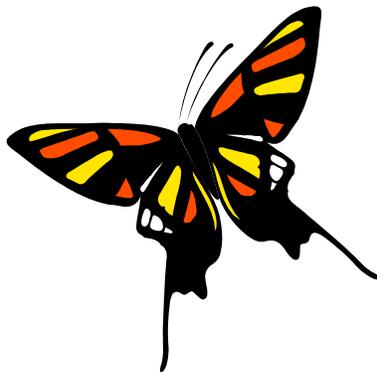


# TEEN HEALTH SURVEY

## 2004



### Directions

*Teachers: Please read these directions out loud to your students*

All CRLS students are taking this survey. It asks you 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. Your name will never be used. Taking this survey is up to you. If you do not want to answer a question, just leave it blank. Please sit with as much space as possible between seats. This will allow privacy for answering the questions.

When you have completed the survey, close and seal it with the sticker provided. Put it in the large envelope on the teacher's desk.

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 check the box that says, "not sure". If the question is confusing, you can ask the teacher for help or you can skip the question.

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 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.

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!**

~ Health, Physical Education and Athletics Department of the Cambridge Public Schools ~  
~ The Public Health Department of the Cambridge Health Alliance ~  
~ Cambridge Prevention Coalition of the Department of Human Services ~  
~ Institute for Community Health ~  
~ Office of Development and Assessment of the Cambridge Public Schools ~

**This section is about your personal background.  
Remember, no one will know your name.**

1. What is your sex? (Check *one* box)

- 1 Male
- 2 Female

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

- 1 Freshman – 9th grade
- 2 Sophomore – 10th grade
- 3 Junior – 11th grade
- 4 Senior – 12th grade
- 5 Other (Write in) \_\_\_\_\_

3. How old are you? (Write in)   Years Old

4. What Small Learning Community are you in?  
(Check *one* box)

- 1 SLC 1
- 2 SLC 2
- 3 SLC 3
- 4 SLC 4
- 5 SLC 5

5. What school did you attend in 8th grade? (Check *one* box)

- 1 Amigos
- 2 Agassiz/Baldwin
- 3 Cambridgeport
- 4 Fitzgerald
- 5 Fletcher Maynard Academy
- 6 Graham & Parks
- 7 Haggerty
- 8 Harrington
- 9 Kennedy
- 10 King
- 11 King Open
- 12 Longfellow
- 13 Morse
- 14 Peabody
- 15 Tobin
- 16 Other (Write in) \_\_\_\_\_

6. Your race is: (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) \_\_\_\_\_

7. Were you born in one of the 50 United States?  
(Check *one* box)

- 1 No
- 2 Yes

7a. If **NO**, how long have you been in the United States?

Years        Months

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

- 1 No
- 2 Yes

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

- English
- Spanish
- Portuguese
- Cape Verdean Creole
- Haitian Kreyol
- Chinese
- Korean
- Amharic or Tegrina
- Gujarati, Hindi, or Bengali
- Arabic
- Another language (Write in) \_\_\_\_\_

10. Are you enrolled in ESL (English as a Second Language) or Bilingual Education classes? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

11. Are you now receiving Special Education services?  
(Check *one* box)

- 1 No
- 2 Yes
- 3 Not Sure

12. Do you have children of your own? (Check *one* box)

- 1 No
- 2 Yes – How Many? (Write in) \_\_\_\_\_
- 3 Not Sure

13. What are your average grades in high 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

14. Where do you usually go for health care? (Check *one* box)

- 1 Private doctor's office
- 2 Harvard Vanguard
- 3 Neighborhood Health Center
- 4 Teen Health Center
- 5 Hospital clinic
- 6 Hospital emergency room
- 7 Other (Write in) \_\_\_\_\_
- 8 I don't always go to the same place
- 9 Not sure

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

- |                            |                           |
|----------------------------|---------------------------|
| <input type="checkbox"/> 1 | During the last 12 months |
| <input type="checkbox"/> 2 | More than 12 months ago   |
| <input type="checkbox"/> 3 | Never                     |
| <input type="checkbox"/> 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. Vision problem that needs glasses	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Hearing problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Overweight	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Underweight	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Migraine headaches	<input type="checkbox"/> 1	<input type="checkbox"/> 2
	No	Yes
g. Diabetes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h. High blood pressure	<input type="checkbox"/> 1	<input type="checkbox"/> 2
i. HIV infection or AIDS	<input type="checkbox"/> 1	<input type="checkbox"/> 2
j. Sexually transmitted disease (STD)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
k. Sickle cell disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2
l. TB (tuberculosis)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
m. An eating disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 2

