

**2005**

**MIDDLE GRADES HEALTH SURVEY  
GRADES 6, 7, 8**



*Health, Physical Education, and Athletics Department, Cambridge Public Schools  
The Cambridge Public Health Department, Cambridge Health Alliance  
Cambridge Prevention Coalition, Department of Human Services Programs  
Institute for Community Health*

*Teacher: Please read these directions out loud with your students*

**Directions**

All 6th, 7th, and 8th grade students are taking this survey. It asks about what you do that affects your health. Your answers will help us understand your health and help us improve programs for you. This is not a test. There are no right or wrong answers.

**DO NOT PUT YOUR NAME ON THIS BOOKLET.** The answers you give will be kept private. No one will know what you write unless you choose to tell them. Taking this survey is up to you. If you do not want to answer a question, just leave it blank.

You will probably not have done all of the things asked about in this survey. Answer what you really do. Please be as honest as you can. If you don't know the answer to a question, be sure to mark the answer that says, "I don't know" or "I'm not sure."

Some questions ask you about things you did or things that happened to you during the last 30 days. This means that you need to think back to the end of February up to today. Be sure to remember both school days and weekends. Other questions ask you about things during the last 12 months. This means that you need to think back to last March, through the summer, and up to today.

Read the boxes at the beginning of each section and the directions that go with each question. If the question is confusing, you can ask the teacher for help.

When you have completed the survey, close and seal it with the sticker provided. Put it in the large envelope on your teacher's desk. No one in your school will read your survey.

After filling out this survey, if you have any questions or concerns, please talk about them with your school nurse, school counselor, teacher, or parent.

***Thank you very much for answering this survey***

THIS SECTION IS ABOUT YOUR PERSONAL BACKGROUND.  
Remember, no one will know your name.

1. Are you? (Check *one* box)

- 1 Male  
 2 Female

2. What grade are you in now? (Check *one* box)

- 1 6<sup>th</sup> grade  
 2 7<sup>th</sup> grade  
 3 8<sup>th</sup> grade

3. How old are you? \_\_\_\_\_ years old (write in)

4. What is your race? (Check *one* box)

- 1 Black or African American  
 2 White  
 3 Hispanic or Latino  
 4 Asian or Pacific Islander  
 5 American Indian or Alaskan Native  
 6 Bi-racial, mixed or multi-racial  
 7 Other, write in: \_\_\_\_\_

5. What school are you in? (Check *one* box)

- 01 Amigos  
 02 Baldwin  
 03 Cambridgeport  
 04 Fletcher-Maynard Academy  
 05 Graham & Parks  
 06 Haggerty  
 07 Kennedy-Longfellow  
 08 King  
 09 King Open  
 10 Morse  
 11 Peabody  
 12 Tobin

6. During the past **12 months**, how would you describe your grades in school? (Check *one* box)

- 1 Mostly A's (90 – 100)  
 2 Mostly B's (80 – 89)  
 3 Mostly C's (70 – 79)  
 4 Mostly D's (60 – 69)  
 5 Mostly F's (59 or below)  
 6 Not Sure

7. Do you or your family receive any public assistance such as Welfare, SSI, Food Stamps, or Free or Reduced School Lunch Program? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not Sure

8. Is English the language spoken most often in your home? (Check *one* box)

- 1 No  
 2 Yes

9. What languages are spoken in your home? (Check *all* that apply)

- English  
 Spanish  
 Haitian Creole  
 Portuguese  
 Chinese, Cantonese, or Mandarin  
 Bengali, Gujarati, Hindi, or Urdu  
 Korean  
 Amharic or Tegrinya  
 Another language, write in: \_\_\_\_\_

10. Who do you live with? (Check *one* box on *each* line)

		No	Yes
a.	Do you live with your mother?	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b.	Do you live with your father?	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c.	Do you live with step-parent(s)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d.	Do you live with foster parent(s) or guardian(s)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e.	Do you live with another adult?	<input type="checkbox"/> 1	<input type="checkbox"/> 2

11. Where are you living now? (Check *one* box)

- 1 A house, condo, or apartment owned or rented by my parent/guardian  
 2 Public Housing (the projects, Section 8)  
 3 A shelter, motel or other temporary housing  
 4 A halfway house or residential program  
 5 I have no regular place to live  
 6 Other (write in): \_\_\_\_\_

12. How much education do you plan to complete in the future? (Check *one* box)

- 1 Graduate high school  
 2 Go to college  
 3 More than college  
 4 Not Sure

THIS SECTION IS ABOUT PERSONAL MATTERS IN YOUR LIFE.  
Remember, no one will know these answers are yours.

