



Questionnaire no.

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MY TEENAGE SON

All answers are confidential

This questionnaire is for the study child's mother or the person taking the role of chief carer.

This questionnaire is for the study teenager's mother or person taking the role of chief carer.

To answer simply tick the box which is most accurate in your opinion.

If you do not want to answer a question or if it does not apply to your son, put a line through it. There are no good or bad answers. Just tell us what is true for you.

THANK YOU FOR YOUR HELP

SECTION A: YOUR SON'S HEALTH

A1. How would you assess the health of your study teenager nowadays?

	(i) in the past month	(ii) in the past year
very healthy, no problems	1 <input type="text"/>	1 <input type="text"/>
healthy, but a few minor problems	2 <input type="text"/>	2 <input type="text"/>
sometimes quite ill	3 <input type="text"/>	3 <input type="text"/>
almost always unwell	4 <input type="text"/>	4 <input type="text"/>

A2. Has he had any of the following in the past 12 months?

In the past 12 months:	Yes and saw a doctor	Yes but did not see doctor	No did not have
a) diarrhoea	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
b) blood in the stools	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
c) vomiting	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
d) cough	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
e) high temperature	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
f) ear ache	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
g) ear discharge (pus not wax)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
h) convulsions/fits	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
i) stomach ache(s)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
j) rash	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
k) wheezing	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

A2.	cont.	Yes and saw a doctor	Yes but did not see doctor	No did not have
	In the past 12 months:			
l)	breathlessness	<div>1</div>	<div>2</div>	<div>3</div>
m)	episodes of stopping breathing	<div>1</div>	<div>2</div>	<div>3</div>
n)	an accident	<div>1</div>	<div>2</div>	<div>3</div>
o)	headache(s)	<div>1</div>	<div>2</div>	<div>3</div>
p)	constipation	<div>1</div>	<div>2</div>	<div>3</div>
q)	worm infection	<div>1</div>	<div>2</div>	<div>3</div>
r)	head lice	<div>1</div>	<div>2</div>	<div>3</div>
s)	scabies	<div>1</div>	<div>2</div>	<div>3</div>
t)	asthma	<div>1</div>	<div>2</div>	<div>3</div>
u)	eczema	<div>1</div>	<div>2</div>	<div>3</div>
v)	hay fever	<div>1</div>	<div>2</div>	<div>3</div>
w)	other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>

.....

A3. Which of the following infections has he **ever** had:

	Yes, in the past 12 months	Yes, but not not in past 12 months	No, never ↓
a) measles	<div>1</div>	<div>2</div>	<div>3</div>
b) chicken pox	<div>1</div>	<div>2</div>	<div>3</div>
c) mumps	<div>1</div>	<div>2</div>	<div>3</div>
d) meningitis	<div>1</div>	<div>2</div>	<div>3</div>
e) cold sores	<div>1</div>	<div>2</div>	<div>3</div>
f) whooping cough	<div>1</div>	<div>2</div>	<div>3</div>

A3. cont.

	Yes, in the past 12 months	Yes, but not not in past 12 months	No, never ↓
g) urinary infection	<div>1</div>	<div>2</div>	<div>3</div>
h) eye infection	<div>1</div>	<div>2</div>	<div>3</div>
i) ear infection	<div>1</div>	<div>2</div>	<div>3</div>
j) chest infection	<div>1</div>	<div>2</div>	<div>3</div>
k) tonsillitis or laryngitis	<div>1</div>	<div>2</div>	<div>3</div>
l) german measles	<div>1</div>	<div>2</div>	<div>3</div>
m) scarlet fever	<div>1</div>	<div>2</div>	<div>3</div>
n) influenza (flu)	<div>1</div>	<div>2</div>	<div>3</div>
o) a cold	<div>1</div>	<div>2</div>	<div>3</div>
p) glandular fever	<div>1</div>	<div>2</div>	<div>3</div>
q) other infection (please tick & describe)	<div>1</div>	<div>2</div>	<div>3</div>

.....

A4. a) Has your teenager been admitted to hospital **since his 9th birthday**?

Yes

1

 No

2

 → **If no, go to A5 on page 6**

If yes,

b) how many times?

A4. c) please describe for each admission:

	Age of child (years)	Reason for admission	No. of nights child stayed in hospital
1.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>



Write 00 if he did not stay overnight

If more than 3 admissions please describe on separate sheet

d) How often did you see him while he was in hospital?

	1st admission	2nd admission	3rd admission
Not at all	<input type="text"/>	<input type="text"/>	<input type="text"/>
Quite often	<input type="text"/>	<input type="text"/>	<input type="text"/>
Every day	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stayed in the hospital with him	<input type="text"/>	<input type="text"/>	<input type="text"/>

A5. Are there any foods or drinks that your teenager is or has been allergic to?

yes definitely yes possibly no, not at all don't know

If no, or don't know
go to A6a on page 8

If yes,

a) please describe which foods or drinks

b) was the reaction caused by eating or touching the food or drink?

eating/drinking touching both

A5. c) what happens when he does have the reaction? (Tick all that apply)

i) bright red rash

☐

→If yes, over what part of body?

.....

ii) hives (white raised bumps on skin)

☐

→If yes, over what part of body?

.....

iii) wheezing or whistling
in the chest

☐

iv) vomiting

☐

v) diarrhoea

☐

vi) difficulty breathing

☐

vii) stop breathing

☐

viii) headache

☐

ix) swelling

☐

→ If yes, describe where

x) other reaction

☐

→ Please tick and describe

.....

d) How long after eating or drinking or touching does this usually happen?

less than 1 hr

☐

1-2 hrs

☐

3-5 hrs

☐

6 hrs or more

☐

don't know

☐

e) How old was he when this first happened?

years old

(put 00 if he was under 12 months)

f) How many times has a reaction happened?

once

☐

2-3 times

☐

4-9 times

☐

10 or more times

☐

don't know

☐

A5. g) How old was he the last time a reaction happened?

years old

h) What treatment has your teenager been given for the problem?

