

Health & Lifestyle Survey of Young People 2012

SCHOOL REFERENCE

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YOUR NAME WILL NOT BE RECORDED ON THIS FORM

Reasons for survey

In Hull, we believe that children and young people are REALLY important and we want to make sure that you are helped to be as healthy and happy as possible and to achieve your full potential. To help with this we are doing a survey to find out about your health and lifestyles. We would like to ask you how you feel, what you think your health is like and how you live your lives. The anonymous information will be used to help us improve the health of young people in Hull.

Confidentiality

Your answers will be anonymous which means that we will only know the school, school year and age of the person who filled in which form, not their name. This means that we can't identify you or know what answer you gave to each question. Therefore you can write down what you really feel and believe.

How to fill in the questionnaire

There are quite a lot of questions, but most only ask you to tick boxes and not write long answers! Most ask you to tick the box that you agree with or is what you think, feel or do and is the best one for you. For some questions you will need to tick one box only, and for some you may be asked to tick several that you agree with or that apply to you. For other questions you may be asked to write your answer in words or numbers in a box, e.g. your postcode or the number of grown ups in your house.

Your answers are important to us

A lot of young people in Hull aged between 11 and 16 years will be filling in this form, so we have questions on a lot of topics, like smoking and drinking. Some may not apply to you, but we would really like you to answer ALL the questions.

Please try to fill in the form as honestly and truthfully as possible. We would like to know about what YOU think, feel and do. There is no right or wrong answer.

Health & Lifestyle Survey of Young People 2012

YOU AND YOUR HOME

1. Are you **male** or **female**?

(Please tick only **one** box)

Male



Female



2. How **old** are you (in years)?

(Please tick only **one** box)

11
1

12
2

13
3

14
4

15
5

16
6

17
7

18
8

3. What **school year** are you in?

(Please tick only **one** box)

Year 7
1

Year 8
2

Year 9
3

Year 10
4

Year 11
5

School 6th form
6

6th form college / FE college
7

4. What is the **postcode** of your **home**
(where you sleep most nights)?

(Please **write it** in the boxes)

H	U		
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5. How many times have you **moved home** in the **last two years**?

(Please tick only **one** box)

0
0

1
1

2
2

3
3

4
4

5 or more
5

6. How many **adults/grown ups live with you** in your home (aged 18
or more)?

(Please **write the number** of people in the box)

7. How many **other children** (not counting you) **live with you**
in your home (under 18)?

(Please **write the number** of other children in the box)



Technology

8. Do you have access to the **internet**?

(Please tick **one** box for each line)

	Yes	No
At home	<input type="checkbox"/> 1	<input type="checkbox"/> 2
At school	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Youth centre	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Library	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Other (please write in box)	<input type="checkbox"/> 1	<input type="checkbox"/> 2

If 'Other', please write where, in this box:

9. When you access the **internet**, are you able to do it **privately** or only in a **public place**?

(Please tick only **one** box)

Only privately	<input type="checkbox"/> 1
Only in a public place	<input type="checkbox"/> 2
Sometimes privately, sometimes in a public place	<input type="checkbox"/> 3
Don't know	<input type="checkbox"/> 4

10. Do you have a **mobile phone**?

(Please tick only **one** box)

Yes, on a contract	<input type="checkbox"/> 1
Yes, on 'pay as you go'	<input type="checkbox"/> 2
Yes, don't know whether contract or 'pay as you go'	<input type="checkbox"/> 3
No, I don't have a mobile phone	<input type="checkbox"/> 4

If yes, please continue with Question 11. If no, please go to Question 12.

11. What do you **use** your **mobile phone** for?

(Please tick **one** box for each line)

	A lot	Sometimes	Never
Texting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Talking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Web browsing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Listening to music/radio	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Playing games	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Taking pictures	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sending emails	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Social networking (e.g. facebook, twitter, Bebo, BBM etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

12. Do you have a **television** in your **bedroom**?

(Please tick **one** box only)

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

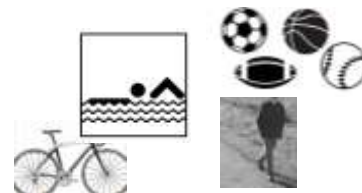
SPORTS AND PHYSICAL ACTIVITIES

13. In the **last week, during or outside school** time, **how many hours** did you spend on sports and physical activities **in total**? As well as sports and physical activities include walking, cycling, gardening, active housework and any activity vigorous enough to make you breathless.