13. During the last **12 months**, have you done any of the following things? (Check *one* box on *each* line)

		No	Yes
a.	Had an eye exam	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b.	Seen a doctor or a nurse (other than a school nurse)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c.	Seen a school nurse	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d.	Seen a counselor (other than a school counselor)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e.	Seen a school counselor	<input type="checkbox"/> 1	<input type="checkbox"/> 2

14. When was the last time you went to a doctor or nurse for a physical exam or check-up when you were **not sick or hurt**? (Check *one* box)

- 1 During the last 12 months
- 2 More than 12 months ago
- 3 Never
- 4 Not Sure

15. When was the last time you went to a dentist? (Check *one* box)

- 1 During the last 12 months
- 2 More than 12 months ago
- 3 Never
- 4 Not Sure

16. Have you ever been told by a doctor, a nurse or your parent that you have any of these health problems? (Check *one* box on *each* line)

		No	Yes
a.	Asthma	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b.	Allergy to peanut butter or bees	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c.	Diabetes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d.	Seizures	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e.	Sickle Cell Disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f.	Migraines	<input type="checkbox"/> 1	<input type="checkbox"/> 2
g.	Eating Disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h.	Hearing Problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2
i.	Overweight	<input type="checkbox"/> 1	<input type="checkbox"/> 2
j.	Underweight	<input type="checkbox"/> 1	<input type="checkbox"/> 2

17. Do you have any allergies that require you to carry an Epi-pen? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

18. How many close friends do you have? (Check *one* box)

- 1 None
- 2 1 or 2
- 3 3 or more

19. Do you participate regularly in a church, synagogue, mosque, or other faith community? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

20. Is there at least one teacher or other adult in this school that you can talk to if you have a problem? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

21. Outside of school, is there an adult (or adults) you can talk to about things that are important to you? (Check *one* box)

- 1 No
- 2 Yes, parent or other adult family member
- 3 Yes, non-family adult (such as religious leader, club advisor, neighbor, etc.)
- 4 Yes, both family and non-family adults
- 5 Not Sure



22. During the last **12 months**, how much did you worry about the following problems? (Check *one* box on *each* line)

	<i>Never</i>	<i>Once in A While</i>	<i>Fairly Often</i>	<i>Most of the Time</i>
a. Physical health problems	1	2	3	4
b. Weight problems (too heavy or too thin)	1	2	3	4
c. Sexual abuse	1	2	3	4
d. Becoming pregnant or getting someone pregnant	1	2	3	4
e. School failure or poor grades	1	2	3	4
f. Drug or alcohol use in your family	1	2	3	4
g. Your own drug or alcohol use	1	2	3	4
h. Physical fights at home	1	2	3	4
i. Physical fights in school	1	2	3	4
j. Being treated unfairly because of your race or ethnicity	1	2	3	4
k. Sexual orientation	1	2	3	4
l. Drugs in your neighborhood	1	2	3	4
m. Violence in your neighborhood	1	2	3	4
n. MCAS	1	2	3	4

23. During the past **30 days**, did you feel sad or hopeless, most of every day for two or more weeks in a row? (Check *one* box)

- |   |          |
|---|----------|
| 1 | No       |
| 2 | Yes      |
| 3 | Not Sure |

24. If you felt sad or hopeless for two weeks or more, did it stop you from doing any of your usual activities at home, in school, or elsewhere? (Check *one* box)

- |   |          |
|---|----------|
| 1 | No       |
| 2 | Yes      |
| 3 | Not Sure |

25. During the last **12 months**, did any of these things happen to you? (Check *one* box on *each* line)

	<i>No</i>	<i>Yes</i>
a. You had one or more failing grades on a report card	1	2
b. You had a problem with alcohol or drugs	1	2
c. A member of your family had an alcohol or drug problem	1	2
d. There was a divorce or separation in your family	1	2
e. Your family moved	1	2

