

Questionnaire Number



A large, empty rectangular box, likely intended for a questionnaire or survey.

Your Changing Life



20/08/10

36854



FILLING IN THE QUESTIONNAIRE

Please use **black** pen. To answer questions simply put a cross in the box which is most accurate in your opinion, like this:



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



then cross the correct box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes.

If you do not want to answer a question or if it does not apply to you, leave it blank. There are no right or wrong answers. Just tell us what is true for you.

THANK YOU FOR YOUR HELP



SECTION A: FEELINGS, FRIENDSHIPS AND ACTIVITIES

A1. We are interested in how you spend your time outside the home. In the last four weeks, have you been to or used the following things?

	Yes	No
a) Library	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b) Parks and other open spaces	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) Shops	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d) Swimming pool/leisure centre/gym	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e) Church/mosque/temple/other place of worship	1 <input type="checkbox"/>	2 <input type="checkbox"/>
f) Community hall	1 <input type="checkbox"/>	2 <input type="checkbox"/>
g) Cinema/theatre	1 <input type="checkbox"/>	2 <input type="checkbox"/>
h) Bowling alley	1 <input type="checkbox"/>	2 <input type="checkbox"/>
i) Outdoor sports pitch/ground	1 <input type="checkbox"/>	2 <input type="checkbox"/>
j) Connexions Centre (in town or at a school/college)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
k) Pubs and clubs	1 <input type="checkbox"/>	2 <input type="checkbox"/>
l) Cafes and restaurants	1 <input type="checkbox"/>	2 <input type="checkbox"/>

A2. a) In the last four weeks (or the last four weeks before school/college/university holidays) have you participated in any group activity that was not part of school lessons or college/university lectures (e.g. sports, arts, youth group)?

Yes ¹ ☐ No ² ☐ Don't know ⁹ ☐

if no or don't know, go
to A3 on the next page

b) If yes, have you taken part in the following activities?

	Yes	No
i) Youth club	¹ <input type="checkbox"/>	² <input type="checkbox"/>
ii) Explorer Scouts, Senior Section Guides	¹ <input type="checkbox"/>	² <input type="checkbox"/>
iii) Sports team or club	¹ <input type="checkbox"/>	² <input type="checkbox"/>
iv) Exercise or dance class	¹ <input type="checkbox"/>	² <input type="checkbox"/>
v) Drama, arts or music groups	¹ <input type="checkbox"/>	² <input type="checkbox"/>
vi) Other organised activities	¹ <input type="checkbox"/>	² <input type="checkbox"/>



Pet ownership

A3. For each of the following ages, please tell us whether you had/have any pets in/at your home(s). If **yes**, please tell us how many of each type you had at that age.

	(a) 7yrs		(b) 11yrs		(c) 13yrs		(d) 15yrs		(e) Now	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
If yes, how many:										
i) Cats	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) Dogs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) Rabbits	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iv) Rodents (e.g. guinea pigs, hamsters, mice)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
v) Birds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
vi) Fish	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
vii) Tortoises/turtles	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
viii) Horses	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you did **not** have a **dog** at any of the ages above please go to A5 below.

A4. In a usual week, how many times per week, if any, did you personally walk or jog with your household dog(s)?

	(a) 7 yrs	(b) 11 yrs	(c) 13 yrs	(d) 15 yrs	(e) Now
Number of times per week	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

A5. In a usual week, how many times per week, if any, did you walk or jog with someone else's dog (e.g. belonging to a friend or other family member not living with you)?

	(a) 7 yrs	(b) 11 yrs	(c) 13 yrs	(d) 15 yrs	(e) Now
Number of times per week	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Different Experiences

A6. For each statement, 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
a) 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"/>
b) 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"/>
c) 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"/>
d) 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"/>
e) 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"/>
f) 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"/>
g) 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"/>
h) 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"/>
i) 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"/>
j) 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"/>

continued on next page...

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A6 (continued). For each statement, 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
k) 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"/>
l) 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"/>
m) 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"/>
n) 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"/>
o) 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"/>
p) 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"/>
q) 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"/>
r) 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"/>
s) 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"/>
t) 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"/>



Friendships

The next two questions are about the personal relationships and close friendships you might have.

A7. Some people feel that having close friends is more important than having close ties with their family, while others disagree. For you, is it more important to have close friends, close ties with your family or are both equally important?
(Please mark **one** box only.)

- | | | |
|--|---|--------------------------|
| Much more important to have close friends | 1 | <input type="checkbox"/> |
| Slightly more important to have close friends | 2 | <input type="checkbox"/> |
| Both equally important | 3 | <input type="checkbox"/> |
| Slightly more important to have close ties with family | 4 | <input type="checkbox"/> |
| Much more important to have close ties with family | 5 | <input type="checkbox"/> |
| Don't know | 6 | <input type="checkbox"/> |
| Don't want to answer | 7 | <input type="checkbox"/> |

A8. How many close friends do you have (i.e. friends you could talk to if you were in some sort of trouble)?

- | | | | | | |
|------------|---|--------------------------|----------------------|---|--------------------------|
| None | 1 | <input type="checkbox"/> | One | 2 | <input type="checkbox"/> |
| 2-3 | 3 | <input type="checkbox"/> | 4-5 | 4 | <input type="checkbox"/> |
| 6-9 | 5 | <input type="checkbox"/> | 10 or more | 6 | <input type="checkbox"/> |
| Don't know | 7 | <input type="checkbox"/> | Don't want to answer | 8 | <input type="checkbox"/> |



Moods and Feelings

A9. These questions are about how you may have been feeling or acting recently.
For each question, please say how much you have felt or acted this way in the past two weeks.