17. How tall are you without your shoes on?

I am  feet and  inches tall

18. How much do you weigh without your shoes on?

I weigh  pounds

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

- |                            |          |
|----------------------------|----------|
| <input type="checkbox"/> 1 | No       |
| <input type="checkbox"/> 2 | Yes      |
| <input type="checkbox"/> 3 | Not Sure |

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

- |                            |                           |
|----------------------------|---------------------------|
| <input type="checkbox"/> 1 | During the last 12 months |
| <input type="checkbox"/> 2 | More than 12 months ago   |
| <input type="checkbox"/> 3 | Never                     |
| <input type="checkbox"/> 4 | Not sure                  |

21. During the past **12 months**, did you do any of the following things? (Check *one* box on *each* line)

	No	Yes
a. Meet with a school counselor	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Meet with a Teen Health Center counselor	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Meet with a therapist with or without your family	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Take medication for a mental health or behavioral problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2

22. Does your family have health insurance to help pay medical or doctors' bills? (Check *one* box)

- |                            |          |
|----------------------------|----------|
| <input type="checkbox"/> 1 | No       |
| <input type="checkbox"/> 2 | Yes      |
| <input type="checkbox"/> 3 | Not Sure |

23. 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)

- |                            |          |
|----------------------------|----------|
| <input type="checkbox"/> 1 | No       |
| <input type="checkbox"/> 2 | Yes      |
| <input type="checkbox"/> 3 | Not Sure |

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

	No	Yes
a. Mother	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Father	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Step-parent	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Foster parents, guardians	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Another adult	<input type="checkbox"/> 1	<input type="checkbox"/> 2

25. Is anyone you are living with over the age of 21? (Check *one* box)

- |                            |     |
|----------------------------|-----|
| <input type="checkbox"/> 1 | No  |
| <input type="checkbox"/> 2 | Yes |

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

- |                            |  |
|----------------------------|--|
| <input type="checkbox"/> 1 | A house, condo, or apartment owned or rented by my parent/guardian |
| <input type="checkbox"/> 2 | Public Housing ("the projects", Section 8)                         |
| <input type="checkbox"/> 3 | A shelter, motel, or other temporary housing                       |
| <input type="checkbox"/> 4 | A halfway house or residential program                             |
| <input type="checkbox"/> 5 | I have no regular place to live                                    |
| <input type="checkbox"/> 6 | Other (Write in) _____   |

27. How likely do you think it will be for you to... (Check *one* box on *each* line)

		Not At All Likely	Not Very Likely	Somewhat Likely	Very Likely
a.	Graduate high school?	1	2	3	4
b.	Own a house or condo?	1	2	3	4
c.	Make more money than your parents?	1	2	3	4
d.	Go to college?	1	2	3	4
e.	Have a full time job?	1	2	3	4

28. What is the highest amount of schooling completed by your **father** or the **man who raised you**? (Check *one* box)

<input type="checkbox"/> 1	He did not finish high school
<input type="checkbox"/> 2	He finished high school
<input type="checkbox"/> 3	He went to vocational school (trade school) after high school
<input type="checkbox"/> 4	He took some college courses
<input type="checkbox"/> 5	He finished college
<input type="checkbox"/> 6	He went to school beyond college
<input type="checkbox"/> 7	I don't know
<input type="checkbox"/> 8	Does not apply (no adult males raised me)

29. What is the highest amount of schooling completed by your **mother** or the **woman who raised you**? (Check *one* box)

<input type="checkbox"/> 1	She did not finish high school
<input type="checkbox"/> 2	She finished high school
<input type="checkbox"/> 3	She went to vocational school (trade school) after high school
<input type="checkbox"/> 4	She took some college courses
<input type="checkbox"/> 5	She finished college
<input type="checkbox"/> 6	She went to school beyond college
<input type="checkbox"/> 7	I don't know
<input type="checkbox"/> 8	Does not apply (no adult females raised me)

**This section is about personal matters in your life. Remember, no one will know these answers are yours.**

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

<input type="checkbox"/> 1	None
<input type="checkbox"/> 2	1 to 2
<input type="checkbox"/> 3	3 or more

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

<input type="checkbox"/> 1	No
<input type="checkbox"/> 2	Yes
<input type="checkbox"/> 3	Not sure

32. How interested do you think your parents are in the following? (Check *one* box on *each* line)

		Not at All Interested	A Little Interested	Pretty Interested	Very Interested
a.	Your grades	1	2	3	4
b.	Your activities	1	2	3	4
c.	Your friends	1	2	3	4
d.	Your future plans	1	2	3	4
e.	Your feelings	1	2	3	4
f.	Your ideas	1	2	3	4

33. 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)

