

Northumberland Secondary School

HEALTH and LIFESTYLE SURVEY 2015

THE HEALTH-RELATED BEHAVIOUR QUESTIONNAIRE

The purpose of this questionnaire is to gain information that will help us as a school to provide a programme of education that is right for you. The information will also help people in public health in planning care for young people.

These questionnaires are confidential and will not be read by anyone connected with your school. All the completed questionnaires will be sent to Exeter for analysis and then the questionnaires will be destroyed.

The questionnaire is not a test and you can **ask for help** whenever you need it.

Also, if there are any questions you do not want to answer **you may leave out any question**.

1) Please answer all questions honestly.

Please do NOT write in any shaded boxes

2) Do NOT write your name on any page

Answer these questions in the box first

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▼ 4

Here are three statements about this survey

Please tick one answer on each row

	No	Yes
A I understand why we have been asked to do this survey	0 <input type="checkbox"/>	1 <input type="checkbox"/>
B I agree to take part in the survey	0 <input type="checkbox"/>	1 <input type="checkbox"/>
C I can leave out any question if I don't want to answer it	0 <input type="checkbox"/>	1 <input type="checkbox"/>
D Are you male or female?		
<i>Please tick one answer</i>		
Male	0 <input type="checkbox"/>	<input checked="" type="checkbox"/>
Female	1 <input type="checkbox"/>	<input type="checkbox"/>
E Which school year are you in?		
<i>Please tick one answer</i>		
Year 7	07 <input type="checkbox"/>	<input checked="" type="checkbox"/>
Year 8	08 <input type="checkbox"/>	<input type="checkbox"/>
Year 9	09 <input type="checkbox"/>	<input type="checkbox"/>
Year 10	10 <input type="checkbox"/>	<input type="checkbox"/>
Year 11	11 <input type="checkbox"/>	<input type="checkbox"/>

F What is your home postcode?

Please write on this dotted line

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1 Which of the following best describes your ethnic background?

Please tick one answer ✓

White

- White British 01
- White Irish 02
- White Romany or Gypsy 03
- White traveller of Irish heritage 04
- Any other White background * 05

Asian

- Bangladeshi Asian 06
- British Asian 07
- Indian Asian 08
- Pakistani Asian 09
- Any other Asian background * 10

Black

- Black African 11
- Black British 12
- Black Caribbean 13
- Any other Black background * 14

Chinese

- British Chinese 15
- Chinese 16
- Any other Chinese background * 17

Mixed

- Mixed White & Asian 18
- Mixed White & Black African 19
- Mixed White & Black Caribbean 20
- Any other mixed background * 21

Other

- Any other background * 22
- Prefer not to say 23

*please describe in box

2 Which adults do you live with?

Please tick one answer ✓

- Mum & dad together 01
- Foster parents 08
- Mainly or only mum 02
- Mainly or only dad 03
- Mum & dad shared 04
- Mum & stepdad/partner 05

- Dad & stepmum/partner 06
- Mum & mum or dad & dad 07
- Residential Worker 09
- Grandparent 10
- Other carer (please describe below) 11

3 a) Are you a practising member of a religion?

(i.e. do you attend a place of worship or worship at home)

Please tick one answer

- No 0
- Not sure 1
- Yes 2

b) If yes, which of the following most nearly describes you?

Please tick one answer ✓

- Christian (Protestant, Roman Catholic, etc.) 0
- Muslim 1
- Hindu 2
- Buddhist 3
- Sikh 4

- Jewish 5
- Bah'ai 6
- Rastafarian 7
- Other (Please describe below) 8

		No	Not sure	Yes	Don't want to say
<i>Please tick one answer on each row</i>					
4	Is someone helping you fill in this questionnaire?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5	Are you disabled?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6	Do you have a long-standing illness?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7	Do you have a special educational need or a learning difficulty?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

If you answered YES to any of the last three questions:



8 Are your additional needs properly looked after in school?

<i>Please tick one answer</i>		✓
No	0	<input type="checkbox"/>
Not sure	1	<input type="checkbox"/>
Yes	2	<input type="checkbox"/>
I don't have any needs like that	3	<input type="checkbox"/>

9 a) Are you a 'young carer'?

Young carers are children and young people under 18 who provide (or intend to provide) care, assistance or support to another family member who is disabled, physically or mentally ill, or has a substance misuse problem.