26. During the last **12 months**, did any of these things happen to you? (Check *one* box on *each* line)

	<i>No</i>	<i>Yes</i>
a. A family member or close friend died	1	2
b. You witnessed violence in your family	1	2
c. You witnessed violence in your neighborhood	1	2
d. You were beaten or physically hurt by someone in your family or home	1	2
e. You were beaten or physically hurt by someone not a family member	1	2
f. You were threatened with a knife or a gun	1	2

27. During the last **12 months**, did any of these things happen to you? (Check *one* box on *each* line)

		No	Yes
a.	You were bullied, threatened or pushed around in school or on the way	1	2
b.	You ran away from home	1	2
c.	You hurt yourself physically on purpose	1	2
d.	You seriously thought about attempting suicide	1	2
e.	You actually attempted suicide	1	2

28. During the last **12 months**, did any of these things happen to you? (Check *one* box on *each* line)

		No	Yes
a.	You had rude sexual comments directed at you	1	2
b.	You were touched, pinched, grabbed or patted in a sexual way against your will	1	2
c.	You were forced, tricked, or pressured to have sex that you did not want	1	2
d.	You were treated unfairly in school because of your race or ethnicity	1	2
e.	You were treated unfairly in school because of what sex you are	1	2

29. Have you had sexual intercourse (made love, had sex, gone all the way)? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

30. During the last **12 months**, have you talked with your parents about sex? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

THIS SECTION IS ABOUT TOBACCO, ALCOHOL AND OTHER DRUGS

**Directions:** In this section, be sure to notice if the question is asking you about the last **30 days** or the last **12 months**. If the question asks you about things that happened to you during the last **30 days**, you need to think back to the end of February, up to today. Be sure to remember both school days and weekends. If the question asks you about things during the last **12 months**, you need to think back to last March, through the summer, and up to today. Remember to include the summer.

31. What best describes your use of cigarettes in the last **30 days**? (Check one box)

- 1 I have never smoked, not even a few puffs
- 2 I have not smoked in the last 30 days
- 3 I smoked less than once a week
- 4 I smoked at least once a week but not every day
- 5 I smoked every day

32. If you smoked at all in the last **30 days**, where did you usually get your cigarettes? (Check *one* box)

- 1 I did not smoke in the last 30 days
- 2 From a store
- 3 From a vending machine
- 4 From another kid
- 5 An adult gave them to me
- 6 I took them from an adult
- 7 Other

33. Does anyone you live with now smoke cigarettes, cigars, or a pipe? Don't count yourself (Check *one* box)

- 1 No one I live with smokes
- 2 Yes, someone I live with smokes

34. How many times (if any) during the last **30 days** did you drink alcohol, like beer, wine, wine coolers, liquor? (Check *one* box)

- 1 Not at all in the last 30 days
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

35. How many times (if any) in the last **30 days** did you have five or more drinks in a row? A drink is a glass of wine, a wine cooler, a bottle of beer, a shot glass of liquor, or a mixed drink. (Check *one* box)

- 1 Not at all in the last 30 days
- 2 Once
- 3 2 to 5 times
- 4 6 to 9 times
- 5 10 or more times

36. If you drank alcohol in the last **30 days**, how did you usually get the alcohol? (Check *one* box)

- 1 I did not drink in the last 30 days
- 2 In a religious ceremony
- 3 From a bar or liquor store
- 4 My parent gave it to me
- 5 An adult, 21 years or older, other than my parent gave it to me
- 6 I took it from my home without anyone knowing
- 7 I took it from an adult other than my parent
- 8 From someone less than 21 years of age

37. During the last **30 days**, were you a passenger in a car with an **adult** driver who you think had 3 or more drinks or who you think was drunk? (Check *one* box)

- 1 No
- 2 Yes
- 3 I don't know

38. During the last **30 days**, were you a passenger in a car with a driver who was **under 21 years old** and who you think had 3 or more drinks or who you think was drunk? (Check *one* box)

- 1 No
- 2 Yes
- 3 I don't know

39. How many times (if any) during the last **30 days** did you use or try marijuana, weed, grass, pot, hash or blunts? (Check *one* box)