<u>In the past 2 weeks:</u>	True	Sometimes true	Not true
a) I felt miserable or unhappy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) I didn't enjoy anything at all	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) I felt so tired that I just sat around and did nothing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) I was very restless	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) I felt I was no good any more	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) I cried a lot	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g) I found it hard to think properly or concentrate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h) I hated myself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i) I felt I was a bad person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j) I felt lonely	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
k) I thought nobody really loved me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
l) I thought I could never be as good as others	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
m) I felt I did everything wrong	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

SECTION B: EDUCATION AND TRAINING

B1. Have you obtained any of these qualifications?

	Yes	No	
a) GCSE grades A*-C	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
b) GCSE grades D-G	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
c) A levels/AS Levels	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , how many? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
d) A levels/A2s	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , how many? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
e) AVCEs (formerly Vocational A Levels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , how many? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
f) 'Key Skills' qualification	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
g) 'Basic Skills' qualification	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
h) Foundation or Intermediate GNVQs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , how many? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
i) NVQs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , at what level? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
j) Edexcel, BTEC or LQL qualifications (NOT A/AS/A2 levels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
k) OCR qualifications (NOT A/AS/A2 levels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
l) City and Guilds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If yes , at what level? <div style="display: inline-block; border: 1px solid black; width: 40px; height: 30px; vertical-align: middle;"></div>
m) Something else	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
n) Don't know	1 <input type="checkbox"/>		

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B2. We would like to know what your main educational or training activity is at the moment. (Please mark **one** box only.)

- Full-time education1☐
- Part-time education2☐
- On a full-time training course, not as part of a job3☐
- On a full-time training course as part of a job4☐
- On a part-time training course, not as part of a job5☐
- On a part-time training course as part of a job6☐
- Not engaged in any education or training7☐→ **if not engaged in any education or training, go to B5 on the next page**

B3. Are you currently studying for any of these qualifications?

- | | Yes | No | |
|---|----------------------------|----------------------------|--|
| a) GCSE grades A*-C | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| b) GCSE grades D-G | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| c) A levels/AS Levels | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | (i) If <u>yes</u> , how many? <div><div></div><div></div></div> |
| d) A levels/A2s | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | (i) If <u>yes</u> , how many? <div><div></div><div></div></div> |
| e) AVCEs (formerly Vocational A Levels) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | (i) If <u>yes</u> , how many? <div><div></div><div></div></div> |
| f) 'Key Skills' qualification | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| g) 'Basic Skills' qualification | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| h) Foundation or Intermediate GNVQs | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | (i) If <u>yes</u> , how many? <div><div></div><div></div></div> |
| i) NVQs | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | (i) If <u>yes</u> , at what level? <div><div></div></div> |

continued on next page...

B3 (continued). Are you currently studying for any of these qualifications?

	Yes	No	
j) Edexcel, BTEC or LQL qualifications (NOT A/AS/A2 levels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
k) OCR qualifications (NOT A/AS/A2 levels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
l) City and Guilds	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(i) If <u>yes</u> , at what level? <input type="text"/>
m) Something else	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
n) Don't know	1 <input type="checkbox"/>		

B4. Do you receive the Educational Maintenance Allowance (EMA)? Yes 1 ☐ No 2 ☐

B5. If you are NOT in full-time education, what is the main reason you left?
(Please mark **one** box only.)

Found school difficult	1 <input type="checkbox"/>
Wanted to do an apprenticeship/learn a trade	2 <input type="checkbox"/>
Did not like/enjoy school or found school boring	3 <input type="checkbox"/>
Could not afford it	4 <input type="checkbox"/>
It's a waste of time	5 <input type="checkbox"/>
Did not get accepted on course I wanted	6 <input type="checkbox"/>
To seek employment/earn money	7 <input type="checkbox"/>
Taking a break from study (e.g. a gap year)	8 <input type="checkbox"/>
Some other reason	9 <input type="checkbox"/>

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Aim Higher: Your school/college may have been involved in a project that supported you in helping you become aware of the benefits of higher education, including courses and opportunities.

B6. Did you take part in an Aim Higher activity? Yes ¹ ☐ No ² ☐

B7. a) Have you ever applied to go to university?

Yes ¹ ☐ —► **if yes, go to B8a below** No ² ☐

b) If **no**, how likely do you think it is that you will apply to go to university to do a degree in the next 5 years?

Very likely ¹ ☐ Fairly likely ² ☐ Not very likely ³ ☐

Not at all likely ⁴ ☐ Don't know ⁹ ☐

now go to B14 on the next page —►

B8. a) If you applied to UCAS, how many choices did you put on the form?

b) Did you apply to universities that would enable you to:

Live at home ¹ ☐

Live away from home ² ☐

A mix of near and far universities ³ ☐

B9. Have you been awarded a place at university?

Yes ¹ ☐ No ² ☐ —► **if no, go to B14 on the next page**

B10. Did you get your first choice of university? Yes ¹ ☐ No ² ☐

B11. Did you get your current university through clearing? Yes ¹ ☐ No ² ☐

B12. What degree subject are you/will you be studying?

B13. What university are you/will you be enrolled in?

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B14. Do you think that the following might be advantages for someone going to university to study for a degree?