<i>Please tick one answer</i>		✓
No	0	<input type="checkbox"/>
Not sure	1	<input type="checkbox"/>
Yes	2	<input type="checkbox"/>
Don't want to say	3	<input type="checkbox"/>

b) If you are a 'young carer', who do you look after?

e.g. mum, dad, grandma, brother or sister



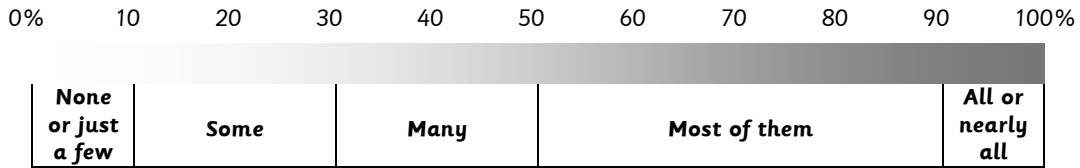
c) If you are a 'young carer', how much of your time does it take up each day?

<i>Please tick one answer</i>		✓
Less than 1 hour	0	<input type="checkbox"/>
1-2 hours	1	<input type="checkbox"/>
More than 2 hours	2	<input type="checkbox"/>
Some time, but I don't do this every day	3	<input type="checkbox"/>

10 In the last 6 years have you ever had free school meals, or vouchers for free meals?

<i>Please tick one answer</i>		✓
No	0	<input type="checkbox"/>
Yes, I have them now	1	<input type="checkbox"/>
Not now, but I have had them in the past 6 years	2	<input type="checkbox"/>
No, but I could have had them if I wanted	3	<input type="checkbox"/>
Don't know	4	<input type="checkbox"/>
Don't want to say	5	<input type="checkbox"/>

We'd like to ask you some questions about what you think other young people your age are doing. We want to ask you what proportion of them do you think have done various things. You might refer to this guide:



11 How many of people of your age, do you believe...?

<i>Please tick one answer on each row</i>	None or just a few	Some	Many	Most of them	All or nearly all
...drank alcohol in the last 7 days?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
...have been drunk at least once in the last 7 days?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
...have smoked a cigarette in the last 7 days?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
...have taken cannabis in the last 7 days?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

These questions are about BEING HEALTHY.

12 In general, how happy do you feel with your life at the moment?

<i>Please tick one answer</i>	✓
Not at all	0 <input type="checkbox"/>
Not much	1 <input type="checkbox"/>
Not sure	2 <input type="checkbox"/>
Quite a lot	3 <input type="checkbox"/>
A lot	4 <input type="checkbox"/>

13 How much do you agree or disagree with these statements?

<i>Please tick one answer on each row</i>	Disagree	Not sure	Agree
"I am in charge of my health."	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
"If I keep healthy, I've just been lucky."	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
"If I take care of myself I'll stay healthy."	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
"Even if I look after myself I can still easily fall ill."	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

14 Which statement describes you best?

<i>Please tick one answer</i>	✓
I would like to put on weight	0 <input type="checkbox"/>
I would like to lose weight	1 <input type="checkbox"/>
I am happy with my weight as it is	2 <input type="checkbox"/>

★ 1

15 What are the main things that affect the way you feel about your appearance?

Please tick up to THREE things ✓✓

Just me	<input type="checkbox"/>
Comments/attitudes of parents	<input type="checkbox"/>
Comments/attitudes of other family members	<input type="checkbox"/>
Comments/attitudes of friends	<input type="checkbox"/>
Comments/attitudes of other people at school	<input type="checkbox"/>
Seeing images of people...	
... on TV and films	<input type="checkbox"/>
... in features about fashion	<input type="checkbox"/>
... in general magazine features	<input type="checkbox"/>
... involved in sport/music/dance	<input type="checkbox"/>
None of the above	<input type="checkbox"/>

16 When choosing what to eat, do you consider your health?

Please tick one answer ✓

Never	0 <input type="checkbox"/>
Sometimes	1 <input type="checkbox"/>
Quite often	2 <input type="checkbox"/>
Very often	3 <input type="checkbox"/>
Always	4 <input type="checkbox"/>

17 What did you do for lunch yesterday?

Please tick one answer ✓

School food	0 <input type="checkbox"/>
Ate a packed lunch from home	1 <input type="checkbox"/>
Bought lunch from a takeaway or shop	2 <input type="checkbox"/>
Went home for lunch	3 <input type="checkbox"/>
Did not have any lunch	4 <input type="checkbox"/>