- 1 Not at all in the last 30 days
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

40. How many times (if any) during the last **30 days** did you sniff, inhale, or breathe something to get high? (Check *one* box)

- 1 Not at all in the last 30 days
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

41. How many times (if any) during the last **30 days** did you use other drugs to get high, like cocaine, crack, LSD, speed, heroin, or downers? (Check *one* box)

- 1 Not at all in the last 30 days
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

42. How many times (if any) during the last **30 days** did you use Oxycontin (sometimes called Oxy or OC) without a doctor's prescription? (Check *one* box)

- 1 Not at all in the last 30 days
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

43. When (if ever) did you first do each of the following things? (Check one box on each line)

		Never	Grade 5 or below	Grade 6	Grade 7	Grade 8
a.	Smoke cigarettes, more than a few puffs	1	2	3	4	5
b.	Drink alcohol, more than a sip	1	2	3	4	5
c.	Try marijuana	1	2	3	4	5
d.	Try sniffing or breathing something to get high	1	2	3	4	5
e.	Try other drugs without a doctor telling you	1	2	3	4	5

44. How much do you think people risk harming themselves (physically or in other ways), if they do any of these things? (Check *one* box on *each* line)

		No Harm	Slight Harm	Moderate Harm	Great Harm	I Don't Know
a.	Smoke cigarettes occasionally	1	2	3	4	5
b.	Drink alcohol occasionally	1	2	3	4	5
c.	Smoke marijuana occasionally	1	2	3	4	5
d.	Try sniffing or breathing something to get high	1	2	3	4	5
e.	Try any other drug once or twice	1	2	3	4	5

45. How would your **friends** feel if they thought you did any of these things? (Check *one* box on *each* line)

		FRIENDS' OPINIONS			
		<i>They Would Approve</i>	<i>Disapprove But Still Be My Friend</i>	<i>Disapprove And Stop Being My Friend</i>	<i>They Wouldn't Care</i>
a.	Smoke cigarettes occasionally	1	2	3	4
b.	Drink alcohol occasionally	1	2	3	4
c.	Smoke marijuana occasionally	1	2	3	4

46. How upset would your **parents** feel if they thought you did any of these things? (Check *one* box on *each* line)

		PARENTS' OPINIONS			
		<i>Not Upset</i>	<i>A Little Upset</i>	<i>Pretty Upset</i>	<i>Very Upset</i>
a.	Smoke cigarettes occasionally	1	2	3	4
b.	Drink alcohol occasionally	1	2	3	4
c.	Smoke marijuana occasionally	1	2	3	4

47. During the last **12 months**, how many times have you talked with your parents about alcohol or other drug use? (Check *one* box)

- 1 Not at all
- 2 1 time
- 3 2 or 3 times
- 4 4 or 5 times
- 5 6 or more times

48. During the last **12 months**, has anyone offered, sold, or given you an illegal drug on school property? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

THIS SECTION DEALS WITH BREAKING RULES. Remember, no one will know your name.

49. During the last **12 months**, did any of these things happen? (Check *one* box on *each* line)

		No	Yes
a.	You missed school because you skipped or “cut”	1	2
b.	You were suspended	1	2
c.	You bullied, threatened or pushed other kids around in school	1	2
d.	You gambled, bet money on the lottery, bingo, sports events, cards, races	1	2
e.	You carried a weapon to school such as a gun, knife or stick	1	2
f.	You carried a weapon in your neighborhood	1	2
g.	You were in a physical fight. Don’t count fights with your family	1	2
h.	You forced, tricked or pressured someone into having sex with you	1	2
i.	You stole or shoplifted from a store	1	2

THIS SECTION IS ABOUT SOME OF YOUR PERSONAL HABITS.