<input type="checkbox"/> 1	No
<input type="checkbox"/> 2	Yes
<input type="checkbox"/> 3	Not sure

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

<input type="checkbox"/> 1	No
<input type="checkbox"/> 2	Yes, parent or other adult family member
<input type="checkbox"/> 3	Yes, non-family adult (such as religious leader, club advisor, neighbor, etc.)
<input type="checkbox"/> 4	Yes, both family and non-family adults
<input type="checkbox"/> 5	Not sure

35. During the past **30 days**, on how many days did you **not** go to school because you felt you would be unsafe at school or on your way to or from school? (Check *one* box)

- |   |                |
|---|----------------|
| 1 | 0 days         |
| 2 | 1 day          |
| 3 | 2 or 3 days    |
| 4 | 4 or 5 days    |
| 5 | 6 or more days |

36. How often do you **worry** about being treated differently or being discriminated against for any of the following reasons?

(Check one box on each line)

	Never	Once in A While	Fairly Often	Most of the Time
a. Your race/ethnicity	1	2	3	4
b. Your sex (gender)	1	2	3	4
c. Your religion	1	2	3	4
d. Your sexual orientation (gay, lesbian, bisexual, other)	1	2	3	4
e. Your appearance is not masculine or feminine enough	1	2	3	4
f. Your disability	1	2	3	4

37. During the past **12 months**, how often did you **worry** about the following? (Check *one* box on each line)

	Never	Once in A While	Fairly Often	Most of the Time
a. Physical health problems	1	2	3	4
b. Weight problems (too heavy or too thin)	1	2	3	4
c. Sexually transmitted disease (STD)	1	2	3	4
d. Becoming pregnant or getting someone pregnant	1	2	3	4
e. HIV infection or AIDS	1	2	3	4
f. Sexual orientation	1	2	3	4
g. School failure or poor grades	1	2	3	4
h. MCAS	1	2	3	4
	Never	Once in A While	Fairly Often	Most of the Time
i. Drug or alcohol use in your family	1	2	3	4
j. Your own drug or alcohol use	1	2	3	4
k. Arguing at home	1	2	3	4
l. Violence in your home	1	2	3	4
m. Violence in your neighborhood	1	2	3	4
n. Violence in school	1	2	3	4
o. Other kids bringing weapons to school	1	2	3	4
p. Your family not having enough money to get by	1	2	3	4
q. Your family not having a place to live	1	2	3	4

38. How often do you ... (Check *one* box on each line)

	Never	Once in A While	Fairly Often	Most of the Time
a. Feel easily annoyed or irritated?	1	2	3	4
b. Have temper outbursts you cannot control?	1	2	3	4
c. Have urges to beat, injure, or harm someone?	1	2	3	4
d. Get into frequent arguments?	1	2	3	4
e. Shout or throw things?	1	2	3	4

39. 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 |

40. 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)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

41. During the past **30 days**, did you feel tense, nervous, or worried every day for two or more weeks in a row? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

42. During the past **30 days**, did you have nightmares, flashbacks, or thoughts you could not get rid of about something terrible you saw or something that happened to you in the past? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

43. During the past **12 months**, did you hurt yourself on purpose (for instance, cut yourself, burn yourself, or bang your head on purpose)? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

44. During the past **12 months**, did you seriously consider attempting suicide? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

45. During the past **12 months**, did you make a plan about how you would attempt suicide? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

46. During the past **12 months**, did you actually attempt suicide? (Check *one* box)

<input type="checkbox"/>	1	No
<input type="checkbox"/>	2	Yes
<input type="checkbox"/>	3	Not sure

47. If you considered or attempted suicide during the past **12 months**, who (if anyone) did you tell about your thoughts or attempt? (Check *all that apply*)

I did NOT consider or attempt suicide during the past 12 months

I did not tell anyone

Told a parent or guardian

Told a brother, sister, or other family member

Told a friend

Told a teacher or other school adult

Told a doctor or nurse

Told a therapist

Told the police

Told another adult

**Continue on to Question # 44**

48. Have you **ever** been hurt or made to feel afraid by a date or someone you were going out with? This would include being threatened, shoved, slapped, hit or forced into any sexual activity? (Check *one* box on *each* line)

	No	Yes
a. I have been threatened or made to feel afraid	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. I have been hurt physically	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. I have been hurt sexually or forced to have vaginal, anal, or oral sex	<input type="checkbox"/> 1	<input type="checkbox"/> 2

