

**I. PERSONAL AND FAMILY INFORMATION**

<b>1. Ethnic Origin:</b> <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Hispanic/Latino <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Native American <input type="radio"/> Mixed Origin <input type="radio"/> Other	<b>2. Sex:</b> <input type="radio"/> Male <input type="radio"/> Female	<b>3. Age:</b> <input type="radio"/> 10 years old or less <input type="radio"/> 11 years old <input type="radio"/> 12 years old <input type="radio"/> 13 years old <input type="radio"/> 14 years old <input type="radio"/> 15 years old <input type="radio"/> 16 years old <input type="radio"/> 17 years old <input type="radio"/> 18 years old <input type="radio"/> 19 years old or more	<b>4. Grade:</b> <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12	<b>5. Do you live with...</b> <input type="radio"/> both parents <input type="radio"/> mother only <input type="radio"/> father only <input type="radio"/> mother & stepfather <input type="radio"/> father & stepmother <input type="radio"/> other	<b>6. Do you have a job?</b> <input type="radio"/> Yes, full-time <input type="radio"/> Yes, part-time <input type="radio"/> No	<b>7. Do your parents have a job?</b> <b>father?</b> <input type="radio"/> Yes, full-time <input type="radio"/> Yes, part-time <input type="radio"/> No <b>mother?</b> <input type="radio"/> Yes, full-time <input type="radio"/> Yes, part-time <input type="radio"/> No	<b>8. What is the educational level of your</b> <b>father?</b> <input type="radio"/> some high school <input type="radio"/> high school graduate <input type="radio"/> some college <input type="radio"/> college graduate <b>mother?</b> <input type="radio"/> some high school <input type="radio"/> high school graduate <input type="radio"/> some college <input type="radio"/> college graduate
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**II. STUDENT INFORMATION**

	NEVER	SOMETIMES	OFTEN	A LOT
1. Do you make good grades?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Do you get into trouble at school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Do you take part in school sports teams?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Do you take part in school activities such as band, clubs, etc.?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Do you take part in community activities such as scouts, rec. teams, youth clubs, etc.?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Do you attend church, synagogue, etc.?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Do your parents talk with you about the problems of tobacco, alcohol and drug use?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Do your teachers talk with you about the problems of tobacco, alcohol and drug use?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Have you skipped school without your parents' permission in the past year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Does your school set clear rules on using drugs at school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Does your school set clear rules on bullying or threatening other students at school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Do your parents set clear rules for you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Do your parents punish you when you break the rules?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Have you been in trouble with the police?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Do you take part in gang activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Have you thought about committing suicide?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Do your friends use tobacco (cigarettes, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Do your friends use alcohol (beer, liquor, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Do your friends use marijuana (pot, hash, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Do your friends use prescription drugs not prescribed to them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Have you had 5 or more glasses of beer, coolers, breezers or liquor within a few hours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Does your school ask any students to take a drug test?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Do you think that you are overweight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Has a doctor told you that you are overweight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Have you bought or sold drugs AT school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Have you bought or sold drugs when NOT at school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Have you carried a gun for protection or as a weapon when NOT at school in the past year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**III. WITHIN THE PAST YEAR HOW OFTEN HAVE YOU...**

	DID NOT USE	6 TIMES YEAR	ONCE MONTH	TWICE MONTH	3 TIMES WEEK	EVERY DAY
1. Used tobacco (cigarettes, cigars, dip, etc.)?	<input type="radio"/>					
2. Drunk alcohol (beer, coolers, liquor, etc.)?	<input type="radio"/>					
3. Smoked marijuana (pot, hash, etc.)?	<input type="radio"/>					
4. Used cocaine (crack, etc.)?	<input type="radio"/>					
5. Used inhalants (glue, gas, etc.)?	<input type="radio"/>					
6. Used hallucinogens (PCP, LSD, etc.)?	<input type="radio"/>					
7. Used heroin (opiates)?	<input type="radio"/>					
8. Used steroids?	<input type="radio"/>					
9. Used ecstasy (MDMA)?	<input type="radio"/>					
10. Used meth (crystal, ice, crank, etc.)?	<input type="radio"/>					
11. Used prescription drugs not prescribed to you (such as Ritalin, Xanax or OxyContin)?	<input type="radio"/>					
12. Used over-the-counter drugs (to get high)?	<input type="radio"/>					

**IV. HOW EASY IS IT TO GET...**

	VERY DIFFICULT	FAIRLY DIFFICULT	FAIRLY EASY	VERY EASY
1. Tobacco (cigarettes, cigars, dip, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Alcohol (beer, coolers, liquor, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Marijuana (pot, hash, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Prescription drugs not prescribed to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**V. HOW MUCH DO YOU THINK PEOPLE RISK HARMING THEMSELVES PHYSICALLY OR IN OTHER WAYS IF THEY...**

	NO RISK	SLIGHT RISK	MODERATE RISK	GREAT RISK
1. Smoke one or more packs of cigarettes per day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Smoke e-cigarettes, e-cigars or e-hookahs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Have five or more drinks of an alcoholic beverage (beer, coolers, liquor) once or twice a week?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Take one or two drinks of an alcoholic beverage (beer, coolers, liquor) nearly every day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Smoke marijuana once or twice a week?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Use prescription drugs that are not prescribed to them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**VI. DURING THE PAST 30 DAYS:**