(Please add up the **total number of hours for the week** and write it in the box)

ALL sports and physical activities

Total hours last week



14. Thinking in more detail about physical activity, in an **average week**, how many **days** do you spend doing at **least 60 minutes** of physical activity? e.g. fast walking, running, gymnastics, etc.?

(Please tick only **one** box)

None	<input type="checkbox"/>	0
1 day	<input type="checkbox"/>	1
2 days	<input type="checkbox"/>	2
3 days	<input type="checkbox"/>	3
4 days	<input type="checkbox"/>	4
5 days	<input type="checkbox"/>	5
6 days	<input type="checkbox"/>	6
7 days	<input type="checkbox"/>	7

15. If you do any activity, when do you do it?

(Please tick as **many as apply**)

PE lessons	<input type="checkbox"/>	1
After school clubs (e.g. football, netball)	<input type="checkbox"/>	2
Out of school clubs (e.g. trampolining, swimming)	<input type="checkbox"/>	3
Play out of school / recreation (e.g. gardening)	<input type="checkbox"/>	4
Just for transport (e.g. walking to school)	<input type="checkbox"/>	5

SAFETY

16. How **safe do you feel** when **outside** in the area near your home **during the daytime**? (by area we mean within a 15-20 minute walk or a 5-10 minute drive from your home)

(Please tick only **one** box)

Very safe	Fairly safe	A bit unsafe	Very unsafe	Don't know
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

17. How **safe do you feel** when **outside** in the area near your home **after dark**?

(Please tick only **one** box)

Very safe	Fairly safe	A bit unsafe	Very unsafe	Don't know
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

18. How **safe do you feel** at school?

(Please tick only **one** box)

Very safe	Fairly safe	A bit unsafe	Very unsafe	Don't know
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

19. How **safe do you feel** at home?

(Please tick only **one** box)

Very safe	Fairly safe	A bit unsafe	Very unsafe	Don't know
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

YOUR FEELINGS

20. How often do you **usually feel happy**?

(Please tick only **one** box)



All of the time	Most of the time	Some of the time	Not much of the time	Rarely or never
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

21. How often do you **usually feel sad**?

(Please tick only **one** box)



All of the time	Most of the time	Some of the time	Not much of the time	Rarely or never
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SCHOOL

22. How far do you agree with these statements?

(Please tick **one** box for each line)

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
My school is a place where...					
...adults at school listen to what I say	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
...the things I learn are important to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
...I really like to go each day	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
...I like learning	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

23. If you are currently in years 7 to 11, what do you **think you will do** after you have finished **year 11**?

(Please tick only **one** box)

- | | | |
|--|--------------------------|---|
| Go to work / get a full time job | <input type="checkbox"/> | 1 |
| Stay in education at college or 6 th form | <input type="checkbox"/> | 2 |
| Job training / apprenticeship | <input type="checkbox"/> | 3 |
| Other (please write in box) | <input type="checkbox"/> | 4 |
| Don't know | <input type="checkbox"/> | 5 |

If 'Other', please **write what**, in this box:

24. Have you **ever** been **bullied** at school?

(Please tick only **one** box)

Yes 1 No 2

If yes, please continue with Question 25. If no, please go to Question 27.

25. Have you been **bullied** in the **last month** at school?

(Please tick only **one** box)

Yes 1 No 2

26. **If you have ever been bullied**, what was the bullying?

(Please tick **one** box for each line)

	Yes, a lot	Yes, a bit	No
Called names, teased, etc	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Pushed, hit, kicked, slapped, etc	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ignored	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Your things or money taken or hidden	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Text messages / email	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lies or rumours spread about you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If there was **something else not on this list**, please **write in the box** below what it was:

27. Have you **ever** **bullied anyone** at school?

(Please tick only **one** box)

Yes 1 No 2

If yes, please continue with Question 28. If no, please go to Question 29.

