/> | | |

Your trip home from school/college/work (yesterday, or the last time you came home from school/college/work)

M4.How long did your trip home take? (Mark one box only)

- | | | | | | |
|---------------------|--------------------------|---------------|--------------------------|----------------------|--------------------------|
| Less than 5 minutes | <input type="checkbox"/> | 5-10 minutes | <input type="checkbox"/> | 11-20 minutes | <input type="checkbox"/> |
| 21-30 minutes | <input type="checkbox"/> | 31-45 minutes | <input type="checkbox"/> | More than 45 minutes | <input type="checkbox"/> |

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M5.How did you go home from school/college/work? (You can mark **more** than **one** answer)

- | | | | |
|-----------------------|----------------------------|---------------------------|----------------------------|
| a) Walked all the way | 1 <input type="checkbox"/> | b) Walked part of the way | 1 <input type="checkbox"/> |
| c) By public bus | 1 <input type="checkbox"/> | d) By school bus | 1 <input type="checkbox"/> |
| e) By car/taxi | 1 <input type="checkbox"/> | f) By bicycle | 1 <input type="checkbox"/> |
| g) By train | 1 <input type="checkbox"/> | | |

M6.How safe do you feel crossing the roads outside your school/college/work place?

- Very safe 1 ☐ Quite safe 2 ☐ A bit unsafe 3 ☐ Not safe at all 4 ☐

M7.How safe do you feel crossing the roads near where you live?

- Very safe 1 ☐ Quite safe 2 ☐ A bit unsafe 3 ☐ Not safe at all 4 ☐

Travelling by car, bus, train and bike

M8.When was the **last time** you travelled in a car or van or taxi? (Mark **one** box only).

- | | | | | | | | |
|---------------------------|----------------------------|-----------------------|----------------------------|--------------|----------------------------|---|----------------------------|
| Today | 1 <input type="checkbox"/> | Yesterday | 2 <input type="checkbox"/> | 2-4 days ago | 3 <input type="checkbox"/> | 5-7 days ago | 4 <input type="checkbox"/> |
| Between 1 and 4 weeks ago | 5 <input type="checkbox"/> | More than a month ago | 6 <input type="checkbox"/> | Never | 7 <input type="checkbox"/> | ➔ If never, go to M12 on page 46 | |

M9.The **last time** you travelled in a car or van or taxi, did you sit in the front seat or the back seat? (Mark **one** box only).

- Front seat 1 ☐ Back seat 2 ☐ Can't remember 3 ☐

M10. The **last time** you travelled in a car or van or taxi, did you wear a seat belt?

- Yes 1 ☐ No 2 ☐ Can't remember 3 ☐



M11. If you did wear a seat belt, was this because: (Please mark **one** box only).

- | | | | |
|---|----------------------------|--------------------------|----------------------------|
| You chose to | 1 <input type="checkbox"/> | The driver asked you to | 3 <input type="checkbox"/> |
| Everyone else had theirs on and you didn't want to be different | 2 <input type="checkbox"/> | I didn't wear a seatbelt | 4 <input type="checkbox"/> |

M12. Does someone in your house own a car or van?

- Yes 1 ☐ No 2 ☐

M13. Have you **ever** driven a car:

Yes **No**

- | | | |
|--|----------------------------|----------------------------|
| a) off the road (e.g. on private land or in a car park)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) on a public road without a licence? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

M14. Have you **ever** been a passenger in a car, knowing that the driver has not passed his driving test and is not supervised by a qualifying accompanying driver?

- Yes 1 ☐ No 2 ☐

M15. Have you **ever** been a passenger in a car, knowing that the driver has been drinking?

- Yes 1 ☐ No 2 ☐

M16. When was the **last time** you travelled on a bus? (Mark **one** box only).

- | | | | |
|---|---|---|---|
| Today 1 <input type="checkbox"/> | Yesterday 2 <input type="checkbox"/> | 2-4 days ago 3 <input type="checkbox"/> | 5-7 days ago 4 <input type="checkbox"/> |
| Between 1 and 5 <input type="checkbox"/>
4 weeks ago | More than a 6 <input type="checkbox"/>
month ago | Never 7 <input type="checkbox"/> | |

M17. When was the **last time** you travelled on a train? (Mark **one** box only).

- | | | | |
|---|---|---|---|
| Today 1 <input type="checkbox"/> | Yesterday 2 <input type="checkbox"/> | 2-4 days ago 3 <input type="checkbox"/> | 5-7 days ago 4 <input type="checkbox"/> |
| Between 1 and 5 <input type="checkbox"/>
4 weeks ago | More than a 6 <input type="checkbox"/>
month ago | Never 7 <input type="checkbox"/> | |

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11

5

- Off the road (e.g. on private land or in a car park)?
- On the road with a licence?
- On the road without a licence?