18 What did you have before lessons this morning?

Please tick all that apply ✓✓

Nothing to eat or drink	<input type="checkbox"/>	Breakfast bars	<input type="checkbox"/>
Energy drink (e.g. Red Bull, Lucozade energy etc.)	<input type="checkbox"/>	Crisp-type snack	<input type="checkbox"/>
Other drink	<input type="checkbox"/>	Chocolate bar, sweets	<input type="checkbox"/>
Toast or bread	<input type="checkbox"/>	Biscuits/cakes	<input type="checkbox"/>
Sugar-coated cereals	<input type="checkbox"/>	Fruit	<input type="checkbox"/>
Porridge/Readybrek	<input type="checkbox"/>	Cooked breakfast	<input type="checkbox"/>
Other cereals	<input type="checkbox"/>	Something else (Please describe below)	<input type="checkbox"/>
Yoghurt	<input type="checkbox"/>		

19 How often do you eat or drink the following?

	Rarely or never	Once a week or less	2-3 days a week	On most days
<i>Please tick one answer on each row</i>				
Any fish/fish fingers	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Fresh fruit	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Salads	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Vegetables	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Water	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Milk	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
'Diet' (low calorie) drinks	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other fizzy drinks	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Energy drinks (e.g. Red Bull, Lucozade energy etc.)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Crisps	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sweets, chocolate, choc bars	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

20 How many portions* of fruit and vegetables did you eat yesterday?

Please circle ONE answer. If more than 8, circle 8.

0 1 2 3 4 5 6 7 8

*** A portion is about a handful.**

To help you decide, all of these examples count as ONE portion:

ONE portion = 80g = any of these...

1 apple, banana, pear, orange or other similar sized fruit

3 heaped tablespoons of vegetables (raw, cooked, frozen or tinned)

1 cupful of grapes, cherries or berries

a glass (150ml) of fruit juice (however much you drink, fruit juice counts as one portion a day)

a dessert bowl of salad

N.B. Potatoes don't count when thinking about 5-a-day

21 How much water did you drink yesterday?

Only count plain water, do not count tea, coffee, squash-type drinks or fizzy drinks.

Please tick one answer

✓

Nothing 0

1 or 2 cups 1

3-5 cups 2

About a litre (6 cups) 3

About 2 litres (12 cups) 4

More than 2 litres 5

22 Are you able to get water at school?

Please tick one answer

✓

No 0

Not easily 1

Yes 2

★2

These questions are about ALCOHOL, SMOKING AND DRUGS

23 Have you had an alcoholic drink in the last 7 days?

Please tick one answer

- No 0
- Yes 1



If you ticked 'No', go to Q27 on page 8 →

24 Have you been drunk in the last 7 days?

Please tick one answer

- No 0
- Yes 1



25 During the last 7 days, how much of the following alcoholic drinks did you drink, if any?

Assume that one small can = half a large can
Please don't count canned/mixed shandy

Please write in these boxes

Do not write in these boxes

Large cans/pints of beer or lager:

Large cans/pints of cider:

Cans/bottles of pre-mixed drinks (e.g. WKD, Reef)

Glasses of wine (a bottle is about 4+ glasses)

Shooters/shots/jelly (number of shots etc.)

Glasses of Baileys, Tia Maria, Martini, Cinzano, Sherry etc.

Measures of spirits (e.g. gin, whisky, vodka, rum, etc.)

Something else (please describe below)

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26 Have YOU obtained alcoholic drink in any of these ways during the last 7 days?

Do not include canned shandy

Please tick all that apply



I bought alcohol myself from a pub/nightclub

I bought alcohol myself from an off-licence

I bought alcohol myself from a supermarket

Parents/carers bought it for me/gave it to me

I took it from my parents/carers without their consent

Friends/family over 18 bought it for me/gave it to me

Friends/family under 18 bought it for me/gave it to me

I got adults outside shops to buy it for me

Other source (please describe below)

27 If you ever drink alcohol, do your parents/carers know?

- Please tick one answer ✓
- I never drink alcohol 0
 - My parents/carers always know 1
 - My parents/carers usually know 2
 - My parents/carers sometimes know 3
 - My parents/carers never know 4

28 a) Is there a special drug and alcohol service for young people in your area?