28. Have you **bullied anyone** in the **last month** at school?

(Please tick only **one** box)

Yes 1 No 2

YOUR WORRIES

29. How much have you **worried** about the following in the **last month**?
(Please tick **one** box for each line)

	A great deal	Quite a lot	A bit but not much	Very little	Not at all
Homework	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
School tests or exams	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Money	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Your health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Getting a job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Boyfriend/girlfriend problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Problems with friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Being bullied	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Problems at home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The way you look	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Smoking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Drinking alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Illegal drugs being available	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Puberty and growing up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Losing weight	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

YOUR FAMILY

30. How many of these people **live in your home** with you (the home where you sleep most nights)?
(Please **write number in each row** and put in 0 for none)

Mother (or step-mother or carer)	Number	<input type="text"/>	Uncles or aunts	Number	<input type="text"/>
Father (or step-father or carer)		<input type="text"/>	Friends of the family		<input type="text"/>
Mother's boyfriend or partner		<input type="text"/>	Person renting room (lodger)		<input type="text"/>
Father's girlfriend or partner		<input type="text"/>	Other children (not brothers or sisters)		<input type="text"/>
Brothers or sisters (or step brothers or sisters)		<input type="text"/>	Other adults		<input type="text"/>
Grandparent or grandparents		<input type="text"/>	I live in a children's home (tick box)		<input type="checkbox"/>

99

31. Is your **mother (female carer)**:
 (Please tick only **one** box)

- | | | | | |
|-------------------------|---|--|--------------------------|---|
| Not in paid work at all | { | In full-time paid work/self-employed | <input type="checkbox"/> | 1 |
| | | In part-time paid work/self-employed | <input type="checkbox"/> | 2 |
| | | Working, but not sure if part or full time | <input type="checkbox"/> | 3 |
| | | At home looking after the family/home | <input type="checkbox"/> | 4 |
| | | Unemployed or looking for a job | <input type="checkbox"/> | 5 |
| | | Disabled or ill (cannot work) | <input type="checkbox"/> | 6 |
| | | A student | <input type="checkbox"/> | 7 |
| | | Don't have one at home | <input type="checkbox"/> | 8 |
| | | Don't know | <input type="checkbox"/> | 9 |

32. Is your **father (male carer)**:
 (Please tick only **one** box)

- | | | | | |
|-------------------------|---|--|--------------------------|---|
| Not in paid work at all | { | In full-time paid work/self-employed | <input type="checkbox"/> | 1 |
| | | In part-time paid work/self-employed | <input type="checkbox"/> | 2 |
| | | Working, but not sure if part or full time | <input type="checkbox"/> | 3 |
| | | At home looking after the family/home | <input type="checkbox"/> | 4 |
| | | Unemployed or looking for a job | <input type="checkbox"/> | 5 |
| | | Disabled or ill (cannot work) | <input type="checkbox"/> | 6 |
| | | A student | <input type="checkbox"/> | 7 |
| | | Don't have one at home | <input type="checkbox"/> | 8 |
| | | Don't know | <input type="checkbox"/> | 9 |

33. Thinking about caring, do you **help look after** any of these people?

(Please tick as **many as apply**)

- | | |
|-----------------------------------|--------------------------|
| No, no-one | <input type="checkbox"/> |
| Disabled or ill mother | <input type="checkbox"/> |
| Disabled or ill father | <input type="checkbox"/> |
| Disabled or ill brother or sister | <input type="checkbox"/> |
| Elderly grandparents | <input type="checkbox"/> |
| Someone else | <input type="checkbox"/> |

ETHNICITY AND LANGUAGE

34. To which of these **ethnic** groups do you belong?

(Please tick only **one** box)

- | | | |
|-----------------------------|--------------------------|---|
| White British or Irish | <input type="checkbox"/> | 1 |
| Eastern European | <input type="checkbox"/> | 2 |
| Other White | <input type="checkbox"/> | 3 |
| Mixed race / Dual Heritage | <input type="checkbox"/> | 4 |
| Asian or Asian British | <input type="checkbox"/> | 5 |
| Middle Eastern | <input type="checkbox"/> | 6 |
| Black or Black British | <input type="checkbox"/> | 7 |
| Chinese or Chinese British | <input type="checkbox"/> | 8 |
| Other (please write in box) | <input type="checkbox"/> | 9 |

If 'Other', please write which ethnic group you belong to, in this box:

35. **At home, is English your first language?**

(Please tick only **one** box)

Yes 1

No 2

If yes, please go to Question 37. If no, please continue with Question 36.

36. **If no, what language** does your family speak in the home?