None ₁ Yes, some treatment ₂ → Please describe

.....

A6. a) Apart from food and drink are there any other things to which he is allergic?

Yes ₁ No ₂ → If **no**, go to A7 below

If **yes**,

b) What is he allergic to? (Tick all that apply)

i) pollen

₁

ii) cat

₁

iii) dog

₁

iv) bee sting

₁

v) wasp sting

₁

vi) house dust

₁

vii) medicine

₁

→ If **yes**, please describe type of medicine

.....

viii) other

₁

→ Please tick and describe

.....

A7. Has he **ever** had a seizure, fit or a convulsion?

Yes ₁ No ₂ → If **no**, go to A8 on page 10

If **yes**,

a) how many has he had?

A7. b) did any of them last more than 15 minutes?

Yes 1 No 2 can't say 3

c) did his body shake and jerk on just one side?

Yes, right side 1 Yes, left side 2 No, it was all over 3 can't say 4

d) did he have a fever at the time?

Yes, each time (or only time) 1 Yes, but not each time 2 No 3 → **If no, go to A7e) below**

If yes,

(i) how high was his temperature? (put NK if you don't know)

(ii) what was the cause of the fever(s)?

.....

(iii) did he have more than one episode of fitting during any feverish illness?

Yes 1 No 2

e) When the first fit or convulsion happened:

how old was he? years

(If less than 1 year put 00)

f) Were there any warning signs before he had a fit or convulsion?

Yes 1 No 2 → **If no, go to A8 on page 10**

If yes,

Please describe:

.....

A8. Does he often have aches and pains in his arms or legs?

yes arm(s)

yes leg(s)

yes both

no, not often



If no, go to A9 below

If yes,

a) does this happen especially when he is tired?

Yes

No

b) what do you think is the cause ?

.....

c) do you find any particular treatment helps ?

Yes

No

d) **If yes,** please describe.....

A9. During sleep, does your study teenager:

	Never	Sometimes	Often
a) snore	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) perspire/sweat a lot	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) fidget	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) talk	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) have nightmares	<input type="text"/>	<input type="text"/>	<input type="text"/>

A10. How often does your teenager wake up in the night?

	Never	Sometimes	Often
a) to go to the toilet	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) because of loud or unusual noises	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) if worried	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) if excited	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) if feeling poorly	<input type="text"/>	<input type="text"/>	<input type="text"/>

A11. Thinking back over the last month, has your teenager been feeling tired or been lacking in energy?

Yes

No

→ If **no**, go to A16 on page 12

If **yes**,

a) Do you know why he has been feeling tired or lacking in energy?

Yes

No

→ If **no**, go to A13 below

A12. What is the main reason he has been feeling tired or lacking in energy?
(please tick all that apply)

a) Illness

b) Problems with sleep

c) Playing a lot of sport
(or other physical exercise)

d) Stress or worry

e) Other reason (please give details)

.....

A13. How long has he been feeling tired or felt he had no energy? (Tick one only)

Less than 3 months

Between 3 and 5 months

Between 6 months and 5 years

More than 5 years

A14. Does he feel better after resting?

Not at all

Only a bit

Definitely better

A15. During the last month, has this tiredness or lack of energy stopped him from playing, taking part in hobbies, sports or other leisure activities?

Not at all

Only a little

Quite a lot

A great deal

A16 During the past year, how many days has your teenager been off school because of this tiredness or lack of energy? (If none, write 00)

--	--

 days

A17. Has he seen a doctor in the past year because of this tiredness or lack of energy?

Yes	<div>1</div>	No	<div>2</div>
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SECTION B: SEEING AND HEARING

Just as some people have better long-distance vision than others, so some people are better at remembering faces they have seen, or seeing people or objects in a crowd. We would like to know how your study teenager responds in the situations described below.

However, if your study teenager's sight is so poor that you feel you cannot answer, please tick this box

1

then go straight to B13 on page 15.

B1. When he sees members of his close family, does he recognise them?

Never	<div>1</div>
Occasionally	<div>2</div>
Most of the time	<div>3</div>
Always	<div>4</div>

B2. Does he recognise friends?

Never	<div>1</div>
Occasionally	<div>2</div>
Most of the time	<div>3</div>
Always	<div>4</div>

B3. Does he recognise people from photographs?

Never

1

Occasionally

2

Most of the time

3

Always

4

B4. Does he lose objects around the house?

Never

1

Occasionally

2

Most of the time

3

Always

4

B5. Does he have difficulty reaching out for and grasping objects?

Never

1

Occasionally

2

Most of the time

3

Always

4

B6. Does he have difficulty distinguishing a step from a line on the ground?

Never

1

Occasionally

2

Most of the time

3

Always

4

B7. Can he find objects on a patterned carpet or bedspread?

Never

Occasionally

Most of the time

Always

B8. Can he find objects in complex pictures?

Never

Occasionally

Most of the time

Always

B9. Does he misjudge going through doorways or along corridors?

Never

Occasionally

Most of the time

Always

B10. Can he find his way around the house?

Never

Occasionally

Most of the time

Always

B11. Does he have difficulty seeing things pointed out in the distance?

Never

Occasionally

Most of the time

Always

B12. Can he find his way around in new surroundings?

Never

Occasionally

Most of the time

Always

B13. Does he prefer music or talking to be loud or soft?