- Please tick one answer ✓
- No 0
 - Don't know 1
 - Yes 2

b) If yes, please write what it is (name):

29 Which statement describes you best?

Please tick one answer and follow the instructions

- I have never smoked at all, not even a puff 0
 - I have tried smoking once or twice 1
 - I used to smoke, but I don't now 2
 - I smoke occasionally (less than 1 cigarette a week) 3
 - I smoke regularly but would like to give it up 4
 - I smoke regularly and don't want to give it up 5
- Skip to Q33

Go on to the next question →

30 How many cigarettes have you smoked during the last 7 days?

Please write the number

(If NONE, write 0)

31 If you have smoked recently, where did you get/buy your last cigarettes from?

Please tick one answer ✓

- | | |
|---|--|
| I bought them <u>myself</u> ... | From brothers/sisters/friends over 18 07 <input type="checkbox"/> |
| ...from a supermarket 01 <input type="checkbox"/> | From brothers/sisters/friends under 18 08 <input type="checkbox"/> |
| ...from a newsagent 02 <input type="checkbox"/> | I was given them 09 <input type="checkbox"/> |
| ...from a vending machine 03 <input type="checkbox"/> | I stole them 10 <input type="checkbox"/> |
| ...from an off-licence 04 <input type="checkbox"/> | They were brought back from abroad ('duty-free') 11 <input type="checkbox"/> |
| ...from a pub or bar 05 <input type="checkbox"/> | Other sources (please describe below) 12 <input type="checkbox"/> |
| ...from a street seller/neighbour/private house/van 06 <input type="checkbox"/> | |

32 Have you ever bought ...?

Please tick all that apply ✓✓

- Cigarettes with health warnings in a different language

- Fake cigarettes (e.g. counterfeit - in packaging that looks like well-known brands)

- Single cigarettes (not in packets)

- Cigarettes from other sellers (i.e. from market stalls, neighbours, car boot etc.)

- None of these

→ *Please tick one answer on each row* **No** **Yes**

- 33 a) Do your parents/carers smoke?** 0 1
-
- b) Does anyone smoke indoors at home in rooms that you use?** 0 1
-
- c) Does anyone smoke in a car when you are in it too?** 0 1
-
- 34 a) Do your parents/carers smoke e-cigarettes (electronic)?** 0 1
-
- b) Have you ever tried e-cigarettes (electronic)?** 0 1

35 Thinking about smoking at home, what best describes what happens in your home?

- Please tick one answer* ✓
- No-one ever smokes at home 0

 - Smoking happens outside only 1

 - Smoking happens on the doorstep only 2

 - Smoking happens in certain rooms only 3

 - Smokers can smoke anywhere 4

36 Do you know anyone personally who you think takes any drugs to get high? (not medicines, tobacco or alcohol)

- Please tick one answer* ✓
- No 0

 - Not sure 1

 - Fairly sure 2

 - Certain 3

37 Have you ever been offered cannabis?

- Please tick one answer* ✓
- No 0

 - Yes 1

38 a) Have you ever been offered other illegal drugs or new psychoactive substances? (these are sometimes called legal highs)?

- Please tick one answer* ✓
- No 0

 - Yes 1

b) If yes, please write what it is (name):

★ 3

39 Have you taken any drugs to get high?

(not medicines, tobacco or alcohol)

Please tick one answer

No ✓ 0

Not sure 1

If you ticked 'No', go to Q42 on page 11 →

40 This question is about your EXPERIENCE of these drugs (not prescribed to you by a doctor)

Please tick one answer on each row

	I have never taken this drug	I have taken during the last month	I have taken during the last year	I took this drug more than one year ago
Amphetamines (e.g. speed, sulphates, sulph, whizz, uppers)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cannabis (resin, leaf or oil, e.g. hash, grass, pot, skunk, dope, weed)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Khat (e.g. Quat, qat, qaadka, chat, ghat)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Ecstasy (e.g. MDMA, E, Doves)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cocaine (e.g. snow, charlie, coke, nose)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Crack (e.g. rock)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hallucinogens: natural (e.g. magic mushrooms)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hallucinogens: synthetic (e.g. acid, LSD)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Heroin (e.g. H, junk, skag, smack, brown)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Ketamine (e.g. Special K, Vitamin K)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other Tranquillisers (e.g. Valium, Temazepam, Prozac)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Muscle-building steroids	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Poppers (e.g. Liquid Gold, Rush, TNT)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Solvents used as drugs (e.g. glue, gas refills, aerosols, cleaning fluid)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Mephedrone (M-cat, Miaow miaow)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other drugs*	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
New psychoactive substances* (sometimes called Legal Highs)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

*Please describe below:

▼ 19

41 Have you EVER taken drugs listed in Q40 and alcohol on the same occasion?

Please tick one answer

No ✓ 0

Don't know 1

Yes 2

42 How much do you worry about the issues listed below?

<i>Please tick one answer on each row</i>	Hardly		Quite a		
	Never	ever	A little	lot	A lot
School-work problems	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Exams and tests	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Bullying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Your physical health	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Your mental health	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Mental health of someone in your family	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Problems with friends	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Family problems	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Money problems/family finances	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
The way you look	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Relationships	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Sexually transmitted infections	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Becoming a parent before I'm ready	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Drugs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
The environment	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Wars and terrorism	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Crime	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Gambling	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
The future	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other (please tick, then describe below)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

43 If you were worried about something, do you know an adult you trust that you can talk to about it? e.g someone at home, someone at school, health professional, adult friend

Please tick one answer

No	0 <input type="checkbox"/>
Maybe	1 <input type="checkbox"/>
Yes	2 <input type="checkbox"/>

44 a) Can you remember learning about Sexually transmitted infections in or out of school?