- | | Yes | No |
|---|----------------------------|----------------------------|
| a) Meeting new people and getting away from home | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) Getting a better paid job and more opportunities | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) Getting better qualifications and improved knowledge | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) Independence and self-confidence | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Don't know what the advantages might be | 1 <input type="checkbox"/> | |

B15. Do you think that the following might be disadvantages for someone going to university to study for a degree?

- | | Yes | No |
|--|----------------------------|----------------------------|
| a) It is expensive and you have to get into debt | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) Having to leave family and friends | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) No guaranteed job at the end and you lose work experience | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) Having to depend on parents and not earn money | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Don't know what the disadvantages might be | 1 <input type="checkbox"/> | |

B16. a) You have told us what you are currently doing with your time. If you think back to your plans before you took your GCSEs, are you actually doing now what you planned to be doing then?

Yes 1 ☐ —► **if yes, go to B17 on the next page** No 2 ☐

b) If **no**, please mark the answer that most closely fits.

- | | |
|--|----------------------------|
| My previous plans were unrealistic | 1 <input type="checkbox"/> |
| I changed my mind as there are no jobs available | 2 <input type="checkbox"/> |
| I changed my mind because I could not do the course I wanted | 3 <input type="checkbox"/> |
| I changed my mind because my family needed me to earn money | 4 <input type="checkbox"/> |
| I just changed my mind | 5 <input type="checkbox"/> |



Employment

- B17. a) We would like to know what your main work activity is at the moment.
If you are temporarily sick or on holiday please mark your usual activity.
(Please mark **one** box only.)

- Full-time paid work (30 or more hours a week) 1 ☐
- Part-time paid work (less than 30 hours a week) 2 ☐
- Government paid work experience or temporary job placement 3 ☐
- Unemployed and looking for work 4 ☐
- Long-term sick/disabled 5 ☐
- Looking after home/family 6 ☐
- Not working at all because in full-time education 7 ☐
- Something else 8 ☐

- b) Have you ever looked for a paid job? Yes 1 ☐ No 2 ☐ → **if no, go to B22 on page 17**

- c) Do you currently have a paid job? Yes 1 ☐ No 2 ☐ → **if no, go to B19 on the next page**

- B18. a) What is the job title of your current paid job?

- b) When did you start your current paid job?
- | Month | |
|-------|--|
| | |
- | Year | | | |
|------|--|--|--|
| | | | |

- c) Please describe the main things you do in your current paid job:

B19. Please complete for all of the paid jobs you have had in the past:

	Month	Year	(iii) Job title and the main things you did:
a) (i) From	<input type="text"/>	<input type="text"/>	
(ii) To	<input type="text"/>	<input type="text"/>	
b) (i) From	<input type="text"/>	<input type="text"/>	
(ii) To	<input type="text"/>	<input type="text"/>	
c) (i) From	<input type="text"/>	<input type="text"/>	
(ii) To	<input type="text"/>	<input type="text"/>	

B20. a) Are you looking for a job (or for a new job) at the moment?

Yes ¹ ☐

No ² ☐

→ if **no**, go to B21 on the next page

b) If **yes**, please tell us whether you are using the following methods:

	Yes	No
i) Internet	¹ <input type="checkbox"/>	² <input type="checkbox"/>
ii) Checking newspaper ads	¹ <input type="checkbox"/>	² <input type="checkbox"/>
iii) Jobcentre	¹ <input type="checkbox"/>	² <input type="checkbox"/>
iv) Recruitment/temp agencies	¹ <input type="checkbox"/>	² <input type="checkbox"/>
v) Contacting employers directly	¹ <input type="checkbox"/>	² <input type="checkbox"/>
vi) Talking to family	¹ <input type="checkbox"/>	² <input type="checkbox"/>
vii) Talking to friends	¹ <input type="checkbox"/>	² <input type="checkbox"/>
viii) Other	¹ <input type="checkbox"/>	² <input type="checkbox"/>

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B20 (continued).

- c) How long do you spend looking for jobs each week?

--	--

 hours
- d) How many jobs have you applied for in the last two weeks?

--	--
- e) What is the lowest wage per hour that you would be prepared to work for?

--	--

 pounds per hour

B21. Please complete for all periods when you have been unemployed and looking for work (not in full-time study) in the past.

	(i)				(ii)				
	Month		Year			Month		Year	
a) From	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	To	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>
b) From	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	To	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>
c) From	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	To	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>	<table border="1" style="width: 30px; height: 30px;"></table>

B22. Which of the following do you think is most likely to be the main thing you'll be doing in 12 months time? (Please mark **one** box only.)

- Looking for work or unemployed 1 ☐
- In an apprenticeship or similar type of training 2 ☐
- In a full-time job (30 or more hours per week) 3 ☐
- Studying full-time for a qualification 4 ☐
- Taking a break from study or work (e.g. a gap year) 5 ☐
- Looking after the home or family full-time 6 ☐
- Doing something else (please specify below) 7 ☐

--

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Voluntary work

B23. a) Are you currently doing voluntary work? Yes ¹ ☐ No ² ☐ → if **no**, go to B24 below

b) If **yes**, what is the job title of your current voluntary work?

--

c) When did you start your current voluntary work?

Month

--	--

Year

--	--	--	--

d) Please describe the main things you do in your current voluntary work:

--

B24. In the past, have you done any voluntary work? Yes ¹ ☐ No ² ☐ → if **no**, go to C1 on page 19

B25. Please complete for all of the voluntary work you have done in the past:

a) **Month** **Year** (iii) Job title and the main things you did:

(i) From

--	--	--	--

(ii) To

--	--	--	--

b)

Month **Year**

(i) From

--	--	--	--

(ii) To

--	--	--	--

c)

Month **Year**

(i) From

--	--	--	--

(ii) To

--	--	--	--



SECTION C: YOUR HEALTH

C1. In general, would you say your health is:

Excellent 1 ☐

Very good 2 ☐

Good 3 ☐

Fair 4 ☐

Poor 5 ☐

C2. Compared to one year ago, how would you rate your health in general now?