49. During the past **12 months**, did any of the following things happen to you? (Check *one* box on *each* line)

	No	Yes
a. You had one or more failing grades on a report card	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. You were injured at work	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. You had a problem with alcohol or drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. A member of your family had an alcohol or drug problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Your parents were divorced or separated	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Your family moved	<input type="checkbox"/> 1	<input type="checkbox"/> 2
g. You ran away from home	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h. A family member or close friend died	<input type="checkbox"/> 1	<input type="checkbox"/> 2

50. During the past **12 months**, did any of the following things happen to you? (Check *one* box on *each* line)

		No	Yes
a.	You witnessed violence in your family	1	2
b.	You witnessed violence in your neighborhood	1	2
c.	You were bullied, threatened, or pushed around in school or on the way	1	2
d.	You were threatened with a knife or a gun in school	1	2
e.	You were threatened with a knife or a gun outside of school	1	2
f.	You were beaten or physically hurt by someone in your family or home	1	2
g.	You were beaten or physically hurt by someone you were going out with	1	2
h.	You were beaten or physically hurt by someone else (not a family member, not a date)	1	2

51. During the past **12 months**, did any of the following things happen to you? (Check *one* box on *each* line)

		No	Yes
a.	You were verbally or emotionally abused by someone in your family	1	2
b.	You were mistreated by someone who thought you were not masculine or feminine enough	1	2
c.	You were sexually abused (someone did something to you sexually which you did not want them to do or touched you in a way that you did not want to be touched)	1	2
d.	You were sexually harassed in school (had rude sexual comments directed at you or were touched, pinched, grabbed, or patted in a sexual way against your will)	1	2
e.	You were treated unfairly in school because of your race or ethnicity	1	2
f.	You were treated unfairly in school because of what sex you are	1	2

**This section is about sexual matters. Remember, your answers are CONFIDENTIAL.**

52. During the last **12 months**, did you have a conversation with your parents about sex? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not sure

53. Which of the following best describes you? (Check *one* box)

- 1 Heterosexual (straight)  
 2 Gay or Lesbian  
 3 Bisexual  
 4 Not sure

54. Some teenagers have had sex and others have not. Have you had sexual intercourse (made love, had sex, gone all the way)? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not sure

55. During the past **12 months**, did you have a sexual experience with someone of the same sex? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not sure

56. How old were you when you first had sexual intercourse (made love, had sex, gone all the way)? (Write your age in years. Write in "0" if you have never had sexual intercourse. Guess how old you were if you're not sure)

I was   years old

57. How old was the person that you first had sexual intercourse with? (Write his/her age in years. Write in "0" if you have never had sexual intercourse. Guess how old he/she was if you're not sure)

The person was   years old

58. During your **lifetime** have you ever been forced or tricked to have sex against your will? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not sure

59. During your **lifetime**, with how many different people have you had sexual intercourse? (Check *one* box)

- 1 I have never had sexual intercourse
- 2 1 person
- 3 2 people
- 4 3 people
- 5 4 people
- 6 5 or more people

60. Did you use alcohol or drugs before you had sexual intercourse the **last time**? (Check *one* box)

- 1 I have never had sexual intercourse
- 2 No
- 3 Yes

61. Have you **ever** been pregnant or gotten someone pregnant? (Check *one* box)

- 1 I have never had sexual intercourse
- 2 No
- 3 Yes
- 4 Not sure

62. Did you **ever** talk about HIV or AIDS with your parents or other adults in your family? (Check *one* box)

- 1 No
- 2 Yes

**Continue on to Question # 63**

63. Has information you received in health or sex education caused you to be more careful about your sexual behavior? (Check *one* box)

- 1 No
- 2 Yes

64. The **last time** you had sexual intercourse, did you or your partner use a condom? (Check *one* box)

- 1 I have never had sexual intercourse
- 2 No
- 3 Yes
- 4 Not sure

65. When you have sexual intercourse, how often do you or your partner use condoms? (Check *one* box)

- 1 I have never had sexual intercourse
- 2 Never
- 3 Sometimes
- 4 Usually
- 5 Always
- 6 Not sure

66. The **last time** you had sexual intercourse, did you or your partner do any of the following things to try to prevent pregnancy? (Check *one* box on *each* line)

	Never Had Sex	No	Yes	Don't Know
a. Birth control pills	1	2	3	4
b. Condoms	1	2	3	4
c. Foam, jelly, or cream spermicide	1	2	3	4
d. Diaphragm	1	2	3	4
e. Rhythm (safe time of the month)	1	2	3	4
f. Withdrawal (pulling out)	1	2	3	4
g. Depo Provera (birth control shots)	1	2	3	4
h. Birth control skin patch	1	2	3	4
i. Some other method ( <i>Write in</i> ) _____	1	2	3	4