(Please **write the language** in the box below)

YOU AND YOUR HEALTH

37. During the **last year** have **you used or visited** any of these as a patient?

(Please tick **one** box for each line)

	Yes	No
Family doctor (GP)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
An Accident and Emergency (A&E) Casualty department or Minor Injuries Unit	<input type="checkbox"/> 1	<input type="checkbox"/> 2
A hospital clinic (out-patient department including orthodontic clinic)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
A hospital as an 'inpatient' (where you stayed overnight)	<input type="checkbox"/> 1	<input type="checkbox"/> 2

38. When did you **last** visit your **dentist**?

(Please tick only **one** box)



During last 6 months	<input type="checkbox"/> 1
Between 7 and 12 months ago	<input type="checkbox"/> 2
Between 1 and 2 years ago	<input type="checkbox"/> 3
More than 2 years ago	<input type="checkbox"/> 4
Never	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 6

39. The **last time** you visited your **dentist, why did you go?** Was it because:

(Please tick only **one** box)

You went for a check-up	<input type="checkbox"/> 1
You were having trouble with your teeth or gums	<input type="checkbox"/> 2
You had a note from school	<input type="checkbox"/> 3
Other reason (please write in box)	<input type="checkbox"/> 4
You can't remember	<input type="checkbox"/> 5
You have never been to a dentist	<input type="checkbox"/> 6

If 'Other', please write what other reason, in this box:

40. **In general**, would you say your **health** is:

(Please tick only **one** box)

Excellent

 1

Very good

 2

Good

 3

Fair

 4

Poor

 5

41. Do you have any **illness or disability** which has **lasted** **more than a month**? Yes 1 No 2

(Please tick only **one** box)

If yes, please continue with Question 42. If no, please go to Question 43.

42. **If yes**, has this meant you have **not been able to do some things** you normally like doing, e.g. your hobbies or activities with your friends? Yes 1 No 2

(Please tick only **one** box)

YOUR DIET



43. **Generally speaking**, do you **think** you have a **healthy diet**?

(Please tick only **one** box)

Yes

 1

No

 2

Don't know what a healthy diet is

 3

Don't know if I have a healthy diet

 4

44. Do you **help make meals** or cook at **home**?

(Please tick only **one** box)

Yes, often

 1

Yes, sometimes

 2

Never or hardly ever

 3

45. **Will you be** or **are you** learning **cooking** at school as part of Food Technology or other lessons **during this school year**?

(Please tick only **one** box)

Yes 1

No 2

46. Are you **attending** an **after school cooking club**?

(Please tick only **one** box)

Yes 1

No 2

YOUR DIET - BREAKFAST

47. **How often** do you **eat** the following during a **usual** school week?

(Please tick **one** box for each line)

	Every day (5 days)	3 or 4 times a week	1 or 2 times a week	Less than once a week	Never
Breakfast before coming to school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Breakfast on way to school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Breakfast at school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

YOUR DIET – LUNCH AND SNACKS DURING THE DAY

48. **How often** do you **eat** the following during a **usual** school week?

(Please tick **one** box for each line)

	Every day (5 days)	3 or 4 times a week	1 or 2 times a week	Less than once a week	Never
School dinners	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
A 'packed lunch' from home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Lunch bought outside school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Lunch at home (go home for lunch)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

49. **Where** did you get **your lunch** and **snacks** mentioned above from?

(Please tick as **many as apply**)

I bought it from school	<input type="checkbox"/>
I brought it from home	<input type="checkbox"/>
I bought it outside school	<input type="checkbox"/>
I ate it at home (went home for lunch)	<input type="checkbox"/>

YOUR DIET – FRUIT AND VEGETABLES

50. **How many portions** or **pieces** of **fruit** did you eat **yesterday**?
(a portion is 1 banana, 1 apple, 1 pear, 2 plums, handful of grapes, etc. Do **not** include glasses of juice)

(Please **write the number** in the box)



51. **How many portions** of **vegetables** did you eat **yesterday (not potatoes)**? (a portion is about a handful or three medium-sized spoons of vegetables like peas, carrots or sweetcorn, or a medium-sized tomato)

(Please **write the number** in the box)



52. **How many glasses** of **real fruit juice** (e.g. Tropicana) did you drink **yesterday (not** squash or juice drinks)?

(Please **write the number** in the box)

53. Please list all the fruits, vegetables and glasses of fruit juice/smoothie that you had yesterday

.....

.....

.....

.....

.....