Much better now 1 ☐
than 1 year ago

Somewhat better 2 ☐
now than 1 year ago

About the same 3 ☐
as 1 year ago

Somewhat worse 4 ☐
now than 1 year ago

Much worse now 5 ☐
than than 1 year ago

C3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

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

C4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Cut down on the <u>amount of time</u> you spent on work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) <u>Accomplished less</u> than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) Were limited in the <u>kind</u> of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) Had <u>difficulty</u> performing the work or other activities (e.g. it took extra effort)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

C5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Cut down on the <u>amount of time</u> you spent on work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) <u>Accomplished less</u> than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) Did work or activities <u>less carefully than usual</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

C6. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

Not at all	1 <input type="checkbox"/>	Slightly	2 <input type="checkbox"/>	Moderately	3 <input type="checkbox"/>
Quite a bit	4 <input type="checkbox"/>	Extremely	5 <input type="checkbox"/>		



C7. How much bodily pain have you had during the past 4 weeks?

- None1☐
- Very Mild2☐
- Mild3☐
- Moderate4☐
- Severe5☐
- Very Severe6☐

C8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- None1☐
- A little bit2☐
- Moderately3☐
- Quite a bit4☐
- Extremely5☐

C9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

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



C10. During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (e.g. visiting friends or relatives)?

All of the time 1 ☐ Most of the time 2 ☐ Some of the time 3 ☐
 A little of the time 4 ☐ None of the time 5 ☐

C11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Definitely false	Mostly false	Don't know
a) I seem to get ill more easily than other people	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) I am as healthy as anybody I know	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) I expect my health to get worse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) My health is excellent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

C12. a) Do you have any long-standing illness, disability or infirmity? (By long-standing we mean anything that has troubled you over a period of time or that is likely to affect you over a period of time.)

Yes 1 ☐ No 2 ☐

b) If yes, does this illness or disability limit your activities in any way?

Yes 1 ☐ No 2 ☐

C13. a) Have you left any job because you felt it was making your health worse?

Yes 1 ☐ No 2 ☐

b) If yes, please explain how the job was making your health worse:



Wheezing and asthma

C14. a) Have you ever had wheezing or whistling in the chest at any time in the past?

Yes ¹ ☐

No ² ☐ → **if no, go to C15 on the next page**

b) Have you had wheezing or whistling in the chest in the past 12 months?

Yes ¹ ☐

No ² ☐ → **if no, go to C15 on the next page**

c) How many attacks of wheezing have you had in the past 12 months?

None ¹ ☐

1-3 ² ☐

4-12 ³ ☐

More than 12 ⁴ ☐

d) In the past 12 months, how often, on average, has your sleep been disturbed due to wheezing?

Never woken ¹ ☐
with wheezing

Less than one ² ☐
night per week

One or more ³ ☐
nights per week

e) In the past 12 months, has wheezing ever been severe enough to limit your speech to only one or two words at a time between breaths?

Yes ¹ ☐

No ² ☐

f) How many days of school/college or work (paid employment) have you missed in the past 12 months due to wheezing in the chest? (If you can't remember, make a guess and mark the guess box as well.)

(i) Number of days off school/college:

--	--

Mark if a guess: ¹ ☐

(ii) Number of days off work:

--	--

Mark if a guess: ¹ ☐

g) In the past 12 months, has your chest sounded wheezy during or after exercise?

Yes ¹ ☐

No ² ☐

C15. a) Have you ever had asthma?

Yes ¹ ☐

No ² ☐ → if no, go to C16 below

b) If you are in paid employment:

(i) Have you lost time from work because of your asthma?

Yes ¹ ☐

No ² ☐

(ii) If yes, how many days in the last year?

--	--

 days

c) During the last 12 months, have your asthma symptoms been better at the weekend?

Yes ¹ ☐

No ² ☐

d) Are your asthma symptoms better when away from work for a longer period (i.e. longer than a weekend)?

Yes ¹ ☐

No ² ☐

C16. In the past 12 months, have you had a dry cough at night, apart from a cough associated with a cold or chest infection?

Yes ¹ ☐

No ² ☐

C17. Have you ever had hayfever?

Yes ¹ ☐

No ² ☐



C18. This question is about when you DO NOT have a cold or the flu.

- a) In the past 12 months, have you had a problem with sneezing or a runny or blocked nose when you DID NOT have a cold or flu (such as running a temperature or feeling generally unwell)?

Yes 1 ☐ No 2 ☐ —▶ if no, go to C19 below

- b) In the past 12 months, has this nose problem been accompanied by itchy or watery eyes?

Yes 1 ☐ No 2 ☐

- c) In which of the past 12 months, did this nose problem occur?
(Please mark **all** that apply.)

(i) January 1 ☐ (v) May 1 ☐ (ix) September 1 ☐

(ii) February 1 ☐ (vi) June 1 ☐ (x) October 1 ☐

(iii) March 1 ☐ (vii) July 1 ☐ (xi) November 1 ☐

(iv) April 1 ☐ (viii) August 1 ☐ (xii) December 1 ☐

- d) Are your symptoms better at the weekend?