**This section is about the use of alcohol.**

67. On how many **occasions** (if any) during the last **30 days** have you had alcoholic beverages to drink (beer, wine, liquor)? (Check *one* box)

- 1 0 occasions
- 2 1-2 occasions
- 3 3-5 occasions
- 4 6-9 occasions
- 5 10-19 occasions
- 6 20-39 occasions
- 7 40 or more occasions

68. On the **occasions** that you drank alcoholic beverages in the last **30 days**, how often did you drink enough to feel drunk or high? (Check *one* box)

- 1 I did not drink in the last 30 days
- 2 0 times
- 3 1 time
- 4 2 to 5 times
- 5 6 to 9 times
- 6 10 or more times

69. Think over the last **30 days**. How many times have you had 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 | 0 times          |
| 2 | 1 time           |
| 3 | 2 to 5 times     |
| 4 | 6 to 9 times     |
| 5 | 10 or more times |

70. If you wanted to get some alcoholic beverages (such as beer, wine, liquor), how easy would it be for you to get some? (Check *one* box)

- |   |              |
|---|--------------|
| 1 | Very Hard    |
| 2 | Sort of Hard |
| 3 | Sort of Easy |
| 4 | Very Easy    |

71. 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 | I got it as part of a religious ceremony                        |
| 3 | I got it 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 | I got it from someone less than 21 years of age                 |

72. If you tried to buy alcohol from a store or restaurant in the last **30 days**, what usually happened? (Check *one* box)

- |   |   |
|---|---|
| 1 | I did not try to buy alcohol in the last 30 days            |
| 2 | I was able to buy the alcohol without showing an ID         |
| 3 | I used a fake ID to buy the alcohol                         |
| 4 | I got an older friend or relative to buy the alcohol for me |
| 5 | I got a stranger to buy the alcohol for me                  |
| 6 | The server refused to sell to me                            |

73. During the last **30 days**, did you drive a car, truck, or motorcycle after drinking alcohol? (Check *one* box)

- |   |     |
|---|-----|
| 1 | No  |
| 2 | Yes |

74. During the last **30 days**, were you a passenger in a car when the driver has been drinking? (Check *one* box)

- |   |     |
|---|-----|
| 1 | No  |
| 2 | Yes |

75. During the last **30 days**, if you were a passenger in a car when the driver had 3 or more drinks in a row, who was driving? (Check *all that apply*)

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | I was not a passenger in a car in the last 30 days when the driver had 3 or more drinks |
| <input type="checkbox"/> | Your parent   |
| <input type="checkbox"/> | An adult other than your parent 21 years or over  |
| <input type="checkbox"/> | Someone less than 21 years of age   |

76. Have you **ever** been helped or treated for alcohol or drug use? (Check *one* box)

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

**This section is about the use of drugs.**

77. On how many **occasions** (if any) during the last **30 days** have you used **marijuana** or **hashish** (weed, reefer, pot, hash, blunts)? (Check *one* box)

- |   |                      |
|---|----------------------|
| 1 | 0 occasions          |
| 2 | 1-2 occasions        |
| 3 | 3-5 occasions        |
| 4 | 6-9 occasions        |
| 5 | 10-19 occasions      |
| 6 | 20-39 occasions      |
| 7 | 40 or more occasions |

78. On how many **occasions** (if any) during the last **30 days** have you used **LSD** (acid)? (Check *one* box)

- |   |                      |
|---|----------------------|
| 1 | 0 occasions          |
| 2 | 1-2 occasions        |
| 3 | 3-5 occasions        |
| 4 | 6-9 occasions        |
| 5 | 10-19 occasions      |
| 6 | 20-39 occasions      |
| 7 | 40 or more occasions |

79. On how many **occasions** (if any) during the last **30 days** have you used **psychedelics other than LSD**, such as mescaline, peyote, psilocybin, PCP, Ecstasy, mushrooms, MDMA? (Check *one* box)

- |   |                      |
|---|----------------------|
| 1 | 0 occasions          |
| 2 | 1-2 occasions        |
| 3 | 3-5 occasions        |
| 4 | 6-9 occasions        |
| 5 | 10-19 occasions      |
| 6 | 20-39 occasions      |
| 7 | 40 or more occasions |

80. On how many **occasions** (if any) during the last **30 days** have you used **cocaine** (coke, crack, rock)? (Check *one* box)

- |   |                      |
|---|----------------------|
| 1 | 0 occasions          |
| 2 | 1-2 occasions        |
| 3 | 3-5 occasions        |
| 4 | 6-9 occasions        |
| 5 | 10-19 occasions      |
| 6 | 20-39 occasions      |
| 7 | 40 or more occasions |