	YES	NO
1. Did you smoke part or all of a cigarette?	<input type="radio"/>	<input type="radio"/>
2. Did you smoke an e-cigarette, e-cigar, or e-hookah?	<input type="radio"/>	<input type="radio"/>
3. Did you drink one or more drinks of an alcoholic beverage?	<input type="radio"/>	<input type="radio"/>
4. Have you used marijuana or hashish?	<input type="radio"/>	<input type="radio"/>
5. Have you used prescription drugs not prescribed to you?	<input type="radio"/>	<input type="radio"/>
6. Have you used over-the-counter drugs (to get high)?	<input type="radio"/>	<input type="radio"/>
7. Have you used inhalants (glue, gas, etc.)?	<input type="radio"/>	<input type="radio"/>

### VII. AT WHAT AGE DID YOU FIRST...

	NEVER USED	10 OR UNDER	11	12	13	14	15	16	17 OR OLDER
1. Use tobacco?	<input type="checkbox"/>								
2. Drink alcohol?	<input type="checkbox"/>								
3. Smoke marijuana (pot, hash, etc.)?	<input type="checkbox"/>								
4. Use cocaine (crack, etc.)?	<input type="checkbox"/>								
5. Use inhalants (glue, gas, etc.)?	<input type="checkbox"/>								
6. Use hallucinogens (PCP, LSD, etc.)?	<input type="checkbox"/>								
7. Use heroin (opiates)?	<input type="checkbox"/>								
8. Use steroids?	<input type="checkbox"/>								
9. Use ecstasy (MDMA)?	<input type="checkbox"/>								
10. Use meth (crystal, ice, crank, etc.)?	<input type="checkbox"/>								
11. Use prescription drugs not prescribed to you?	<input type="checkbox"/>								
12. Use over-the-counter drugs (to get high)?	<input type="checkbox"/>								

### VIII. HOW WRONG DO YOUR PARENTS FEEL IT WOULD BE FOR YOU TO...

	NOT AT ALL WRONG	A LITTLE BIT WRONG	WRONG	VERY WRONG
1. Smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have one or two drinks of an alcoholic beverage nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Smoke marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Use prescription drugs not prescribed to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### IX. HOW WRONG DO YOUR FRIENDS FEEL IT WOULD BE FOR YOU TO...

	NOT AT ALL WRONG	A LITTLE BIT WRONG	WRONG	VERY WRONG
1. Smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have one or two drinks of an alcoholic beverage nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Smoke marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Use prescription drugs not prescribed to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### X. WHERE DO YOU USUALLY...

(You may mark more than 1 response for each question)

	DO NOT USE	AT HOME	AT SCHOOL	IN A CAR	FRIEND'S HOUSE	OTHER
1. Use tobacco?	<input type="checkbox"/>					
2. Drink alcohol?	<input type="checkbox"/>					
3. Smoke marijuana (pot, hash, etc.)?	<input type="checkbox"/>					
4. Use prescription drugs not prescribed to you?	<input type="checkbox"/>					

### XI. WHEN DO YOU USUALLY...

(You may mark more than 1 response for each question)

	DO NOT USE	BEFORE SCHOOL	DURING SCHOOL	AFTER SCHOOL	WEEK NIGHTS	WEEKENDS
1. Use tobacco?	<input type="checkbox"/>					
2. Drink alcohol?	<input type="checkbox"/>					
3. Smoke marijuana (pot, hash, etc.)?	<input type="checkbox"/>					
4. Use prescription drugs not prescribed to you?	<input type="checkbox"/>					

### XII. HOW DO YOU FEEL ABOUT SOMEONE YOUR AGE HAVING ONE OR TWO DRINKS OF AN ALCOHOLIC BEVERAGE NEARLY EVERY DAY?

- Neither approve nor disapprove       Strongly disapprove  
 Somewhat disapprove                       Don't know or can't say

### XIII. WHAT EFFECT DO YOU MOST OFTEN GET WHEN YOU...

	DO NOT USE	A LITTLE HIGH	VERY HIGH	BOMBED/STONED
1. Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke marijuana (pot, hash, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Use prescription drugs not prescribed to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### XIV. VEHICLE SAFETY

	0 times	1 time	2 or 3 times	4 or 5 times	6 or more times
1. During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?	<input type="checkbox"/>				
2. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?	<input type="checkbox"/>				
3. How often do you wear a seatbelt when driving a car? <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always <input type="radio"/> Seldom <input type="radio"/> Most of the time <input type="radio"/> I don't drive	<input type="checkbox"/>				
4. How often do you wear a seat belt when riding in a car driven by someone else? <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always <input type="radio"/> Seldom <input type="radio"/> Most of the time	<input type="checkbox"/>				

### XV. WHILE AT SCHOOL HAVE YOU...(Past Year)

	NEVER	ONE TIME	2-5 TIMES	6 OR MORE TIMES
1. Carried a handgun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Carried a knife, club or other weapon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Threatened a student with a handgun, knife or club?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Threatened to hurt a student by hitting, slapping or kicking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Hurt a student by using a handgun, knife or club?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hurt a student by hitting, slapping or kicking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Been threatened with a handgun, knife or club by a student?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Had a student threaten to hit, slap or kick you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Been afraid a student may hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Been hurt by a student using a handgun, knife or club?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Been hurt by a student who hit, slapped or kicked you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### XVI. IN MY SCHOOL, I FEEL SAFE...

	NEVER	SOMETIMES	OFTEN	A LOT
1. In the classroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the cafeteria (lunchroom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the halls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. On the school bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. At school events (ballgames, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. On the playground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the parking lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### XVII. ADDITIONAL QUESTIONS

- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H
- A  B  C  D  E  F  G  H