2 ☐2 ☐2 ☐No 2 ☐No 2 ☐

5-7 days ago 4 ☐

Never 7 ☐

**If never, go to
M25 on page 48**

2 ☐

More than 5 miles 4 ☐

Not safe at all 4 ☐

Can't remember

3 ☐3 ☐3 ☐

Accidents

M25. In the **last 6 months** have you had any kind of accident, which caused you to see a doctor or to go to hospital? (Please mark **any** that apply).

	Yes	No
a) Fall	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) Fracture (broken bone), please describe:	1 <input type="checkbox"/>	2 <input type="checkbox"/>

c) Burn or scald	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) Indigestion/swallowing something	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) Sports injury	1 <input type="checkbox"/>	2 <input type="checkbox"/>
f) Other, please describe:	1 <input type="checkbox"/>	2 <input type="checkbox"/>

M26. Since your **14th birthday**, have you had a head injury resulting in loss of consciousness (passing out)?

Yes 1 ☐ No 2 ☐

If yes, please describe:

M27. In the **last year**, have you ever been involved in a road accident?

Yes 1 ☐ No 2 ☐ —▶ If no, please go to section N on page 50

M28. Thinking about the **last** accident you had, how were you travelling? (Mark **one** box only).

In a car as a driver 1 ☐ In a car as a passenger 2 ☐ As a pedestrian 3 ☐
As a cyclist 4 ☐ Something else, please describe: 5 ☐



M29. Who was with you at the time of the accident? (Please mark **all** the ones you were with)

- a) On my own ¹ ☐ c) Brother(s) or sister(s) ¹ ☐
b) Parent or other adult ¹ ☐ d) With friends ¹ ☐

M30. What were you doing at the time of the accident? (Mark **one** box only).

- Going to or from school/college/work ¹ ☐
Playing or hanging out in the streets ² ☐
Going to or from a club ³ ☐
Going to or from the park ⁴ ☐
Going to or from church, temple, synagogue or mosque ⁵ ☐
Other journey, please mark and describe: ⁶ ☐
-

M31. When did the accident happen? (Mark **one** box only).

- Before school/college/work ¹ ☐ After school/college/work ² ☐
At the weekend ³ ☐ During school holidays ⁴ ☐

M32. Were you hurt?

- Yes ¹ ☐ No ² ☐ —————> **If no, go to Section N on page 50**

M33. Did you see a family doctor?

- Yes ¹ ☐ No ² ☐

M34. Did you go to the casualty department at hospital?

- Yes ¹ ☐ No ² ☐

M35. If you went to the casualty department, did you stay overnight in hospital?

- Yes ¹ ☐ No ² ☐

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SECTION N: OCCUPATION

We are interested in whether you work or not and the type of work you do.

N1. Are you in full-time education?

Yes ¹ ☐ —▶ **If yes, go to
N2 below**

No ² ☐ —▶ **If no, go to
N3 below**

N2. Do you ever do any work in a spare-time **paid** job in term-time (even if it's only for an hour or two now and then)? Please don't include jobs you only do during the school holidays or voluntary work.

Yes ¹ ☐ —▶ **If yes, go to
N4 below**

No ² ☐ —▶ **If no, go to
N5 on page 51**

N3. Are you currently? (You **can** mark **more** than one box).

- a) Unemployed and seeking work ¹ ☐ —▶ **Go to N5 on page 51**
- b) Unemployed through sickness/disability ¹ ☐ —▶ **Go to N5 on page 51**
- c) Doing voluntary work ¹ ☐ —▶ **Go to N5 on page 51**
- d) Working part-time ¹ ☐ —▶ **Go to N4a) below**
- e) Working full-time ¹ ☐ —▶ **Go to N4a) below**

N4. a) What is you current job title?

Month

Year

2

0

0

/

c) Please describe the main things you do in this job:



N5. In the past, have you had any **paid** jobs?

Yes ¹ ☐ —▶ **If yes, go to N6 below**

No ² ☐ —▶ **If no, go to Section O on the back page**

N6. Please fill in as much information for all of the jobs you have had in the past.

i)

a) From

Month

Year

 /

b) To

Month

Year

 /

c) Job title and the main things you did

ii)

a) From

Month

Year

 /

b) To

Month

Year

 /

c) Job title and the main things you did

iii)

a) From

Month

Year

 /

b) To

Month

Year

 /

c) Job title and the main things you did



Section O:

O1. 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 ☐

O2. What is your date of birth?

Day			Month			Year			
<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text" value="1"/>	<input type="text" value="9"/>	<input type="text" value="9"/>	<input type="text"/>

O3. What is today's date?

Day			Month			Year			
<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text" value="2"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text"/>

Thank you VERY much for your help

When completed, please send this back to:

**Professor George Davey-Smith
Children of the Nineties - ALSPAC
24 Tyndall Avenue
Bristol
BS8 1BR**

All the answers you have given are confidential. You might want to talk to someone about some of the subjects in this questionnaire, so we have included details of confidential Helplines on a separate sheet.

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