81. On how many **occasions** (if any) during the last **30 days** have you taken **amphetamines** on your own – that is, without a doctor telling you to? Amphetamines are a prescription drug also called speed, crystal-meth, ice, uppers, ups, bennies, or dexies? (Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

82. On how many **occasions** (if any) during the last **30 days** have you used **tranquilizers** (Librium, Valium, Xanax) on your own – that is, without a doctor telling you to? (Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

83. On how many **occasions** (if any) during the last **30 days** have you used **barbiturates** (downs, downers, goofballs, yellows, reds, blues, rainbows) on your own – that is, without a doctor telling you to? (Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

84. On how many **occasions** (if any) during the last **30 days** have you used **heroin** (smack, horse, skag)?

(Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

85. On how many **occasions** (if any) during the last **30 days** have you used **narcotics other than heroin**, such as methadone, opium, morphine, codeine, Demerol, paregoric, on your own – that is, without a doctor telling you to? (Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

86. On how many **occasions** (if any) during the last **30 days** have you sniffed glue or breathed the contents of aerosol spray cans or inhaled any other gases or fluids in order to get high? (Check *one* box)

1	0 occasions
2	1-2 occasions
3	3-5 occasions
4	6-9 occasions
5	10-19 occasions
6	20-39 occasions
7	40 or more occasions

87. During your **lifetime**, have you ever injected (shot up) an illegal drug? (Check *one* box)

1	No
2	Yes

Continue on to Question # 84

88. When (if ever) did you **first** do each of the following things? Don't count anything you took because a doctor told you to. (Check *one* box on *each* line)

		GRADE OF FIRST USE						
		Never	Grade 6 or below	Grade 7 or 8	Grade 9	Grade 10	Grade 11	Grade 12
a.	Smoke cigarettes, more than a few puffs	1	2	3	4	5	6	7
b.	Smoke cigarettes daily	1	2	3	4	5	6	7
c.	Drink alcohol, more than a sip	1	2	3	4	5	6	7
d.	Try beedies (hand rolled cigarettes from India)	1	2	3	4	5	6	7
e.	Try marijuana	1	2	3	4	5	6	7
f.	Try inhalants (sniffing glue)	1	2	3	4	5	6	7
g.	Try LSD	1	2	3	4	5	6	7
h.	Try psychedelics other than LSD	1	2	3	4	5	6	7

89. When (if ever) did you **first** do each of the following things? Don't count anything you took because a doctor told you to. (Check *one* box on *each* line)

		GRADE OF FIRST USE						
		Never	Grade 6 or below	Grade 7 or 8	Grade 9	Grade 10	Grade 11	Grade 12
a.	Try amphetamines	1	2	3	4	5	6	7
b.	Try barbiturates	1	2	3	4	5	6	7
c.	Try tranquilizers	1	2	3	4	5	6	7
d.	Try cocaine	1	2	3	4	5	6	7
e.	Try heroin	1	2	3	4	5	6	7
f.	Try narcotics other than heroin	1	2	3	4	5	6	7

90. During the past **30 days**, on how many days did you attend class within one hour of using alcohol, marijuana, or other drugs? (Check *one* box)

1	0 days
2	1 day
3	2 to 5 days
4	6 to 9 days
5	10 or more days

91. If you and your parents have had any conversations about alcohol or other drug use by teenagers during the last **12 months**, how helpful were the conversations? (Check *one* box)

1	We didn't talk about alcohol or other drugs
2	Not at all helpful
3	Somewhat helpful
4	Very helpful

92. How upset would your **parents** feel if they thought you... (Check *one* box on *each* line)

If they thought you...		Your PARENTS would feel...			
		Not At All Upset	A Little Upset	Pretty Upset	Very Upset
a.	Tried cigarettes	1	2	3	4
b.	Smoke cigarettes regularly	1	2	3	4
c.	Tried alcohol	1	2	3	4
d.	Drink alcohol regularly	1	2	3	4
e.	Tried marijuana	1	2	3	4
f.	Smoke marijuana regularly	1	2	3	4

93. How would your **friends** feel if they thought you... (Check *one* box on *each* line)

If they thought you...		Your FRIENDS would...			
		They would approve	Disapprove but still be my friend	Disapprove and stop being my friend	They wouldn't care
a.	Smoke cigarettes regularly	1	2	3	4
b.	Drink alcohol regularly	1	2	3	4
c.	Smoke marijuana regularly	1	2	3	4

94. Estimate the percentage of students **in your grade** who are doing the following. (Write a number between 0% and 100% for each item. 0% is none of them and 100% is all of them.)