Yes 1 ☐ No 2 ☐

- e) Are your symptoms better when away from work for a longer period (i.e. longer than a weekend)?

Yes 1 ☐ No 2 ☐

C19. Have you ever had eczema?

Yes 1 ☐ No 2 ☐

C20. a) Have you had an itchy red rash at any time in the past 12 months?

Yes 1 ☐ No 2 ☐ —▶ if no, go to D1 on the next page

- b) Has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears or eyes?

Yes 1 ☐ No 2 ☐

- c) Has this rash cleared completely at any time during the past 12 months?

Yes 1 ☐ No 2 ☐

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SECTION D: EATING AND EXERCISE PATTERNS

D1. a) How often, 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 D2 below**

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

Less than a week 1 ☐

1-3 weeks 2 ☐

1-3 months 3 ☐

3-6 months 4 ☐

6-12 months 5 ☐

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) 3 ☐

Yes, 1-5 pounds ($\frac{1}{2}$ -2 $\frac{1}{2}$ kilos) 2 ☐

No 4 ☐ → **if no, go to D2 below**

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

No, did not regain any of the weight 1 ☐

Gained back most of the weight 3 ☐

Gained back a little of the weight 2 ☐

Put on more than I lost 4 ☐

D2. 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 a week 1 ☐

1-4 times a week 2 ☐

1-3 times a month 3 ☐

Less than once a month 4 ☐

Never 5 ☐ → **if never, go to D3 on the next page**

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

Yes, sometimes 1 ☐

Yes, frequently 2 ☐

No 3 ☐

continued on next page...



D2. c) Did you exercise in order to lose weight or avoid gaining weight?

Yes, sometimes ¹ ☐ Yes, frequently ² ☐ No ³ ☐ → **if no, go to D3 below**

d) If **yes**, do you feel guilty after missing an exercise session?

No ⁰ ☐ Yes, ¹ ☐ sometimes Yes, ² ☐ frequently Do not miss any ³ ☐ exercise sessions

D3. 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 a ³ ☐ month
Once a ⁴ ☐ week 2 or more times ⁵ ☐ a week

D4. 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 a ³ ☐ month
Once a ⁴ ☐ week 2-6 times a ⁵ ☐ week Every day ⁶ ☐

D5.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 D6 on the next page**

b) If **yes**, how often?

Never ¹ ☐ Less than once ² ☐ a month 1-3 times a ³ ☐ month
Once a ⁴ ☐ week 2-6 times a ⁵ ☐ week Every day ⁶ ☐

D6. Sometimes people will go on an “eating binge,” where they eat an amount of food that most people would consider an unusually large amount of food (for example a whole large tub of ice cream, or a whole packet of biscuits (containing more than 10 biscuits), or more than 3 small packets of crisps, or a whole large pack of crisps), 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 <u>never</u>, go to D9 on the next page	

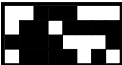
D7. These questions refer to when you were on a binge.

	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"/>

D8. a) In the past year, if there was a period of time when you went on eating binges at least once a week, how long did you do this altogether?

1 month	1 <input type="checkbox"/>	2 months	2 <input type="checkbox"/>	3 or more months	3 <input type="checkbox"/>
Didn't do this at least once a week	4 <input type="checkbox"/>	→ if you <u>didn't do this at least once a week</u>, go to D9 on the next page			

continued on next page...



D8 (continued).

D8. b) During that time, did you do any of the following:

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

Yes ¹ ☐ No ² ☐

(ii) Use laxatives to keep from gaining weight?

Yes ¹ ☐ No ² ☐

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

Yes, monthly ¹ ☐ Yes, weekly ² ☐

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

D9. How would you describe your weight currently?

Very ¹ ☐ Slightly ² ☐ About the ³ ☐
underweight underweight right weight

Slightly ⁴ ☐ Very ⁵ ☐
overweight overweight

D10. Which of the following are you trying to do about your weight?

I am not trying to do ¹ ☐ Stay the same ² ☐
anything about my weight

Gain weight ³ ☐ Lose weight ⁴ ☐

D11. In the past year, how happy have you been with the way your body looks?

Very unhappy ¹ ☐ A little unhappy ² ☐

Quite happy ³ ☐ Very happy ⁴ ☐

D12. In the past year, how much has your weight made a difference to how you feel about yourself?

Not at all ¹ ☐ A little ² ☐ Somewhat ³ ☐

Quite a lot ⁴ ☐ A lot ⁵ ☐

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D13. Has anyone ever told you that they thought you had an eating disorder, such as anorexia nervosa or bulimia? (Please mark **all** that apply.)

- a) No 1 ☐
- b) Yes, a friend 1 ☐
- c) Yes, a parent 1 ☐
- d) Yes, a doctor, nurse, or other health care provider 1 ☐

D14. Have you ever been treated for an eating disorder by a doctor, nurse or other health care provider?

Yes, am being treated now 3 ☐ Yes, in the past 2 ☐ No 1 ☐ → **if no, go to D15 below**

a) If **yes**, what treatment have you had:

- i) Psychological therapy (taking therapy on your own) 1 ☐
- ii) Family therapy (taking therapy together with your family) 1 ☐
- iii) In-patient admission to private hospital 1 ☐
- iv) In-patient admission to NHS hospital 1 ☐
- v) Other/or don't know (please describe below) 1 ☐

D15. Do you ever have strong cravings for food, or find food difficult to resist?