YOUR DIET – CHANGES TO DIET AND EXERCISE

54. **Would you like to...**
 (Please tick **one** box for each line)

	Very much	A bit	Not really	Don't know
...eat a healthier diet?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
...lose weight?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
...increase your weight?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
...play more sports/take more exercise?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
...be more active?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

ALCOHOL

55. Have you **ever** had a **whole alcoholic drink (including alcopops)**, i.e. **not** just a sip? Yes 1 No 2
 (Please tick only **one** box)

If yes, please continue with Question 56. If no, please go to Question 64.

56. How often do you **normally** have an **alcoholic drink**?
 (Please tick only **one** box)

Rarely	<input type="checkbox"/> 1	1-3 days a month	<input type="checkbox"/> 3	4-6 days a week	<input type="checkbox"/> 5
Less than once a month	<input type="checkbox"/> 2	1-3 days a week	<input type="checkbox"/> 4	Every day	<input type="checkbox"/> 6

57. During the **last 7 days**, on **how many days** did **you drink** some **alcohol**?
 (do not include cans of shandy)
 (Please tick only **one** box)

0 days	<input type="checkbox"/> 0	4 days	<input type="checkbox"/> 4
1 day	<input type="checkbox"/> 1	5 days	<input type="checkbox"/> 5
2 days	<input type="checkbox"/> 2	6 days	<input type="checkbox"/> 6
3 days	<input type="checkbox"/> 3	7 days	<input type="checkbox"/> 7

If "0 days", please go to Question 60. If you did drink in the last 7 days, please continue with Question 58.

58. If you have had any **alcoholic drinks** in the **last 7 days**, please **write how much** of these drinks you have had:

(Assume that one small can or bottle is half a pint (1/2), 1 standard or large can or bottle is 1 pint and one litre is 2 pints.)

(Please write in the number you have drunk in each box)

	Write in number	
Shandy (canned)	<input type="text"/>	pints
Shandy (mixed)	<input type="text"/>	pints
Ordinary beer or lager (e.g. John Smiths, Heineken, etc)	<input type="text"/>	pints
Strong beer or lager (e.g. Stella Artois, Tennant's Extra, etc)	<input type="text"/>	pints
Low alcohol beer or lager	<input type="text"/>	pints
Ordinary cider (e.g. Woodpecker, etc)	<input type="text"/>	pints
Strong cider (e.g. White lightning, Diamond White , etc)	<input type="text"/>	pints
Wine (including babycham, lambrini and champagne)	<input type="text"/>	pub glasses
Low alcohol wine	<input type="text"/>	glasses
Sherry, martini, cinzano, port, etc	<input type="text"/>	glasses
Spirits (e.g. gin, whisky, vodka, rum, brandy, Bacardi, etc)	<input type="text"/>	pub measures
Shots (e.g. Aftershock, Sidekick, etc)	<input type="text"/>	measures
Alcopops/pre-mixed spirits (e.g. Bacardi Breezer, Smirnoff Ice, WKD, etc)	<input type="text"/>	small bottles



If there is **any alcoholic drink you have drunk which is not listed above**, please **write it below** and the **amount drunk**:

59. Did **you drink alcohol** at any of these **places** during the **last 7 days**?

(Please tick one box for each line)

	Yes		No	
At home	<input type="checkbox"/>	1	<input type="checkbox"/>	2
At a friend's	<input type="checkbox"/>	1	<input type="checkbox"/>	2
At a club, party or disco	<input type="checkbox"/>	1	<input type="checkbox"/>	2
At a pub or bar	<input type="checkbox"/>	1	<input type="checkbox"/>	2
At a relation's home	<input type="checkbox"/>	1	<input type="checkbox"/>	2
In a restaurant	<input type="checkbox"/>	1	<input type="checkbox"/>	2
In a public place (e.g. street, park)	<input type="checkbox"/>	1	<input type="checkbox"/>	2
Somewhere else (write in box)	<input type="checkbox"/>	1	<input type="checkbox"/>	2

If somewhere else, please **write** in the box **where**:

60. How often do **you get drunk?**

(Please tick only **one** box)

I have never been drunk	<input type="checkbox"/>	1
I have only been drunk a few times	<input type="checkbox"/>	2
Less than once a month	<input type="checkbox"/>	3
About once a month	<input type="checkbox"/>	4
About once every two weeks	<input type="checkbox"/>	5
About once a week	<input type="checkbox"/>	6
More than once a week	<input type="checkbox"/>	7