- \_\_\_\_\_ % of students in **my grade** smoke **cigarettes**
- \_\_\_\_\_ % of students in **my grade** drink **alcohol**
- \_\_\_\_\_ % of students in **my grade** smoke **marijuana**
- \_\_\_\_\_ % of students in **my grade** take **other drugs**

95. How much do you think people risk harming themselves (physically or in other ways), if they...

(Check <i>one</i> box on <i>each</i> line)		PERCEIVED RISK				
		No Risk	Slight Risk	Moderate Risk	Great Risk	I Don't Know
a.	Smoke cigarettes regularly	1	2	3	4	5
b.	Try marijuana once or twice	1	2	3	4	5
c.	Smoke marijuana regularly	1	2	3	4	5
d.	Take steroids	1	2	3	4	5
e.	Try LSD once or twice	1	2	3	4	5
f.	Take LSD regularly	1	2	3	4	5

96. How much do you think people risk harming themselves (physically or in other ways), if they...

(Check <i>one</i> box on <i>each</i> line)		PERCEIVED RISK				
		No Risk	Slight Risk	Moderate Risk	Great Risk	I Don't Know
a.	Try heroin once or twice	1	2	3	4	5
b.	Take heroin regularly	1	2	3	4	5
c.	Try barbiturates (downers) once or twice	1	2	3	4	5
d.	Take barbiturates regularly	1	2	3	4	5
e.	Try amphetamines (uppers) once or twice	1	2	3	4	5
f.	Take amphetamines regularly	1	2	3	4	5
g.	Try cocaine once or twice	1	2	3	4	5
		No Risk	Slight Risk	Moderate Risk	Great Risk	I Don't Know
h.	Take cocaine regularly	1	2	3	4	5
i.	Try crack once or twice	1	2	3	4	5
j.	Take crack regularly	1	2	3	4	5
k.	Try one or two drinks of alcohol (beer, wine, liquor)	1	2	3	4	5
l.	Take one or two drinks nearly every day	1	2	3	4	5
m.	Take four or five drinks nearly every day	1	2	3	4	5
n.	Have five or more drinks once or twice each weekend	1	2	3	4	5

**This section is about tobacco.**

97. What best describes your smoking habits? (Check *one* box)

- 1 I have never smoked, not even a few puffs
- 2 I tried it a few times and stopped
- 3 I smoked for some time but stopped
- 4 I have smoked within the last 30 days
- 5 I haven't smoked in the last 30 days but I do smoke once in a while

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

- 1 I haven't smoked in the last 30 days
- 2 I smoked less than once a week
- 3 I smoked at least once a week but not every day
- 4 I smoked every day

99. If you smoked cigarettes daily in the last **30 days**, how many cigarettes did you smoke in a day?

- (Check *one* box)
- 1 I don't smoke cigarettes daily
  - 2 1-4 cigarettes
  - 3 About half a pack
  - 4 About a pack
  - 5 About one and a half packs
  - 6 2 or more packs

100. 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 a friend
- 5 An adult gave them to me
- 6 I took them from an adult
- 7 I got them through the internet
- 8 Other

101. If you tried to buy cigarettes in the store in the last **30 days**, did you have difficulty getting the store clerk to sell to you? (Check *one* box)

- 1 I have not tried to buy cigarettes in the last 30 days
- 2 I can buy cigarettes from a store without a problem
- 3 Sometimes the store won't sell to me
- 4 The store usually won't sell cigarettes to me
- 5 The store never sells cigarettes to me

102. Have you **ever** tried to quit smoking cigarettes?  
(Check *one* box)

- 1 I have not smoked
- 2 I have only smoked a few puffs
- 3 Yes, I have tried to quit
- 4 No, I never tried to quit

103. On how many **occasions** (if any) have you used **beedies** (hand rolled cigarettes from India)? (Check *one* box)

- 1 0 times
- 2 1 or 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

104. How many times (if any) during the last **12 months** did you smoke a **cigar**? (Check *one* box)

- 1 0 times
- 2 1 or 2 times
- 3 3 to 5 times
- 4 6 to 9 times
- 5 10 to 19 times
- 6 20 or more times

105. 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

**THIS SECTION DEALS WITH ACTIVITIES THAT ARE AGAINST THE RULES.  
Remember, your answers are CONFIDENTIAL.**

106. During the last **4 weeks** of school, how often have you missed a full day of school because of an unexcused absence (you skipped or "cut")? (Check *one* box)

- 1 Never
- 2 1 to 2 times
- 3 3 to 5 times
- 4 6 to 10 times
- 5 11 or more times

107. During **this school year**, (since September), have you been suspended? (Check *one* box)

- 1 No
- 2 Yes, 1 time
- 3 Yes, 2 times
- 4 Yes, 3 or more times

108. On how many **occasions** (if any) have you gambled; for example, bet money on the lottery, bingo, sports events, cards, casinos, races, etc.? (Check *one* box on *each* line)