He hates loud sounds

He doesn't mind if it's
loud or not

He loves loud sounds

Can't say

B14. How do you rate his hearing?

Excellent

Good

OK

Some sounds he can't hear

He can't hear much at all

SECTION C: TICS AND UNINTENDED HABITS

Many teenagers have strange habits that they do not intend and often are not aware of them. Please indicate whether your study teenager has had any of these in the past year.

In the past year:		Definitely	Probably	No, not At all
C1.	Repeated movements of parts of the face and head (e.g. eye blinking, grimacing, sticking tongue out, licking lips, spitting)	<div>1</div>	<div>2</div>	<div>3</div>
C2.	Repeated movements of the neck, shoulder or trunk (e.g. twisting around, shoulder shrugging, bending over, nodding)	<div>1</div>	<div>2</div>	<div>3</div>
C3.	Repeated movements of the arms, hands, legs or feet (e.g. clapping hands, touching himself or others, hopping, kicking)	<div>1</div>	<div>2</div>	<div>3</div>
C4.	Repeated noises and sounds (e.g. coughing, clearing throat, grunting, gurgling, hissing)	<div>1</div>	<div>2</div>	<div>3</div>
C5.	Repeated words and phrases	<div>1</div>	<div>2</div>	<div>3</div>
C6.	If definitely or probably to any of the above:			
a)	Please describe what is repeated			
			
b)	About how often does/did this happen in the last year?			
	Less than once a month	<div>1</div>		
	1-3 times a month	<div>2</div>		
	about once a week	<div>3</div>		
	more than once a week	<div>4</div>		
	every day	<div>5</div>		

C6. c) Does this happen more at particular times?

Yes ☐ 1 No ☐ 2

If yes, please tick all that apply:

(i) when tired ☐ 1

(ii) when anxious or stressed ☐ 1

(iii) other time (please tick and describe) ☐ 1

.....

SECTION D: SOCIAL SKILLS

D1. How do you feel your study teenager compares with people of his own age in regard to the following:

	A lot worse than average	A bit worse than average	About average ↓	A bit better than average	A lot better than average
a) Able to laugh around with others, e.g. accepting light-hearted teasing and responding appropriately	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b) Easy to chat with, even if it isn't on a topic that specially interests him	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c) Able to compromise and be flexible	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d) Finds the right thing to say or do in order to defuse a tense or embarrassing situation	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
e) Graceful when he doesn't win or get his own way. A good loser	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
f) Other people feel at ease around him	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
g) By reading between the lines of what people say, he can work out what they are really thinking and feeling	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
h) After doing something wrong, he's able to say sorry and sort it out so that there are no hard feelings.	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
i) Can take the lead without others feeling they are being bossed about	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
j) Aware of what is and isn't appropriate in different social situations	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

SECTION E: ATTITUDES AND BEHAVIOUR TOWARDS ANIMALS

Some teenagers have had a liking for all animals from being very small. Others are afraid and don't like certain animals. Sometimes they try to hurt or harm animals. We would like to ask you some questions about how your teenager feels towards animals.

How often:	Never	Rarely	Sometimes	Often	Always
E1. Is he scared of dogs?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E2. Is he scared of insects or spiders?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E3. Is he rough with animals?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E4. Does he harm animals?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E5. Does he show an interest in animals?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E6. Does he show an interest in insects?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
E7. Does he show concern for the suffering of animals?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

	Never	Accidentally	In curiosity	Maybe on purpose	Definitely on purpose
E8. My teenager has harmed animals	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

	Yes	No	
E9. My teenager has harmed small insects	<div>1</div>	<div>2</div>	
E10. My teenager has harmed the family pets	<div>1</div>	<div>2</div>	Has never had a pet <div>7</div>
E11. My teenager has harmed other people's pets	<div>1</div>	<div>2</div>	
E12. My teenager has harmed animals (not pets)	<div>1</div>	<div>2</div>	

	Never	More than one year ago	Last week	Yesterday	Today
E13. The last time my teenager hurt an animal was	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

How often:	Never	Rarely	Sometimes	Often	Always	Don't know
E14. Has he hurt animals whilst on his own ?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>
E15. Has he, together with others, hurt animals?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>
E16. Has he secretly hurt animals?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>
E17. Has he shown pleasure when hurting animals?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>
E18. Is he forgiving if an animal bites or scratches?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>
E19. Will he go out of his way to fuss and stroke an animal?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="9"/>

SECTION F: MEDICINES, PILLS, LOTIONS, CREAMS AND IMMUNISATIONS

We are interested in finding out whether children have any difficulties in correctly taking medicines **by mouth**. For example, you may have had to crush tablets/pills or empty out the contents of a capsule and add them to a drink or a spoonful of jam, because of difficulty in swallowing them whole or a dislike of the taste.

F1. Is your study teenager able to swallow pills/tablets **whole**?

Yes No Don't know, never takes any

F2 a) Has your study teenager **ever** been given a medicine, pill or capsule that he was unable to take in the correct manner?

Yes No → **If no, go to the top of page 23**

If yes, what type of medicine was difficult for him to take? (tick all that apply)

	Yes	Please give name(s) of medicines
i) tablets	<input type="text" value="1"/> →
ii) hard capsules (usually contain granules or powder)	<input type="text" value="1"/> →
iii) soft capsules (may contain a liquid)	<input type="text" value="1"/> →
iv) liquid medicine	<input type="text" value="1"/> →

b) What did you have to do to help him take the medicine? (If more than 1 type of medicine, answer separately for each)

i) Medicine 1
Name of medicine

Tick one only

Yes

Crush or break up tablets

Empty capsules

Add the medicine to a drink

→ **If yes**, what type of drink?

.....

Other, please tick and describe

→

.....