61. **Where** do you get your **alcohol?**

(Please tick as **many as apply**)

I buy it in a supermarket	<input type="checkbox"/>	Sold to me by friends	<input type="checkbox"/>
I buy it in a corner shop	<input type="checkbox"/>	Sold to me by other people or students at school	<input type="checkbox"/>
I buy it in a garage shop	<input type="checkbox"/>	Given to me by parents or carers	<input type="checkbox"/>
I buy it in an off-licence	<input type="checkbox"/>	Given to me from brothers or sisters	<input type="checkbox"/>
I buy it from another type of shop	<input type="checkbox"/>	Given to me from other relatives or family	<input type="checkbox"/>
I buy it at a pub or club	<input type="checkbox"/>	Given to me from friends	<input type="checkbox"/>
Ask family members to buy it for me	<input type="checkbox"/>	Given to me from other people or students at school	<input type="checkbox"/>
Ask friends to buy it for me	<input type="checkbox"/>	Take from home	<input type="checkbox"/>
Ask strangers to buy it for me	<input type="checkbox"/>		

If you **get your alcohol from somewhere else**, please **write it** in the box below (please do not give people's names):

62. Have **any** of these **happened to you** after drinking **alcohol?**

(Please tick **one** box for **each line**)

	Never	In last 4 weeks	In last year
Got drunk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Got into an argument	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Got into a fight	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Attended casualty (A&E)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Missed school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Was sick/vomited	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Had unprotected sex	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tried smoking for the first time	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Tried illegal drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Had memory loss	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Passed out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Committed a crime	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Committed an act of vandalism or damaged property	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Arrested	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Caused others to complain to the police	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

63. Do you think that the **amount** of alcohol **you usually drink** could **damage your health?**

(Please tick only **one** box)

No	<input type="checkbox"/>	1
Possibly	<input type="checkbox"/>	2
Yes, it is likely	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	4

TOBACCO

64. Have you **smoked any cigarettes** during the **last 7 days?**

(Please tick only **one** box)

Yes No
1 2

If yes, please continue with Question 65. If no, please go to Question 66.



65. **If yes, how many** cigarettes have you smoked during the **last 7 days?**

(Please **write number** of cigarettes smoked in the box)

66. What statement **best describes you?**

(Please tick only **one** box)

I have never smoked at all, not even a drag	<input type="checkbox"/>	1
I have tried smoking once or twice	<input type="checkbox"/>	2
I used to smoke, but I don't now	<input type="checkbox"/>	3
I smoke occasionally	<input type="checkbox"/>	4
I smoke regularly	<input type="checkbox"/>	5

67. What statement **best describes you?**

(Please tick only **one** box)

I don't smoke now and I never will	<input type="checkbox"/>	1
I don't smoke now but I may when I am older	<input type="checkbox"/>	2
I smoke, but would like to give up	<input type="checkbox"/>	3
I smoke and don't want to give up	<input type="checkbox"/>	4

68. **If you have ever tried** a cigarette, how old were you when you smoked your **first cigarette?**

(Please **write age** you first tried a cigarette in box or **tick the other box** if never smoked)

Write in **your age** when you smoked your **first cigarette**

OR **tick** if never smoked

 99

69. **If you have ever smoked regularly**, how old were you when you **became a regular smoker?**

(*Write age when you became a regular smoker in box or tick the other box if never regularly smoked*)

Write in **your age** when you
became a regular smoker

OR **tick** if never
smoked regularly

 99

70. Do any people who **live in your house smoke** regularly (not you)?

(Please tick only **one** box)

No, no-one

 1

Yes, they smoke but not inside the house

 2

Yes, they smoke in the house

 3

71. **Where** do you get your **cigarettes?**

(Please tick as **many as apply**)

I do not smoke

Ask strangers to buy them for me

I buy them in a supermarket

Sold to me by friends

I buy them in a corner shop

Sold to me by other people or
students at school

I buy them in a garage shop

Given to me by parents or carers

I buy them in an off-licence

Given to me from brothers or sisters

I buy them from another type of shop

Given to me from other relatives or
family

I buy them from vending machines

Given to me from friends

Ask family members to buy them for
me

Given to me from other people or
students at school

Ask friends to buy them for me

Take from home

If you **get** your **cigarettes from somewhere else**, please **write it** in the box below
(please do not give people's names):

DRUGS

72. Has anyone **offered or encouraged you to try any drugs** in the **last three months**?

Yes ₁ No ₂

(Please tick only **one** box)

If yes, please continue with Question 73. If no, please go to Question 74.