		NUMBER OF OCCASIONS			
		0	1-2	3-9	10+
a.	During the last <b>12 months</b>	0	1	2	3
b.	During the last <b>30 days</b>	0	1	2	3

109. During the last **30 days**, on how many days did you carry a weapon **in school**, such as a gun, knife, or club? (Check *one* box)

- 1 0 days
- 2 1 to 3 days
- 3 4 or more days

110. During the last **30 days**, on how many days did you carry a weapon **outside of school**, such as a gun, knife, or club? (Check *one* box)

- 1 0 days
- 2 1 to 3 days
- 3 4 or more days

111. During the last **30 days**, what **one** kind of weapon did you carry most often? (Check *one* box)

- 1 I did not carry a weapon during the last 30 days
- 2 A handgun
- 3 Other gun, such as a rifle or shotgun
- 4 A knife or razor
- 5 A club, stick or bat
- 6 Some other weapon

112. During the last **12 months**, how many times were you in a physical fight? (Check *one* box)

- 1 0 times
- 2 1 to 3 times
- 3 4 to 7 times
- 4 8 to 11 times
- 5 12 or more times

113. The **last time** you were in a physical fight, who did you fight? (Check *one* box)

- 1 I have never been in a physical fight
- 2 A total stranger
- 3 A friend or someone I know
- 4 A boyfriend, girlfriend, or date
- 5 A parent
- 6 A brother, sister, or other family member
- 7 Someone not listed above
- 8 More than one of the persons listed above

114. During the last **12 months**, were you a gang member? (Check *one* box)

- 1 No
- 2 Yes
- 3 Not sure

115. During the last **12 months**, did you sell drugs?

(Check *one* box)

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

117. During the last **12 months**, were you arrested?

(Check *one* box)

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

116. During the last **12 months**, did you force, trick or pressure someone to have sex with you? (Check *one* box)

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

**Continue on to Question # 117**

**This section is about some of your personal habits.**

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

		NUMBER OF HOURS					
		None	Less than 1 hour	1 hour	2 hours	3 hours	4 or more hours
a.	Watch TV, videos, or video games	1	2	3	4	5	6
b.	Study or complete homework outside of school hours	1	2	3	4	5	6

119. 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

120. 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

121. 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

122. Is there a TV in the room where you usually sleep?

(Check *one* box)

- 1 No  
 2 Yes

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

- 1 Walk  
 2 Get a ride  
 3 Drive yourself  
 4 Take a bus  
 5 Other

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

- 1 Very underweight  
 2 Slightly underweight  
 3 About the right weight  
 4 Slightly overweight  
 5 Very overweight

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

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

126. In the **past 30 days**, did you do any of these things to help you lose or keep from gaining weight?

(Check *one* box on *each* line)

	No	Yes
a. Exercise	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Smoke cigarettes	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Take diet pills, powders or liquids	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Skip meals	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Take laxatives	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Eat less at meals	<input type="checkbox"/> 1	<input type="checkbox"/> 2
g. Eat fewer snacks	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h. Vomit (throw up) on purpose after eating	<input type="checkbox"/> 1	<input type="checkbox"/> 2
i. Eat fewer fried and high-fat foods	<input type="checkbox"/> 1	<input type="checkbox"/> 2
j. Go on a weight loss program	<input type="checkbox"/> 1	<input type="checkbox"/> 2

127. How many days a week do you eat breakfast?

(Check *one* box)

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

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

- 1 No  
 2 Yes  
 3 Not sure

129. The next questions ask about food you ate **yesterday**. Think about all 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)

		NUMBER OF TIMES			
		0 times	1 time	2 times	3 or more times
a.	How many times did you eat fruit yesterday?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b.	How many times did you drink 100% fruit juice yesterday?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c.	How many times did you eat green salad or raw vegetables yesterday?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d.	How many times did you eat cooked vegetables yesterday?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e.	How many times did you drink soda yesterday?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f.	How many times did you drink sweetened drinks like punch, Kool-Aid, iced tea, sports drinks, or other fruit-flavored drinks?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

130. During the last **12 months**, did you use steroids (body building hormones)? (Check *one* box)

- 1 No  
 2 Yes  
 3 Not sure

131. The **last time** you rode a bike, skateboard, or roller blades, 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

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

- 1 No  
 2 Yes

**THIS IS THE END OF THE QUESTIONNAIRE.**  
 Close this booklet and read the instructions on the back.  
**THANK YOU FOR YOUR PARTICIPATION!**

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

**THANK YOU**