Please tick all that apply

Never learned about it anywhere	<input type="checkbox"/>
Learned about it from school lessons	<input type="checkbox"/>
Learned about it from parents/ carers	<input type="checkbox"/>
Learned about it from friends	<input type="checkbox"/>
Learned about it from Internet or magazines	<input type="checkbox"/>
Other (please write below)	<input type="checkbox"/>

b) Can you remember learning about contraception in or out of school?

Please tick all that apply

✓✓

- Never learned about it anywhere
- Learned about it from school lessons
- Learned about it from parents/ carers
- Learned about it from friends
- Learned about it from Internet or magazines
- Other (please write below)

45 a) Do you know where you can get condoms free of charge?

Please tick one answer

✓

- No 0
- Yes 1

b) If yes, please write where:

46 a) Is there a special sexual health service for young people in your area?

Please tick one answer

✓

- No 0
- Don't know 1
- Yes 2

b) If yes, please write where:

47 Where do you think young people would like to get condoms or emergency contraception from if they needed it?

Please tick all that apply

✓✓

- GP
- Chemist
- School nurse
- Youth Centres
- Young people's sexual health clinic
- College sites
- Health Centres
- Walk-in Centres
- Other (please write below)

THE NEXT TWO QUESTIONS ARE FOR YEAR 10 ONLY

YEAR 8 PUPILS PLEASE GO TO Q50 below →

48 At what age do you think most young people start having sex?

Please tick one answer

14 or younger 15 16 17 18 19 or older

49 Nationally, we know that most under 16s have not had sex (28% of under 16s report having sex). Which of the following best describes you?

Please tick one answer

Not had a sexual relationship 0
 Currently in a relationship and thinking about having sex 1
 Had a sexual relationship in the past 2
 Currently in a sexual relationship 3



50 How long ago did you last visit the doctor?

Please tick one answer ✓

In the past week <input type="checkbox"/> 0 <input type="checkbox"/>	In the past 6 months <input type="checkbox"/> 3 <input type="checkbox"/>
In the past month <input type="checkbox"/> 1 <input type="checkbox"/>	In the past year <input type="checkbox"/> 4 <input type="checkbox"/>
In the past 3 months <input type="checkbox"/> 2 <input type="checkbox"/>	More than a year ago <input type="checkbox"/> 5 <input type="checkbox"/>

51 On this last visit to the doctor, how did the reception and waiting room environment make you feel?

Please tick one answer

Very uneasy 0 ✓
 Quite uneasy 1
 OK 2
 At ease 3

52 Do you know who your school nurse is?

Please tick one answer

No 0 ✓
 Not sure 1
 Yes 2
 Don't have one 3

53 Do you know how to get to see you school nurse?

Please tick one answer

No 0 ✓
 Not sure 1
 Yes 2
 Don't have one 3

54 How long ago did you last visit the dentist?

Please tick one answer ✓

In the past week <input type="checkbox"/> 0 <input type="checkbox"/>	In the past year <input type="checkbox"/> 3 <input type="checkbox"/>
In the past 3 months <input type="checkbox"/> 1 <input type="checkbox"/>	More than a year ago <input type="checkbox"/> 4 <input type="checkbox"/>
In the past 6 months <input type="checkbox"/> 2 <input type="checkbox"/>	I have never been to the dentist <input type="checkbox"/> 5 <input type="checkbox"/>

These questions are about STAYING SAFE.