73. **If yes, what drugs** were you offered or encouraged to use or try?

(Please tick as **many as apply**)



Anabolic steroids – for body building/strength (e.g. Deca)	<input type="checkbox"/>
Cannabis (e.g. grass, pot, marijuana, dope, blow, skunk, hash, puff, draw, ganja, spliff, joints, smoke, weed, Leb black, moroccan)	<input type="checkbox"/>
Cocaine (e.g. snow, coke, Charlie, C)	<input type="checkbox"/>
Ecstasy (E, MDMA, XTC, Mitsibishis/Mitzis, Rolexes, Doves, Beans, Rolls, X)	<input type="checkbox"/>
Heroin (e.g. H, junk, smack, skag, gear, Brown)	<input type="checkbox"/>
LSD (e.g. acid, tabs, trips, dots)	<input type="checkbox"/>
Semeron (Sem)	<input type="checkbox"/>
Solvents used as drugs (e.g. glue sniffing, glue, gas refills, cleansing fluid)	<input type="checkbox"/>
Legal highs (mephedrone, MCAT, plant food, Methoxetamine, MEX, Ivory Cove, etc.)	<input type="checkbox"/>
Other drug not listed above (please write in box)	<input type="checkbox"/>
Other legal high not listed above (please write in box)	<input type="checkbox"/>

If you were offered **other drugs not listed above**, please **write what it was** in the box below:

If you were offered **other legal highs not listed above**, please **write what it was** in the box below:

74. Have you **ever used or tried any drugs** (not medicines like paracetamol or aspirin)?

Yes ₁ No ₂

(Please tick only **one** box)

If yes, please continue with Question 75. If no, please go to Question 76.

75. **If yes**, please say **when you have used** any of the **drugs** listed below.

(Please tick **one** box for each line)

	In last 4 weeks	In last year	More than a year ago
Anabolic steroids – for body building/strength (e.g. Deca)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cannabis (e.g. grass, pot, marijuana, dope, blow, skunk, hash, puff, draw, ganja, spliff, joints, smoke, weed, Leb black, moroccan)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cocaine (e.g. snow, coke, Charlie, C)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Ecstasy (E, MDMA, XTC, Mitsibishis/Mitzis, Rolexes, Doves, Beans, Rolls, X)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Heroin (e.g. H, junk, smack, skag, gear, Brown)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LSD (e.g. acid, tabs, trips, dots)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Semeron (Sem)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Solvents used as drugs (e.g. glue sniffing, glue, gas refills, cleansing fluid)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Legal highs (mephedrone, MCAT, plant food, Methoxetamine, MEX, Ivory Cove, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other drug not listed above (please write in box)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If you used or tried **other drugs not listed above**, please **write** in the box below **what** it was:

If you used or tried **other legal highs not listed above**, please **write** in the box below **what** it was:

76. **Where** would you go, or **who** would you ask, for **help or advice** about any **drug** (including alcohol and tobacco)?

(Please tick as **many as apply**)

My parents / carers	<input type="checkbox"/>	Internet	<input type="checkbox"/>
School teacher	<input type="checkbox"/>	Chat rooms	<input type="checkbox"/>
Friends	<input type="checkbox"/>	Magazines/newspapers	<input type="checkbox"/>
Brothers, sisters, other close relations	<input type="checkbox"/>	Leaflets	<input type="checkbox"/>
Family Doctor (GP)	<input type="checkbox"/>	Connexions	<input type="checkbox"/>
School nurse	<input type="checkbox"/>	NHS Direct	<input type="checkbox"/>
Health Trainers	<input type="checkbox"/>	NHS Choices	<input type="checkbox"/>
Refresh	<input type="checkbox"/>	Drinkline	<input type="checkbox"/>
FRANK / talk to Frank Campaign	<input type="checkbox"/>	Childline	<input type="checkbox"/>
Youth worker	<input type="checkbox"/>	r u thinking	<input type="checkbox"/>
Radio	<input type="checkbox"/>	Warren	<input type="checkbox"/>
TV	<input type="checkbox"/>	Drinkaware	<input type="checkbox"/>
National Treatment Agency	<input type="checkbox"/>	Books	<input type="checkbox"/>
Someone else / somewhere else	<input type="checkbox"/>	Don't know	<input type="checkbox"/>