F2.b) ii) Medicine 2
Name of medicine

Tick one only

Yes

Crush or break up tablets

1

Empty capsules

2

Add the medicine to a drink

3



If yes, what type of drink?

.....

Other, please tick and describe

4



.....

iii) Medicine 3
Name of medicine

Tick one only

Yes

Crush or break up tablets

1

Empty capsules

2

Add the medicine to a drink

3



If yes, what type of drink?

.....

Other, please tick and describe

4



.....

Medicines often have some unwanted effects, which we know to expect, such as causing a dry mouth. However, we are interested in finding out about more severe and/or unexpected reactions, which required some further action, such as seeking advice from your doctor or pharmacist, and/or stopping or changing the medicine.

F3. a) Has your son ever had a bad reaction or side effect, which was thought to be due to a medicine he was taking or using, and which required some action to be taken? (By medicine we mean **pills/tablets, liquid mixture, cream or ointment, injection or vaccine, eye drops, herbal medicine etc.**)

Yes No → If **no**, go to Section G on page 28

If **yes**,

Please give the details separately for each type of medicine that caused a bad reaction (if he had side effects to more than 3 medicines, give details for the 3 most serious or severe reactions)

	Medicine A	Medicine B	Medicine C
b) Name of medicine:
c) What type of medicine was it?			
tablets/capsules/pills	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="1"/>
liquid medicine (taken by mouth)	<input type="text" value="2"/>	<input type="text" value="2"/>	<input type="text" value="2"/>
cream/ointment/lotion	<input type="text" value="3"/>	<input type="text" value="3"/>	<input type="text" value="3"/>
injection/vaccine/immunisation	<input type="text" value="4"/>	<input type="text" value="4"/>	<input type="text" value="4"/>
eye drops/eye ointment	<input type="text" value="5"/>	<input type="text" value="5"/>	<input type="text" value="5"/>
other (please describe)	<input type="text" value="6"/>	<input type="text" value="6"/>	<input type="text" value="6"/>

d) What was the medicine being used for (e.g. chest infection, stomach upset, skin problem)?
e) How old was he at the time the reaction happened?	<input type="text" value=""/> <input type="text" value=""/> years	<input type="text" value=""/> <input type="text" value=""/> years	<input type="text" value=""/> <input type="text" value=""/> years

F4. Which of the following best describes the reaction or side effects? (tick all that apply)

	Medicine A	Medicine B	Medicine C
a) skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) feeling/being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) effects on digestion e.g. diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) bad headache(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) dizziness/feeling faint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) severe allergic reaction or anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) other, please tick and describe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F5. Please choose **one** of the following for each medicine, that best describes how often, and for how long each time, the side effects happened. **(Tick just one for each medicine)**

	Medicine A	Medicine B	Medicine C
Single isolated incident (e.g. severe allergic reaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated episodes over 1-2 days (e.g. dizzy spells)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated episodes over 3-7 days (e.g. dizzy spells or headaches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated episodes over more than 7 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous, but lasted less than 2 days (e.g. headache or skin rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous, lasting 2-7 days (e.g. skin rash, itching)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous, lasting more than 7 days (e.g. blood disorder or jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please tick and describe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....			
.....			

F6. How serious, severe and/or unexpected was the reaction? (tick all that apply)

	Medicine A	Medicine B	Medicine C
a) Unexpected (i.e. you were not aware or had not been warned that some people may experience these side effects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) The side effects were bad enough to prevent him doing things that he would normally have done (after allowing for the illness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) The side effects were bad enough for advice to be sought from a healthcare professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, who was this? (tick all that apply):			
(i) family doctor/GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) hospital doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) pharmacist/chemist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) other (please tick and describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....			
d) The reaction was so bad that he had to stop using the medicine (leave blank for one-off doses e.g. vaccines)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) He was admitted to hospital because of the side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) How long did he stay in hospital?	<input type="text"/> <input type="text"/> days	<input type="text"/> <input type="text"/> days	<input type="text"/> <input type="text"/> days

F6. cont.		Medicine A	Medicine B	Medicine C
f)	He recovered fully from the side effects after stopping the medicine	<div><div>1</div></div>	<div><div>1</div></div>	<div><div>1</div></div>
g)	He recovered fully from the side effects and was able to continue taking the medicine	<div><div>1</div></div>	<div><div>1</div></div>	<div><div>1</div></div>
h)	He has had this medicine again but did not have the same bad reaction	<div><div>1</div></div>	<div><div>1</div></div>	<div><div>1</div></div>
i)	He has had this medicine again and the side effects were repeated	<div><div>1</div></div>	<div><div>1</div></div>	<div><div>1</div></div>
j)	He still nowadays has some effects from having taken the medicine	<div><div>1</div></div>	<div><div>1</div></div>	<div><div>1</div></div>
F7.	As medicines can react with each other, we would like to know if he was using any other medicines at that time, if you can remember.			
	i)			
	ii)			
	iii)			
	iv)			

SECTION G: MOODS AND FEELINGS

G1. We are interested in studying the patterns of behaviour that children have. Please could you try to describe the kind of person your child is. When answering the questions, think about how he has tended to feel, think, and act over the past several years. Remember that there are no correct answers.

	Is often like this	Is sometimes like this	Is never like this
a) He goes to extremes to prevent those he loves from leaving him	<div>1</div>	<div>2</div>	<div>3</div>
b) He either loves someone or hates them, with nothing in between	<div>1</div>	<div>2</div>	<div>3</div>
c) He often wonders who he really is	<div>1</div>	<div>2</div>	<div>3</div>
d) He has tried to hurt or kill himself	<div>1</div>	<div>2</div>	<div>3</div>
e) He is a very moody boy	<div>1</div>	<div>2</div>	<div>3</div>
f) He feels his life is dull and meaningless	<div>1</div>	<div>2</div>	<div>3</div>
g) He has difficulty controlling his anger or temper	<div>1</div>	<div>2</div>	<div>3</div>
h) When he gets stressed out, things happen, e.g. he gets paranoid or complains of feeling detached from himself or things around him	<div>1</div>	<div>2</div>	<div>3</div>

G2. As far as you know, has he done things on impulse that can get him into trouble?