55 Do you ever feel afraid of going to school because of bullying?

- Please tick one answer* ✓
- Never 0
 - Sometimes 1
 - Often 2
 - Very often 3

56 Have you been bullied at or near school in the last 12 months?

- Please tick one answer* ✓
- No 0
 - Don't know 1
 - Yes 2

57 Have you bullied someone else at school in the last 12 months?

- Please tick one answer* ✓
- No 0
 - Don't know 1
 - Yes 2

58 How well does your school deal with bullying?

- Please tick one answer* ✓
- Don't know 0
 - Bullying is not a problem in my school 1
 - Badly 2
 - Not very well 3
 - Quite well 4
 - Very well 5

59 Have any of the following happened to you in the last month

- Please tick all that apply* ✓✓
- Been teased/made fun of
 - Called nasty names
 - Received nasty/threatening text message
 - Received nasty/threatening e-mail
 - Received nasty/threatening message in a chatroom
 - Seen nasty things written about you online
 - Pushed/hit for no reason
 - Had belongings taken/broken
 - Been threatened for no reason
 - Been threatened for money
 - Been forced to do things you didn't want to do
 - Been ganged up on
 - Other (please write in the box below)
 - None of these

If you ticked 'None of these' in Q59 please go on to Question 63 →

60 Where did they happen?

- Please tick all that apply* ✓✓
- At or near home

 - On the way to or from school

 - During lesson time

 - In a classroom (playtime/lunchtime)

 - In the toilets

 - In the corridors

 - Outside at school (playtime/lunchtime)

 - Other (please write below)

61 If you have been bullied recently, did you tell anyone about it?

- Please tick all that apply* ✓✓
- Teacher or other staff at school

 - Friend

 - Mum or Dad/carer

 - Other trusted adult

 - Brother or sister

 - No one

62 . . . and did the problem stop after telling someone?

- Please tick one answer* ✓
- No 0

 - Don't know 1

 - Yes 2



63 Do you think you have ever been picked on or bullied for any of the following?

- Please tick all that apply* ✓✓
- Your size or weight

 - The way you look

 - The clothes you wear

 - Your colour or race

 - Your religion or faith

 - Your sexuality (straight, gay, lesbian or bisexual)

 - Your gender (being male or female)

 - A disability or learning difficulty

 - Your ability (being better or worse at lessons than most people)

 - Your family background

 - Your health

 - Other (please write in the box below)

 - I have never been picked on or bullied

64 When a friend wants me to do something I don't want to do...

Please tick one answer ✓

I can usually or always say no	0	<input type="checkbox"/>
I can sometimes say no	1	<input type="checkbox"/>
I can rarely say no	2	<input type="checkbox"/>
I can never say no	3	<input type="checkbox"/>

65 How do you rate the following in the area where you live?

Please tick one answer on each row

	Very poor	Poor	Adequate	Good	Very good
Your safety when going out after dark	0	1	2	3	4
Your safety when going out during the day	0	1	2	3	4
Your safety at school	0	1	2	3	4
Your safety when going to and from school	0	1	2	3	4

66 Do you try anything to avoid sunburn?

e.g. Wear a hat, Wear long sleeves, put on sun screen, stay in the shade

Please tick one answer ✓

Never	0	<input type="checkbox"/>
Sometimes	1	<input type="checkbox"/>
Usually	2	<input type="checkbox"/>
Whenever possible	3	<input type="checkbox"/>

★ 6

These questions are about SCHOOL and LEISURE TIME.

67 How many lessons do you enjoy at school?

Please tick one answer ✓

All of them	0	<input type="checkbox"/>
Most of them	1	<input type="checkbox"/>
About half of them	2	<input type="checkbox"/>
Less than half of them	3	<input type="checkbox"/>
Hardly any of them	4	<input type="checkbox"/>

68 How useful have you found school lessons about the following?

	Can't remember any	Not at all useful	Some use	Quite useful	Very useful
<i>Please tick one answer on each row</i>					
Managing money	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Citizenship	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Drug education (including alcohol & tobacco)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Emotional health and well-being	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Bullying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Healthy eating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Physical activity	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Safety	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Sex and Relationships education	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

69 Do you think it is important to go to school regularly?

Please tick one answer ✓

No	0	<input type="checkbox"/>
Don't know	1	<input type="checkbox"/>
Yes	2	<input type="checkbox"/>

70 In the last 12 months, have any of the following stopped you from going to school?

<i>Please tick all that apply</i> ✓✓			✓✓
Illness or injury	<input type="checkbox"/>	Worries about school	<input type="checkbox"/>
Caring for family members	<input type="checkbox"/>	Worries about bullying	<input type="checkbox"/>
Medical/dental appointments	<input type="checkbox"/>	Effects of my social life	<input type="checkbox"/>
Day trips or holiday in term time	<input type="checkbox"/>	Other (please write in the box below)	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	I haven't missed any days	<input type="checkbox"/>