If there is **someone else you would ask** or **somewhere else you would look**, please **write it** in box (please do not give people's names):

SEXUAL HEALTH

77. If you wanted some **help and advice** about **sexual health who would you ask or where would you look?**

(Please tick **one** box for each line)

	Yes	No	Not sure
My parents / carers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
School teacher	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Brothers, sisters, other close relations	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Family Doctor (GP)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
School nurse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Health Trainers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Family Planning Clinic / Conifer House	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Youth worker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Radio	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
TV	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Books	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Chat rooms	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Magazines/newspapers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Leaflets	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Connexions	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
NHS Direct	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
NHS Choices	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Childline	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sexwise	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
r u thinking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Warren	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Cornerhouse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Johnny Woman	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Do not know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Do not want any advice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If there is **someone else you would ask** or **somewhere else you would look**, please **write it** in box (please do not give people's names):

78. Have you **ever heard of** any of these **sexually transmitted infections?**

(Please tick **one** box for each line)

	Yes	No	Don't know
Gonorrhoea	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Syphilis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Chlamydia	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Genital Herpes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HIV/AIDS	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If "yes" to ANY of Question 78, please continue with Question 79.

If "no" or "don't know" to ALL of Question 78, please go to Question 80.

Your name will not be recorded on this form. No-one will know the answers you give.

79. If **yes**, where did you get to hear about them?

(Please tick as **many as apply**)

My parents / carers	<input type="checkbox"/>	Chat rooms	<input type="checkbox"/>
School teacher	<input type="checkbox"/>	Magazines/newspapers	<input type="checkbox"/>
Friends	<input type="checkbox"/>	Leaflets	<input type="checkbox"/>
Brothers, sisters, other close relations	<input type="checkbox"/>	Connexions	<input type="checkbox"/>
Family Doctor (GP)	<input type="checkbox"/>	NHS Direct	<input type="checkbox"/>
School nurse	<input type="checkbox"/>	NHS Choices	<input type="checkbox"/>
Family Planning Clinic / Conifer House	<input type="checkbox"/>	Childline	<input type="checkbox"/>
Health Trainers	<input type="checkbox"/>	Sexwise	<input type="checkbox"/>
Youth worker	<input type="checkbox"/>	r u thinking	<input type="checkbox"/>
Radio	<input type="checkbox"/>	Warren	<input type="checkbox"/>
TV	<input type="checkbox"/>	Cornerhouse	<input type="checkbox"/>
Books	<input type="checkbox"/>	Johnny Woman	<input type="checkbox"/>
Internet	<input type="checkbox"/>	Don't know or remember	<input type="checkbox"/>

If it was from **someone else or somewhere else**, please **write it** in box (please do not give people's names):

80 What do you think is the **best way** to get **information** about contraception or sexual health?

(Please tick as **many as apply**)

Written information only (a leaflet or similar)	<input type="checkbox"/>
Written information (website)	<input type="checkbox"/>
Talking to a health professional (school nurse, etc)	<input type="checkbox"/>
Talking to a parent/carer, other relation or close friend	<input type="checkbox"/>
Talking to a teacher or youth worker	<input type="checkbox"/>
Talking to someone and having written information to take away	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

81. **Where would you go** if you needed **contraception**?

(Please tick as **many as apply**)

Conifer House or Family Planning	<input type="checkbox"/>
Family Doctor (GP)	<input type="checkbox"/>
School nurse	<input type="checkbox"/>
Pharmacy/chemist	<input type="checkbox"/>
Warren	<input type="checkbox"/>
Cornerhouse	<input type="checkbox"/>
Johnny Woman	<input type="checkbox"/>
Vending machines in public toilets	<input type="checkbox"/>
From someone/somewhere else	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If from **someone else or somewhere else**, please **write it** in box (please do not give people's names):

ANYTHING ELSE?

82. Is there **anything else you would like to add** to your answers you have already given?

(Please write in the box)

**THANK-YOU VERY MUCH FOR FILLING IN
THIS QUESTIONNAIRE**

A small number of questions used in this survey originally came from the School Health Education Unit in Exeter. Permission was kindly given to use these questions in the 1996 local Children's and Young People's survey, and extended to this questionnaire.