	Yes	No
a) Has he gone on eating binges?	<div>1</div>	<div>2</div>
b) Has he drunk too much alcohol?	<div>1</div>	<div>2</div>
c) Has he taken drugs?	<div>1</div>	<div>2</div>

		Yes	No
G2.	d) Has he spent more money than he has?	<input type="text"/>	<input type="text"/>
	e) Has he yelled at people?	<input type="text"/>	<input type="text"/>
	f) Has he broken things?	<input type="text"/>	<input type="text"/>
	g) Has he hit people?	<input type="text"/>	<input type="text"/>
	h) Has he stolen things?	<input type="text"/>	<input type="text"/>

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

		True	Sometimes true	Not true
In the past 2 weeks:				
G3.	He felt miserable or unhappy	<input type="text"/>	<input type="text"/>	<input type="text"/>
G4.	He didn't enjoy anything at all	<input type="text"/>	<input type="text"/>	<input type="text"/>
G5.	He felt so tired that he just sat around and did nothing	<input type="text"/>	<input type="text"/>	<input type="text"/>
G6.	He was very restless	<input type="text"/>	<input type="text"/>	<input type="text"/>
G7.	He felt he was no good any more	<input type="text"/>	<input type="text"/>	<input type="text"/>
G8.	He cried a lot	<input type="text"/>	<input type="text"/>	<input type="text"/>
G9.	He found it hard to think properly or concentrate	<input type="text"/>	<input type="text"/>	<input type="text"/>
G10.	He hated himself	<input type="text"/>	<input type="text"/>	<input type="text"/>
G11.	He felt he was a bad person	<input type="text"/>	<input type="text"/>	<input type="text"/>
G12.	He felt lonely	<input type="text"/>	<input type="text"/>	<input type="text"/>
G13.	He thought nobody really loved him	<input type="text"/>	<input type="text"/>	<input type="text"/>
G14.	He thought he could never be as good as other kids	<input type="text"/>	<input type="text"/>	<input type="text"/>
G15.	He felt he did everything wrong	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION H: DIETING, WEIGHT AND BODY SHAPE

H1. a) What is your study teenager's height at the moment (without shoes)?

feet

inches

OR

metres

centimetres

Don't know

b) What is his weight at the moment?

Please fill in using kilos or stones.

stones

pounds

OR

kilos

Don't know

c) What was his lowest weight in the last 12 months?

stones

pounds

OR

kilos

Don't know

d) What was his highest weight ever?

stones

pounds

OR

kilos

Don't know

H2. At present would you describe your study teenager as:

Very thin

Thin

Average

Plump

Fat

H3. How do you feel he compares this year with previous years?

Thinner in previous years

About the same

A little thinner this year

A lot thinner this year

H4. At present would he describe himself as:

Very thin

Thin

Average

Plump

Fat

H5. Have you or other people (e.g. family, friend, a doctor) been seriously concerned that his weight has been bad for his physical health?

Yes

No

H6. Does your study teenager think his weight has been bad for his physical health?

Yes

No

H7. Is he afraid of gaining weight or getting fat?

No

A little

A lot

It really terrifies him

H8. If a doctor told your study teenager that he needed to put on 5 pounds (2 kilos) for the sake of his health, how would he find this?

He may have a physical problem that makes it hard for him to put on weight. Here we are asking if he is willing to try, not whether he can succeed.

Easy

Difficult

Impossible

H9. Does he avoid the sorts of food that he thinks will make him fat?

No

A little

A lot

H10. How often does he avoid fattening food?

Never

Sometimes

Most of the time

Always

H11. Does he spend a lot of his time thinking about food?

Yes

No

Don't know

H12. Sometimes people say that they have such a strong desire for food, and that this desire is so hard to resist, that it is like an addict feels about drugs or alcohol. Does this apply to your study teenager?

No

A little

A lot

H13. Sometimes people lose control over what they eat, and then they eat a very large amount of food in a short time. Does your study teenager ever do this?

Yes

No

→ If **no**, go to H14 on page 33

If **yes**,

a) Over the last 3 months, how often has this happened?

Hasn't happened

Occasionally

About once a week

Two or more times a week

b) When this happens, does he have a sense of losing control over his eating?

Yes

No

Not sure

c) Please describe how much he typically eats during one of his episodes of eating too much:

.....

.....

.....

H14. Over the last 3 months, has your study teenager done any of the following to avoid putting on weight?

	No	A little	A lot	Tried to but not allowed	Don't know
a) Ate less at mealtimes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
b) Skipped meals	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
c) Went without food for long periods, e.g. all day or most of the day	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
d) Hid or threw away food that others gave him	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
e) Exercised more	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
f) Made himself sick	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
g) Took pills or medicines in order to lose weight	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
Please tick & describe what he took:					
.....					
h) Did other things. Please tick and describe what he does:	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="9"/>
.....					