50. Is there a TV in the room where you usually sleep? (Check *one* box)

- <sub>1</sub> No  
<sub>2</sub> Yes

51. On **most days** of the week, how do you get to school? (Check *one* box)

- <sub>1</sub> Walk  
<sub>2</sub> Get a ride  
<sub>3</sub> Take a bus  
<sub>4</sub> Other

52. How do you describe your **weight**? (Check *one* box)

- <sub>1</sub> Very underweight  
<sub>2</sub> Slightly underweight  
<sub>3</sub> About the right weight  
<sub>4</sub> Slightly overweight  
<sub>5</sub> Very overweight

53. Which of the following are you trying to do about your weight? (Check *one* box)

- <sub>1</sub> Lose weight  
<sub>2</sub> Gain weight  
<sub>3</sub> Stay the same weight  
<sub>4</sub> I am not trying to do anything about my weight

54. In the last **12 months** did you do any of these things to help you lose or maintain weight? (Check *one* box on *each* line)

		No	Yes
a.	Exercise	1	2
b.	Take diet pills, powders or liquids	1	2
c.	Eat less food, fewer calories, or foods low in fat	1	2
d.	Go without eating for 24 hours or more (fasting)	1	2
e.	Vomit or take laxatives	1	2



55. How many days a week do you eat breakfast? (Check *one* box)

- 1 0 days a week
- 2 1 to 2 days a week
- 3 3 to 5 days a week
- 4 6 to 7 days a week



56. In the last **12 months**, were you ever hungry because there was not enough money to buy food for your family? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

57. The next questions ask about food you ate **yesterday**. Think about all of the meals and snacks you ate yesterday from the time you got up until you went to bed (be sure to include food you ate at home, at school, at restaurants, or anywhere else). (Check one box on each line)

		0 times	1 time	2 times	3 or more times
a.	How many times did you eat fruit yesterday?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b.	How many times did you drink 100% fruit juice yesterday?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c.	How many times did you eat green salad or raw vegetables yesterday?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d.	How many times did you eat cooked vegetables yesterday (do not count potatoes, french fries, or fried potatoes)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e.	How many times did you drink soda yesterday?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f.	How many times did you drink sweetened drinks like punch, Kool-Aid, iced tea, sports drinks, or other fruit-flavored drinks yesterday?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

58. The last time you rode a bike, skateboard, scooter, roller blades or motorcycle, did you wear a helmet? (Check *one* box)

- 1 I have never ridden any of those
- 2 No, I did not wear a helmet
- 3 Yes, I did wear a helmet



59. The last time you were a passenger in a car, did you wear a seat belt? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

60. On an **average school day**, how many hours do you spend doing the following things? (Check *one* box on *each* line)

		None	Less than 1 hour	1 Hour	2 Hours	3 Hours	4 or more hours
a.	Watching TV, videos, or video games	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b.	At home with no adult there with you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c.	Doing homework or studying	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

61. During **this school year** (since September), did you do any of these things? (Check *one* box on *each* line)

		No	Yes
a.	Participate in academic groups, clubs, or student government	1	2
b.	Participate in music, band, or choir	1	2
c.	Participate in community service, in or out of school	1	2
d.	Participate in school-organized or interscholastic sports (such as junior varsity, varsity, 9 <sup>th</sup> grade, or clubs)	1	2
e.	Participate in community-organized youth sports	1	2

62. During the **last 7 days**, did you do any of these things? (Check *one* box on *each* line)

		No	Yes
a.	Read (not required for school)	1	2
b.	Work for money	1	2
c.	Take care of family responsibilities or chores (like baby-sitting, cleaning, cooking, or taking out the trash)	1	2
d.	Participate in after-school programs, youth programs, church programs, teen centers	1	2
e.	Do hobbies (pastimes, pleasurable activity, or interest) on your own time	1	2

63. On how many of the **last 7 days** did you do any of these things? (Check *one* box on *each* line)

		NUMBER OF DAYS							
		0	1	2	3	4	5	6	7
a.	Exercise or participate in sports for at least 20 minutes that made you sweat and breath hard (such as basketball, jogging, swimming, tennis, fast bicycling, or similar aerobic activities)	0	1	2	3	4	5	6	7
b.	Participate in other physical activity for at least 30 minutes (such as walking, bicycling or skating)	0	1	2	3	4	5	6	7

After filling out this survey, if you have any questions or concerns, please talk about them with your school nurse, school counselor, teacher, or parent.

## Thank you very much for your help



## THE END

**Close your survey and seal it with the stickers provided to ensure your privacy. Place it in the large manila envelope on your teacher's desk.**

**THANK YOU**