Please tick one answer on each row

	No	Yes
71 a) Have you ever chatted online?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
If Yes:		
Do you use a webcam to chat online, e.g. Skype?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Do you chat to just your friends or family?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Do you chat to friends of friends?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Do you chat to other people who you don't know?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b) Have you ever got a message or picture that scared you or made you upset?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
c) Have any of these things ever happened to you online?		
Received a hurtful, unwanted or nasty message online	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Hurtful comments were posted about you on a social networking site	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Someone used your identity/password to post false or hurtful things online	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Someone changed your password	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Someone posted private information about you (including pictures)	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Someone used/changed a picture to humiliate you	0 <input type="checkbox"/>	1 <input type="checkbox"/>
An offensive video clip was taken or posted about you	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Someone voted for you in an insulting online poll	0 <input type="checkbox"/>	1 <input type="checkbox"/>
A nasty webpage was set up about you	0 <input type="checkbox"/>	1 <input type="checkbox"/>
Other (please describe below)	0 <input type="checkbox"/>	1 <input type="checkbox"/>



▼ 39

Please tick one answer on each row

	No	Yes
d) Has anyone you don't know in person asked to meet with you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
If YES, was this person (as far as you know) quite a bit older than you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
e) Have you ever been told how to stay safe while online?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
If YES, do you always follow the advice you have been given?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
f) Have you ever sent personal information or images to someone and then wished you hadn't done or had thought more about?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
g) Have you ever visited websites which promote...?		
...Illegal downloading	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Extreme dieting	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Suicide	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Racism/extreme views	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Sexualised images (pictures)	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Self-harm	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Strong religious views	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...Strong political views	0 <input type="checkbox"/>	1 <input type="checkbox"/>

★ 7

72 How much do you enjoy physical activities?

Please tick one answer ✓

Not at all	0	<input type="checkbox"/>
A little	1	<input type="checkbox"/>
Quite a lot	2	<input type="checkbox"/>
A lot	3	<input type="checkbox"/>

73 On which days did you do any physical activity in the last 7 days?

Physical activity means things like PE in school lessons, a school sports club, playing running games after school or doing hard housework at home.

Please tick all that apply ✓✓

NONE	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>
Monday	<input type="checkbox"/>	Friday	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	Saturday	<input type="checkbox"/>



If NONE, please tick the 'none' box and skip to Question 76 →

74 On which days did you get out of breath and/or sweaty while doing physical activity, in the last 7 days?

Please tick all that apply ✓✓

NONE	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>
Monday	<input type="checkbox"/>	Friday	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	Saturday	<input type="checkbox"/>

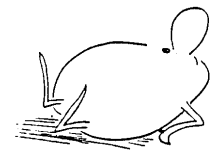


If NONE, please tick the 'none' box and skip to Question 76 →

75 On which days did you get out of breath and/or sweaty while doing physical activity for an hour or more, in the last 7 days?

Please tick all that apply ✓✓

NONE	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>
Monday	<input type="checkbox"/>	Friday	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	Saturday	<input type="checkbox"/>



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→

76 Was this week's pattern of activity usual?

Please tick one answer ✓

Yes, a normal week	2	<input type="checkbox"/>
More active than usual	1	<input type="checkbox"/>
Less active than usual	0	<input type="checkbox"/>

77 Does anything stop you from exercising as much as you would like?

- Please tick all that apply* ✓✓
- Nothing stops me
 - I don't have enough time
 - I don't know what to do
 - I know what I want to do but I don't know where to go
 - I don't like the places you go to
 - Transport to get there is a problem
 - It costs a lot to get there or to take part
 - My parents won't let me go
 - I don't like the people who go there
 - I am shy in front of other people
 - I don't like to try new things
 - I'm not comfortable about how I look
 - The facilities don't cater for my special needs
 - Other (Please write below)

78 How long did you spend doing each of these things below after school yesterday?

<i>Please tick one answer on each row</i>	No time at all	Up to 1 hour	Up to 2 hours	Up to 3 hours	More than 3 hours
Watching TV	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Doing homework	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Playing computer games (e.g. Playstation, DS, PC, etc.)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Talking/texting on the 'phone	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Talking/messaging online (e.g. Facebook, Twitter)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

79 Did you spend any time doing any of these things after school yesterday?

- Please tick all that apply* ✓✓
- Met with friends
 - Used a computer for school work
 - Read a book
 - Cared for pets
 - Played a musical instrument
 - Sport
 - Cared for family members
 - Extra lessons/tutoring
 - Listened to music
 - Helping and volunteering outside the home
 - None of the above

80 What time did you go to bed last night to go to sleep?

Please tick one answer

✓

8 – 9pm 0

9 – 10pm 1

10 – 11pm 2

11 – 12pm 3

12 midnight or later 4

81 Which of the devices listed below did you use in the last hour before going to sleep?

Please tick all that apply

✓✓

Computer

Mobile phone

MP3 player, iPod etc

Tablet

Game console

TV, DVD etc.