	Yes	No	Don't know
H15 a) Has your study teenager <u>ever</u> thought he was fat even when other people said he was very thin?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
b) Would he be ashamed if other people knew how much he eats?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
c) Has he <u>ever</u> deliberately made himself sick?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
d) Do worries about eating really interfere with his life?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
			Never eats too much
e) If he eats too much, does he blame himself a lot?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

	No, not at all	Yes a little	Yes quite a lot	Yes a great deal	Don't know
H16. Is he upset or distressed about his weight or body shape?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	9 <input type="text"/>

H17. How much do you think his eating pattern or concern about weight and body shape has interfered with:

	Not at all	A little	Quite a lot	A great deal
a) how well he gets on with you and the rest of the family?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
b) making and keeping friends?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
c) learning or class work?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
d) hobbies, sports or other leisure activities?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>

H18. Has his eating pattern or concern about weight or body shape put a burden on you or the family as a whole?	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
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SECTION I: STRENGTHS AND DIFFICULTIES

Please think how your teenager has been in the past 6 months

	In the last six months:	Not true	Somewhat true	Certainly true	Don't know
I1.	He has been considerate of other people's feelings	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I2.	He has been restless, overactive, cannot stay still for long	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I3.	He has often complained of headaches, stomach aches or sickness	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I4.	He has shared readily with other children and teenagers (treats, toys, pencils etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I5.	He has often had temper tantrums or hot tempers	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I6.	He is rather solitary, tends to play alone	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I7.	He is generally obedient, usually does what adults request	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I8.	He has many worries, often seems worried	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I9.	He is helpful if someone is hurt, upset or feeling ill	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I10.	He is constantly fidgeting or squirming	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I11.	He has at least one good friend	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I12.	He often fights or bullies other children or teenagers	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I13.	He is often unhappy, down-hearted or tearful	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I14.	He is generally liked by other children	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I15.	He is easily distracted, his concentration wanders	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I16.	He is nervous or clingy in new situations, easily loses confidence	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>

	In the last six months:	Not true	Somewhat true	Certainly true	Don't know
I17.	He is kind to younger children	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I18.	He often lies or cheats	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I19.	He is picked on or bullied by other children	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I20.	He often volunteers to help others (parents, teachers, other children)	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I21.	He thinks things out before acting	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I22.	He steals from home, school or elsewhere	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I23.	He gets on better with adults than with other teenagers	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I24.	He has many fears, is easily scared	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>
I25.	He sees tasks through to the end, has good attention span	<div>1</div>	<div>2</div>	<div>3</div>	<div>9</div>

SECTION J: EATING

- J1. a) Some teenagers just have snacks all day while others wait for meals. How would you describe your study teenager?

	(i) On school days	(ii) At the weekend
snacks all day, no real meals	1 <input type="text"/>	1 <input type="text"/>
snacks all day, but also has meals	2 <input type="text"/>	2 <input type="text"/>
doesn't snack much, just has meals	3 <input type="text"/>	3 <input type="text"/>
other (please tick & describe)	4 <input type="text"/>	4 <input type="text"/>
.....	

- b) How many real meals a day does your study teenager have now?

--	--

- J2. In the past year have you had difficulties getting him to eat what you wanted him to?

Yes, great difficulty	1 <input type="text"/>	→If <u>yes</u>, please describe the problems:
Yes, some difficulty	2 <input type="text"/>	
Yes, occasional difficulty	3 <input type="text"/>	
No, no difficulty	4 <input type="text"/>	

- J3. In the past 18 months has he at any time:

	Yes, often	Yes, occasionally	Never
a) deliberately not eaten a sufficient amount of food	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
b) refused to eat the food you think he should eat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
c) been choosy with food	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
d) over-eaten	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
e) been difficult to get into an eating routine/missed meals you wanted him to eat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

J4. Meals in School in the past year

a) In term time does your study teenager ever have a mid-day meal provided by the school?

Yes

No → **If no, go to J4c below**

If yes,

b) How many times per week?

Rarely,
ocasionally

Once
a week

2 or 3
times
a week

4 times
a week

5 times
a week
or more

c) Does your study teenager ever have a packed lunch provided by you?

Yes

No → **If no, go to J5 on page 39**

If yes,

d) How many times per week?

Rarely,
ocasionally

Once
a week

2 or 3
times
a week

4 times
a week

5 times
a week
or more

J5-J25. Thinking about all the food **that you provide** which he eats during the day, **including packed lunches, meals bought out and takeaways**, how often does he eat the following foods? Please answer every question even if he never eats the food (in this case tick “never” or “rarely”). **Do not include meals provided by school.**

J5.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Meat sausages, burgers	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b)	Meat pies/pasties (pork pie, steak/meat pie etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c)	Vegetarian Pies/ pasties (cheese and onion pasties, vegetable samosa, onion bhaji, vegetable grills etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d)	Ham, bacon, and cold meats (e.g. salami, luncheon meat, garlic sausage etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
e)	Meat roast, chops, stews and curries, shepherds pie, bolognaise etc. (e.g. beef, lamb, pork, mince)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
f)	Liver, kidney, heart, pâté	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
g)	Chicken/turkey in crispy coating (e.g. chicken nuggets, turkey burgers, chicken fingers etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
h)	Poultry: roast, grilled, fried, boiled, stewed (chicken, turkey etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

J5.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
i)	Shellfish (prawns, crab, cockles, mussels etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	White fish in breadcrumbs or batter (e.g. fish fingers/shapes, chip shop fish, breaded cod etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	White fish without coating (eg. grilled fish, cod in parsley sauce etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Tuna	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Other fish (pilchards, sardines, mackerel, herring, kippers, trout, salmon etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	Eggs, quiche, omelettes, flan etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	Cheese	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Pizza	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Lunchbox snack meals e.g. Lunchables Snack-attacks, Dunkers etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Oven chips	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Chips (fried), potato waffles or croquettes, Alphabites etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Roast potatoes (cooked in fat or oil)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