Never 1 ☐ Occasionally 2 ☐ Sometimes 3 ☐ Always 4 ☐

HELPLINE: BEAT (beating eating disorders) is the leading UK charity for people with eating disorders and their families

Tel: 0845 634 1414
Email: help@b-eat.co.uk



SECTION E: DRUGS AND ALCOHOL

E1. a) Have you ever smoked a whole cigarette (including roll-ups)?

Yes ¹ ☐

No ² ☐ → if **no**, go to E5 on the next page

b) If **yes**, how old were you when you first smoked a whole cigarette?

--	--

years

c) How many cigarettes have you smoked altogether in your lifetime?

Less than 5 ¹ ☐

50-99 ⁴ ☐

5-19 ² ☐

100 plus ⁵ ☐

20-49 ³ ☐

E2. a) Have you smoked any cigarettes in the past 30 days?

Yes ¹ ☐ → if **yes**, go to E3 below

No ² ☐

b) If **no**, how old were you when you last smoked a whole cigarette?

--	--

years → now go to E5 on the next page

E3. a) Do you smoke every day?

Yes ¹ ☐

No ² ☐ → if **no**, go to E4 below

b) If you smoke every day, how many cigarettes do you smoke per day on average?

--	--

cigarettes per day → now go to E5 on the next page

E4. a) Do you smoke every week?

Yes ¹ ☐

No ² ☐ → if **no**, go to E5 on the next page

b) If you smoke every week, how many cigarettes do you smoke per week on average?

--	--

cigarettes per week

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Alcohol

The next questions are about drinking alcohol (this includes beer, wine, "alcopops", cider and spirit drinks like vodka). Your answers to all these questions are confidential, so they will never be seen by anyone who knows you.

Please see our Drinkogram that translates common types of alcoholic drinks and their amounts into a standard number of drinks or units.

E5. a) Have you ever had a whole drink? (A "whole drink" is a small bottle or ½ pint of beer, a small glass of wine or a "shot" of whisky, gin or vodka.)

Yes 1 ☐

No 2 ☐



if no, go to E16 on page 35

b) If yes, how old were you the first time you had a whole drink? years

E6. How often do you have a drink containing alcohol?

Never 1 ☐

Monthly
or less 2 ☐

2-4 times
a month 3 ☐

↓
**if never, go to
E16 on page 35**

2-3 times
a week 4 ☐

4 or more
times a week 5 ☐

E7. How many units (standard drinks) containing alcohol do you have on a typical day when you are drinking? (See Drinkogram.)

1 or 2 1 ☐

3 or 4 2 ☐

5 or 6 3 ☐

7-9 4 ☐

10 or more 5 ☐

- E8. How often, during the past year, have you had six or more units (standard drinks) on one occasion?
(See Drinkogram - 6 units is 4 alcopops, 3 pints of normal strength beer or cider, 2 pints of strong beer or cider, 6 small glasses or 3 large glasses of wine, 6 single shots of spirits or a combination of these.)

Never	1 <input type="checkbox"/>	Once or twice	2 <input type="checkbox"/>
Less than monthly	3 <input type="checkbox"/>	Monthly	4 <input type="checkbox"/>
Weekly	5 <input type="checkbox"/>	Daily or almost daily	6 <input type="checkbox"/>

- E9. How often, during the past year, have you found that you were not able to stop drinking once you had started?

Never	1 <input type="checkbox"/>	Once or twice	2 <input type="checkbox"/>
Less than monthly	3 <input type="checkbox"/>	Monthly	4 <input type="checkbox"/>
Weekly	5 <input type="checkbox"/>	Daily or almost daily	6 <input type="checkbox"/>

- E10. How often, during the past year, have you failed to do what was normally expected of you because of drinking (e.g. go to school/college or work, play sport, go out with family or friends)?

Never	1 <input type="checkbox"/>	Once or twice	2 <input type="checkbox"/>
Less than monthly	3 <input type="checkbox"/>	Monthly	4 <input type="checkbox"/>
Weekly	5 <input type="checkbox"/>	Daily or almost daily	6 <input type="checkbox"/>

- E11. How often, during the past year, have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	1 <input type="checkbox"/>	Once or twice	2 <input type="checkbox"/>
Less than monthly	3 <input type="checkbox"/>	Monthly	4 <input type="checkbox"/>
Weekly	5 <input type="checkbox"/>	Daily or almost daily	6 <input type="checkbox"/>



E12. How often, during the past year, have you had a feeling of guilt or remorse after drinking?

- | | | | |
|-------------------|----------------------------|-----------------------|----------------------------|
| Never | 1 <input type="checkbox"/> | Once or twice | 2 <input type="checkbox"/> |
| Less than monthly | 3 <input type="checkbox"/> | Monthly | 4 <input type="checkbox"/> |
| Weekly | 5 <input type="checkbox"/> | Daily or almost daily | 6 <input type="checkbox"/> |

E13. How often, during the past year, have you been unable to remember what happened the night before because you had been drinking?

- | | | | |
|-------------------|----------------------------|-----------------------|----------------------------|
| Never | 1 <input type="checkbox"/> | Once or twice | 2 <input type="checkbox"/> |
| Less than monthly | 3 <input type="checkbox"/> | Monthly | 4 <input type="checkbox"/> |
| Weekly | 5 <input type="checkbox"/> | Daily or almost daily | 6 <input type="checkbox"/> |

E14. Have you or has someone else been injured as a result of your drinking?