None of these.

82 Please think about each of the following statements.

Please tick one answer on each row

Disagree Not sure Agree

“I feel happy talking to other pupils at school.” 0 1 2

“There are lots of things about myself that I would like to change.” 0 1 2

“When I have something to say in front of teachers in class, I usually feel uneasy.” 0 1 2

“I often fall out with other pupils at school.” 0 1 2

“I often feel lonely at school.” 0 1 2

“I think other pupils usually say nasty things about me.” 0 1 2

“When I want to tell a teacher something I usually feel shy.” 0 1 2

“I often have to find new friends because my old ones are with somebody else.” 0 1 2

“I usually feel foolish when I have to talk to my parents/carers” 0 1 2

These questions are about MAKING a POSITIVE CONTRIBUTION.

83 The next questions are about whether adults ask young people for their opinions about changes at school and changes in their community

a) Are you asked for your ideas and opinions ...?

Please tick one answer on each row

	No	Yes
...About what you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About how you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About the school environment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...In your community?	0 <input type="checkbox"/>	1 <input type="checkbox"/>

b) Do the opinions of young people make a difference to decisions...?

Please tick one answer on each row

	No	Yes
...About what you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About how you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About the school environment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...In your community?	0 <input type="checkbox"/>	1 <input type="checkbox"/>

c) Would you like to be asked for your ideas and opinions more often...?

Please tick one answer on each row

	No	Yes
...About what you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About how you learn in school?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...About the school environment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
...In your community?	0 <input type="checkbox"/>	1 <input type="checkbox"/>

84 If something goes wrong...

Please tick one answer on each row

	Never	Sometimes	Usually	Always
I get upset and feel bad for ages	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I might feel a bit bad but soon forget it	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I'm calm and can carry on	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I learn from it for next time	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I might feel something else (please tick and write in the box below)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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85 If something goes wrong...

Please tick one answer on each row

	Never	Sometimes	Usually	Always
I blame someone else	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I keep on trying until I do	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I might have another go	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I give up	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I try a different way of doing it	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I ask for help	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I go and do something else	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I just accept that I can't do it	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

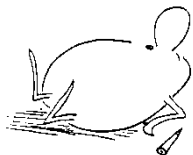
86 Please think about each of the following statements.

<i>Please tick one answer on each row</i>	Disagree	Not sure	Agree
The school cares whether I am happy or not	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
My work is marked so I can see how to improve it	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
I set my own targets and I am helped to meet them	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
My achievements in and out of school are recognised	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
The school teaches me to deal with my feelings positively	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
The school helps me work as part of a team	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
In this school people with different backgrounds are valued	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
The school encourages everyone to take part in decisions, e.g. class discussions or school council	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
The school encourages me to contribute to community events	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
The school prepares me for when I leave this school	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

These questions are about YOUR FUTURE.

87 At the end of Year 11, do you want to...

<i>Please tick one answer on each row</i>	No	Don't know	Yes
Continue in full-time education?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Find a job as soon as you can?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Get training for a skilled job?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Start a family?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other (please describe below)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>



THE END!

Thank you for completing this questionnaire

If you have time, please go back over your answers and check that you have not left any out.

▼62

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★9

Practice Page

There are four main types of question in this questionnaire

1. With most of them, you are asked to "Tick ONE number for each answer" :

Are you male or female?
Please tick one answer

Male	✓	0 <input type="checkbox"/>
Female		1 <input type="checkbox"/>

2. With some questions you may tick more than one answer at the right-hand side of the page.

Which colours are you wearing now?
Please tick all that apply

Red	✓✓	<input type="checkbox"/>
Blue		<input type="checkbox"/>
Green		<input type="checkbox"/>
White		<input type="checkbox"/>

3. With some you tick one answer on each line:

With these questions, you might also need to write an answer.

88 At the end of Year 11, do you want to...

Please tick one answer on each row

	No	Don't know	Yes
Continue in full-time education?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Find a job as soon as you can?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Get training for a skilled job?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Start a family?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other (please describe below)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

4. Some questions will ask you to follow directions if your answer is no

Have you been swimming in the last 7 days?
Please tick one answer

No	✓	0 <input type="checkbox"/>
Yes		1 <input type="checkbox"/>

If you ticked 'No', go to Q27 on page 8 →

Before going to Question 1, please make sure you have filled in Questions A to F on the front cover.