J5.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
u)	Boiled, mashed, jacket potatoes	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
v)	Rice (boiled, or fried, <u>not</u> rice pudding)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
w)	Canned pasta (spaghetti rings, ravioli, macaroni cheese etc.) Pot Noodles, Super Noodles etc.	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
x)	Boiled pasta (e.g. spaghetti, fusilli, lasagna) bulgar wheat and cous-cous	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
y)	Fried food (e.g. fried fish, eggs, bacon, chops etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

J6.	Does he eat the fat on meat?				
	yes, all of it	1 <input type="text"/>	no, always leaves fat	3 <input type="text"/>	never eats meat
	yes, some of it	2 <input type="text"/>	no, never given meat with fat	4 <input type="text"/>	5 <input type="text"/>

J7.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Baked beans	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b)	Peas, broad beans	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c)	Sweetcorn	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

J7.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
d)	Green vegetables (e.g. broccoli, cauliflower, cabbage, leeks, Brussels sprouts, courgettes, green beans etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Carrots	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Other root vegetables (turnip, swede, parsnip etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Tomatoes (cooked or raw)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Salad (lettuce, cucumber, peppers, other raw vegetables etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	Pulses and pulse dishes (dahl, lentil soup, falafel, dried peas, beans, chick peas)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Quorn pieces/mince/ fillets, Quorn sausages or burgers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	Soya 'Meat', TVP, Soya-type Vegeburgers, Vegebangers, Bean Curd (Tofu, Miso etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Peanuts, peanut butter	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Other nuts (e.g. cashew), nut roast	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	Canned fruit	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
J7.						
o)	Yoghurt, Fromage Frais	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Milk puddings (e.g. rice pudding, semolina), mousse, Angel Delight etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Ice cream, choc ice, chocolate ice cream bar etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Ice lollies	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Pudding (e.g. fruit pie, crumble, cheesecake, gateaux)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Custard, cream, Elmlea, Tip-Top, evaporated milk etc. on puddings	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
u)	Cakes or buns (fruit cake, sponge, teacake, doughnut, flapjack, scone, custard tart, cream cake etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
v)	Crispbreads (Ryvita, crackerbread etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
w)	Ketchup/brown sauce etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
x)	Mayonnaise, salad cream or dressing etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

- J8. a) Taking all foods provided by you together, in total, how many portions of vegetables e.g. broccoli, cauliflower, peas, carrots courgettes, cabbage, leeks, green beans etc. does he eat in a week? **Do not** include potatoes.

--	--

 portions

- b) Out of these total portions, how many are dark green leafy vegetables e.g. broccoli, Brussels sprouts, cabbage, spinach?

--	--

 portions

- J9. a) In total how many pieces of raw fruit e.g. apple, banana, orange, Satsuma, peach, grapes, strawberries etc. does he eat in a week? (For small fruit such as grapes etc, one “piece” will be a “helping” e.g. a small dish of strawberries or a small sprig of grapes.)

--	--

 pieces

- b) Out of these, how many of them are:

- i) citrus fruit e.g. tangerine, orange, satsuma, grapefruit

--	--

- ii) bananas

--	--

- iii) apples

--	--

- iv) other fruit

--	--

- J10. a) Does he eat breakfast cereals at all?

Yes

1

No

2

 → If **no**, go to J12 on page 46

If **yes**,

What type of breakfast cereal does he eat nowadays?

	Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
b) Oat cereals (e.g. porridge, Ready Brek, Muesli, chocolate Ready Brek)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

J10.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
c)	Wholegrain or bran cereals (e.g. All Bran, Bran Flakes, Weetabix, Wheatflakes, Fruit & Fibre, Shreddies, Shredded Wheat, Sugar Puffs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d)	Other cereals (e.g. Cornflakes, Rice Krispies, Frosties, Special K, Coco Pops)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e)	Breakfast cereal bars e.g. Rice Krispies bars, cornflakes bars	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

J11. **When he has breakfast cereals**

- a) How often are they sugar/honey coated or chocolate flavoured (e.g. Frosties, Coco Pops etc.)

Always

Sometimes

Never

→ If **never** go to J11c below

- b) How many teaspoonfuls of sugar does he have on **this type** of cereal (i.e. sugar coated etc.)

None

½ teaspoon

One teaspoon

2 teaspoons

More than 2 teaspoons

- c) How many teaspoonfuls of sugar does he have on **other types** of cereal (i.e. plain cereal)?

None

**½
teaspoon**

**One
teaspoon**

**2
teaspoons**

**More than
2 teaspoons**

**Doesn't have
plain cereal**

- d) How many times **per week** does he have milk on cereal? times

J12. How many times a week nowadays does he drink:

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Plain tap water on its own	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Bottled mineral/fizzy water	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Milk on its own	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Flavoured milk drinks (e.g. Horlicks, Ovaltine, milkshakes) or yoghurt drinks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Fruit juice	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

J13. How often does he eat each of these types of bread including in a packed lunch on school days?