- | | |
|-------------------------------|----------------------------|
| No | 1 <input type="checkbox"/> |
| Yes, but not in the past year | 2 <input type="checkbox"/> |
| Yes, during the past year | 3 <input type="checkbox"/> |

E15. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?

- | | |
|-------------------------------|----------------------------|
| No | 1 <input type="checkbox"/> |
| Yes, but not in the past year | 2 <input type="checkbox"/> |
| Yes, during the past year | 3 <input type="checkbox"/> |



Drug use

The next set of questions are about cannabis and other drugs. **Please remember that your answers to all these questions are confidential, so they will never be seen by anyone who knows you or linked to your name.**

E16. a) Have you ever tried cannabis (also called marijuana, hash, skunk, grass, smoke, weed)?

Yes

☐

No

☐

→ if **no**, go to E21 on page 37

b) If **yes**, how old were you when you first tried cannabis?

--	--

years

E17. a) When was the last time you used cannabis? (Please mark **one** box only.)

In the last 3 days

☐

Not in the last 3 days, but in the past 2 weeks

☐

Not in the past 2 weeks, but in the last month

☐

Not in the last month, but in the last 3 months

☐

Not in the last 3 months, but in the last 12 months

☐

More than 12 months ago

☐

b) How old were you when you last tried cannabis?

--	--

years

E18. In the last 12 months, how often have you used cannabis?

Once or
twice

☐

Less than
monthly

☐

Monthly (but
less than weekly)

☐

Weekly

☐

Daily or
almost daily

☐

E19. How many joints/spliffs, pipes or bongs do you have on a typical day when you smoke cannabis?

--	--

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E20. We would like to know about your use of cannabis in the past 12 months.

	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 use 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 because of your use of cannabis (e.g. argument, fight, accident, bad result at school, other problems)?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------

Please describe the problems below:

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

E21. In your life, which of the following substances have you ever used?
(NON-MEDICAL USE ONLY.)

Drug	No	Yes		(i)		(ii)		
				If <u>YES</u> , have you taken the drug in the last year	If <u>YES</u> , have you taken the drug in the last 3 months			
a) Cocaine (also called Charlie, 'C', coke)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
b) Crack (also called rock, stone)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
c) Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
d) Inhalants (glue, petrol, paint thinner, etc.)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
e) Sedatives or sleeping pills (Valium, Rohypnol, etc.)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
f) Hallucinogens (LSD, acid, mushrooms, PCP, Ketamine, Special K, etc.)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
g) Opioids (heroin, morphine, methadone, codeine, etc.)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
h) Other stimulants (mephedrone, khat)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>
i) Other (please specify)	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>	→	2 <input type="checkbox"/>	1 <input type="checkbox"/>



Things you may have done

E22. How often in the last year have you:

	Not at all	Just once	2-5 times	6 or more times
a) Been rowdy or rude in a public place so that people complained or you got in trouble?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Stolen something from a shop or store?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Bought something that you knew or suspected was stolen?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) Broken into a car or van to try and steal something out of it?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Taken and/or driven a vehicle without the owner's permission?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Broken into a house or building to try and steal something?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Stolen any money or property that someone was holding, carrying or wearing at the time?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Hit, kicked or punched someone else on purpose with the intention of really hurting them?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) Deliberately damaged or destroyed property that did not belong to you?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j) Hurt or injured animals or birds on purpose?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k) Carried a knife or other weapon with you for protection or in case it was needed in a fight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l) Used a cheque book, credit card or cash point card which you knew or suspected to be stolen to get money out of a bank account or to purchase something?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

SECTION F: ROAD USE AND ACCIDENTS

F1. We would like to know about your trip home from school/college or work yesterday (or the last time you came home from school/college or work):

a) How long did your trip home take? (Please mark **one** box only.)

- | | | | |
|---------------------|----------------------------|----------------------|----------------------------|
| Less than 5 minutes | 1 <input type="checkbox"/> | 5-10 minutes | 2 <input type="checkbox"/> |
| 11-20 minutes | 3 <input type="checkbox"/> | 21-30 minutes | 4 <input type="checkbox"/> |
| 31-45 minutes | 5 <input type="checkbox"/> | More than 45 minutes | 6 <input type="checkbox"/> |

b) How did you go home from school/college or work? (Please mark **all** that apply.)

- | | | | |
|----------------------------------|------------------------------|--|----------------------------|
| (i) Walked all the way | 1 <input type="checkbox"/> | (ii) Walked part of the way | 1 <input type="checkbox"/> |
| (iii) By public bus | 1 <input type="checkbox"/> | (iv) By car/taxi | 1 <input type="checkbox"/> |
| (v) By bicycle | 1 <input type="checkbox"/> | (vi) By metro/train | 1 <input type="checkbox"/> |
| (vii) Other
(please describe) | 1 <input type="checkbox"/> → | <div style="border: 1px solid black; height: 60px; width: 400px;"></div> | |

F2. a) When was the last time you travelled in a car, van or taxi?
(Please 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 & 4 weeks ago | 5 <input type="checkbox"/> | More than a month ago | 6 <input type="checkbox"/> |
| Never | 7 <input type="checkbox"/> → | if <u>never</u>, go to F3 on the next page | |

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

- | | | | | | |
|------------|----------------------------|-----------|----------------------------|----------------|----------------------------|
| Front seat | 1 <input type="checkbox"/> | Back seat | 2 <input type="checkbox"/> | Can't remember | 3 <input type="checkbox"/> |
|------------|----------------------------|-----------|----------------------------|----------------|----------------------------|

continued on next page...



F2 (continued).

- c) (i) The last time you travelled in a car, van or taxi did you wear a seat belt?

Yes ¹ ☐

No ² ☐

Can't remember ³ ☐

→ **if no or can't
remember,
go to F3 below**

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

You chose to obey the law? ¹ ☐

The driver asked you to? ² ☐

Everyone else had theirs on and you didn't want to be different? ³ ☐

- F3. a) Do you have a car driving licence?

Yes, provisional ¹ ☐

Yes, full ² ☐

No ³ ☐

→ **if yes, go to F4 below**

- b) If you do NOT have a licence, have you ever driven a car:

Yes

No

(i) Off the road (e.g. on private land or in a car park)? ¹ ☐ ² ☐

(ii) On the road without a licence? ¹ ☐ ² ☐

- F4. a) Have you ever been a passenger in a car knowing that the driver had not passed his/her driving test and was not supervised by a qualified accompanying driver?

Yes ¹ ☐

No ² ☐

- b) Have you ever been a passenger in a car knowing that the driver had been drinking?

Yes ¹ ☐

No ² ☐

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F5. Have you ever driven a motorbike or scooter:

	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 the road with a licence?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c) On the road without a licence?	1 <input type="checkbox"/>	2 <input type="checkbox"/>

F6. a) Do you own a bicycle?	Yes	1 <input type="checkbox"/>	No	2 <input type="checkbox"/>
b) Do you own a bicycle helmet?	Yes	1 <input type="checkbox"/>	No	2 <input type="checkbox"/>

F7. a) When was the last time you rode a bicycle? (Please 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 <u>never</u> , go to F8 on the next page	

b) How far did you ride your bicycle at that time? (Please mark **one** box only.)

Less than a mile	1 <input type="checkbox"/>	1-3 miles	2 <input type="checkbox"/>
3-5 miles	3 <input type="checkbox"/>	More than 5 miles	4 <input type="checkbox"/>

c) The last time you rode a bike did you wear: (Please mark **one** box on each line.)

	Yes	No	Can't remember
(i) A helmet?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(ii) Fluorescent clothing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(iii) Reflective clothing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>



Accidents

F8. a) In the last 6 months, have you had any kind of accident that caused you to see a doctor or go to hospital?

Yes ¹ ☐

No ² ☐ → **if no, go to F9 below**

b) If yes, please mark all that apply:

(i) Fall ¹ ☐

(ii) Fracture (broken bone) ¹ ☐ → Please describe:

(iii) Burn or scald ¹ ☐

(iv) Ingestion/swallowing something ¹ ☐

(v) Sports injury ¹ ☐

(vi) Other ¹ ☐ → Please describe:

F9. Since your 17th birthday, have you had a head injury resulting in loss of consciousness?

Yes ¹ ☐ No ² ☐

↓
If yes, please describe:

F10. In the last year, have you had an accident that occurred at work?

Yes ¹ ☐

No ² ☐

Have not worked in the last year ³ ☐

F11. a) In the last year, have you been involved in a road accident?

Yes ¹ ☐

No ² ☐ → **if no, go to G1 on page 44**

b) Thinking about the last road accident you had, how were you travelling?
(Please 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 ☐

On a motorbike/scooter ⁵ ☐

Something else (please describe) ⁶ ☐

continued on next page...

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c) Who was with you at the time of the road accident? (Please mark **all** that apply.)

- | | | | |
|-------------------------------|----------------------------|--|----------------------------|
| (i) On my own | 1 <input type="checkbox"/> | (ii) Parent(s) | 1 <input type="checkbox"/> |
| (iii) Brother(s) or sister(s) | 1 <input type="checkbox"/> | (iv) Friend(s)/partner | 1 <input type="checkbox"/> |
| (v) Other adult(s) | 1 <input type="checkbox"/> | (vi) Children (your own or someone else's) | 1 <input type="checkbox"/> |

d) What were you doing at the time of the road accident? (Please mark **one** box only.)

- | | | | |
|---|----------------------------|--|----------------------------|
| Going to or from school/college or work | 1 <input type="checkbox"/> | Going to or from a daytime activity (e.g. sport, shops, cafe) or exercising | 4 <input type="checkbox"/> |
| Hanging out in the streets | 2 <input type="checkbox"/> | Going to or from a place of worship (e.g. church, temple, synagogue, mosque) | 5 <input type="checkbox"/> |
| Going to or from an evening activity (e.g. pub, club, cinema) | 3 <input type="checkbox"/> | Other journey (please describe below) | 6 <input type="checkbox"/> |

e) When did the road accident happen? (Please mark **one** box only.)

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

f) Were you hurt in the road accident? Yes 1 ☐ No 2 ☐ ➔ **if no, go to G1 on the next page**

- | | | |
|---|----------------------------|----------------------------|
| g) If <u>yes</u> : | Yes | No |
| (i) Did you see a family doctor? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (ii) Did you go to the casualty department at hospital? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (iii) Did you stay overnight in hospital? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

(iv) If you were in paid employment, how long were you off work as a result?

--	--

 days

SECTION G:

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

No ☐

Yes ☐



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

a) A parent helped ☐

b) Someone else helped ☐

G2. 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"/>

G3. 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="1"/>	<input type="text"/>

Thank you VERY much for your help

Space for any additional comments you would like to make

N.B: Please remember we cannot reply to any comment unless you sign it

When completed, please send this back to: **Professor George Davey-Smith**
Children of the Nineties - ALSPAC
Oakfield House
Oakfield Grove
Bristol BS8 2BN

Office use only ☐

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