		Usually	Sometimes	Never
a)	white bread	<div>1</div>	<div>2</div>	<div>3</div>
b)	soft grain white bread	<div>1</div>	<div>2</div>	<div>3</div>
c)	brown/granary bread	<div>1</div>	<div>2</div>	<div>3</div>
d)	wholemeal bread	<div>1</div>	<div>2</div>	<div>3</div>
e)	chappatis, pitta bread	<div>1</div>	<div>2</div>	<div>3</div>
f)	naan bread	<div>1</div>	<div>2</div>	<div>3</div>

		(i) School days		(ii) Other days	
J14.a)	How many slices of bread, rolls or chappatis provided by you does he eat on a usual day? (Include packed lunch provided from home)	<div></div>	<div></div>	<div></div>	<div></div>
b)	How many slices of bread (or rolls) spread with butter or margarine does he eat each day? (Include packed lunch provided from home)	<div></div>	<div></div>	<div></div>	<div></div>
c)	How many slices of bread (or rolls) spread with jam/honey/chocolate spread etc. does he eat each day? (Include packed lunch provided from home)	<div></div>	<div></div>	<div></div>	<div></div>

J15. What sort of fat does he have:

		(i) on bread or vegetables		(ii) for frying	
		Yes	No	Yes	No
a)	Butter, ghee, dripping, lard, solid cooking fat	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
b)	Olive oil margarine	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
c)	Full-fat polyunsaturated margarine (e.g. Flora, Vitalite, sunflower margarine)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
d)	Other full-fat margarine e.g. Stork, Blue Band, supermarket own brand, Clover, Golden Crown, Willow	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
e)	Low-fat polyunsaturated margarine (e.g. Flora lite, Vitalite Lite, low-fat sunflower margarine)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
f)	Other low-fat spread, not polyunsaturated (e.g. Delight, St Ivel Gold)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
g)	Sunflower oil, corn oil, soya oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
h)	Olive oil, hazelnut oil, rapeseed oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
i)	Other vegetable oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
j)	Other (please tick & describe)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>

.....

.....

J16. What type(s) of milk does he have?

	Yes usually	Yes sometimes	No not at all
a) Full fat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
b) Semi-skimmed	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
c) Skimmed	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
d) Goat/sheep milk	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
e) Soya milk	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
f) Flavoured milk	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
g) Other (please describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

.....

J17. How many times a week does he eat away from home in each of the following places?

	Never or rarely	Once a month	Once in 2 weeks	1-2 times a week	3-4 times a week	5 times a week or more
a) Fast food restaurant	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
b) Other café or restaurant	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
c) Grandparents or other family	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
d) Friends	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
e) Childminder	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>

J18. a) Does he drink tea?

Yes 1 No 2 → If no, go to J19a on page 49

If yes,

J18. b) How many cups of tea does he drink in total in a day? (do not include herbal teas) cups a day

c) How many spoons of sugar in each cup? spoons

d) How many of the cups of tea that he drinks are decaffeinated? cups a day

e) Which description best fits the amount of milk in the tea he drinks?

No milk	a little milk	about $\frac{1}{4}$ milk	about $\frac{1}{2}$ milk	about $\frac{3}{4}$ milk	almost all milk
---------	---------------	--------------------------	--------------------------	--------------------------	-----------------

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

J19. a) Does he drink coffee?

Yes No → If no, go to J20a on page 50

If yes,

b) How many cups of coffee (real, instant or decaffeinated) does he drink in total in a day? cups a day

c) How many spoons of sugar in each cup? spoons

d) How many of the cups of coffee he drinks are made using real coffee (i.e. not instant)? cups a day

e) How many of the cups of coffee he drinks are decaffeinated? cups a day

f) Which description best fits the amount of milk in the coffee he drinks?

No milk	a little milk	about $\frac{1}{4}$ milk	about $\frac{1}{2}$ milk	about $\frac{3}{4}$ milk	almost all milk
---------	---------------	--------------------------	--------------------------	--------------------------	-----------------

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

J20. a) Does he drink herbal teas at all?

yes, often 1 yes, occasionally 2 no, not at all 3 → **If no, go to J21 below**

If yes,

b) how many cups/mugs of herbal tea has cups a week
he drunk in the past week?

c) Please list the types of herbal teas he has drunk in the past 3 months:

.....

J21. Apart from herbal teas, are there any other health foods (whether or not
bought from a health food shop) that he often eats or drinks?

Yes 1 No 2 → **If no, go to J22a below**

If yes, please describe:

.....

J22. a) How often does he have any of the following:

		More than once a week	Once a week	Less than once a week	Not at all
i)	wine	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4
ii)	beer, lager	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4
iii)	spirits (gin, vodka, brandy)	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4
iv)	other alcohol (please tick and describe)	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4

.....

J22. b) What would you say best describes your teenager's alcohol drinking:

he has a glass of his own containing a normal adult portion

he has a glass of his own, but less than an adult portion

he just has a taste of other people's drink

he rarely has any alcohol

he never has any alcohol

J23. Is your teenager at present a vegetarian?

Yes

No

J24. Is your teenager at present a vegan (i.e. does not eat meat, poultry, fish, eggs, butter, milk or cheese)?

Yes

No

J25. Is your teenager at present on any other kind of special diet?

Yes

No

If yes,

a) Which kind of special diet?

Yes

(i) gluten-free (coeliac)

(ii) diabetic

(iii) nut free

(iv) other (please tick and describe)

.....

SECTION K:

K1. This questionnaire was completed by (please tick all that apply):

	Yes		Yes
a) teenager's biological mother	<input type="checkbox"/>	d) study teenager	<input type="checkbox"/>
b) teenager's mother-figure	<input type="checkbox"/>	e) someone else	<input type="checkbox"/>
c) teenager's biological father	<input type="checkbox"/>	(please describe)	<input type="checkbox"/>

K2. Please give the date on which you completed this questionnaire:

day	month	year
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

K3. Please give your date of birth:

day	month	year
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	19 <input type="checkbox"/> <input type="checkbox"/>

K4. Please give your study teenager's date of birth:

day	month	year
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	199 <input type="checkbox"/>

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comments you would like to make

NB Please remember we cannot reply to any comment unless you sign it.
When completed, please return the questionnaire to:

Professor Jean Golding
Children of the Nineties - ALSPAC
24 Tyndall Avenue
Bristol BS8 1BR
Tel: Bristol 928 8793

For office use only	
<i>Coder</i>	<i>Int</i>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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