

THE HEALTH-RELATED BEHAVIOUR QUESTIONNAIRE

The purpose of this questionnaire is to help us plan health care for young people, and to help your teachers plan work in schools. To do this, they need some information about yourself.

These questionnaires are confidential. This means they will be kept private and will not be read by anyone connected with your school. All the analysis is carried out in Exeter.

- 1) Please answer all questions honestly.
- 2) Do NOT write your name on any page
- 3) If you don't want to answer a question, you may leave it out

Please do NOT write in shaded boxes

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▼4

Answer these questions in the box first, there is also a practice page on the back.

A Are you male or female?

Please tick one answer ✓

Male 0

Female 1

B How old are you? Please write here years


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C Which school year are you in?

Please tick one answer ✓

Year 8 Year 10

D What is your home postcode?

Please write on the dotted line 

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E Which of the following best describes your ethnic background?

Please tick the one that most describes you ✓

White

- White British..... 01
- White Cornish..... 02
- White Irish..... 03
- Any other White background..... 04
- Gypsy/Roma..... 05
- Traveller of Irish Heritage..... 06

Asian

- Bangladeshi Asian..... 07
- British Asian..... 08
- Cornish Asian..... 09
- Indian Asian..... 10
- Pakistani Asian..... 11
- Any other Asian background..... 12

Black

- Black African..... 13
- Black British..... 14
- Black Caribbean..... 15
- Black Cornish..... 16
- Any other Black background..... 17

Chinese

- British Chinese..... 18
- Chinese..... 19
- Cornish Chinese..... 20
- Any other Chinese background..... 21

Mixed

- Mixed White & Asian..... 22
- Mixed White & Black African..... 23
- Mixed White & Black Caribbean..... 24
- Any other mixed background..... 25
- Any other background..... 26
- Prefer not to say..... 27

1 Which adults do you live with?

Please choose the nearest answer, or what you do most in the week ✓

- Mum & dad together..... 01
- 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
- Foster parents..... 08
- Other carer (please describe below) 09

2 Are you disabled or do you have a long-standing illness?

Please tick one answer ✓ **No** 0 **Not sure** 1 **Yes** 2 **Don't want to say** 3

3 Do you get extra help in lessons with your learning or behaviour?

Please tick one answer ✓ **No** 0 **Not sure** 1 **Yes** 2 **Don't want to say** 3

4 Do you get free school meals or vouchers for free school meals?

Please tick one answer ✓ **No** 0 **Not sure** 1 **Yes** 2 **Don't want to say** 3

5a) Are you a 'young carer'?

A young carer is a child who regularly helps look after someone in their family because they are disabled or have difficulty looking after themselves.

Please tick one answer ✓ **No** 0 **Not sure** 1 **Yes** 2 **Don't want to say** 3
If yes, please tick and go to 5b) if not, please tick and go to Q6 below →

b) If you are a 'young carer', who do you look after? e.g. mum, dad, grandma



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

Please tick one answer ✓ **Less than 1 hour** 0 **1-2 hours** 1 **More than 2 hours** 2
Some time, but I don't do this every day 3

d) Does your school know you are a 'young carer'?

Please tick one answer ✓ **No** 0 **Not sure** 1 **Yes** 2

e) If yes, do you get any help from school for being a 'young carer'?

Please tick one answer ✓ **No** 0 **Yes** 1 If yes, please say what help you get below

→ **6 a) Do you have a parent/carer who is in the British Army, Royal Navy, Royal Air Force, or the Reserves?** This is just about your mum/dad/carer, do not include uncles/grandparents etc. unless they are your main carer

Please tick one answer ✓

- No..... 0
- Not sure 1
- Yes..... 2
- Don't want to say 3

If YES, tick 'yes' and carry on to the next question; everyone else go to Question 7 →

b) Who is it?

Please tick one answer ✓

- Mum or Dad 01
- Mum or Dad's partner 02
- Foster carer 03
- Other carer (please tick then write) 04





These questions are about BEING HEALTHY.

→ **7 In general, how happy do you feel with your life at the moment?**

Please tick one answer ✓

- Not at all** 0 **Not much** 1 **Not sure** 2 **Quite a lot** 3 **A lot** 4

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

Please tick ONE answer on each line ✓

- a "I am in charge of my health." **Disagree** 0 **Not sure** 1 **Agree** 2
- b "If I keep healthy, I've just been lucky." **Disagree** 0 **Not sure** 1 **Agree** 2
- c "If I take care of myself I'll stay healthy." **Disagree** 0 **Not sure** 1 **Agree** 2
- d "Even if I look after myself I can still easily fall ill." **Disagree** 0 **Not sure** 1 **Agree** 2

9 How would you describe your weight?

Please tick ONE answer ✓

- Under weight** 0 **Healthy weight** 1 **Over weight** 2

10 Which statement describes you best?

Please tick ONE answer



- I would like to put on weight 0
- I would like to lose weight 1
- I am happy with my weight as it is..... 2

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

Please tick ONE answer ✓

- Never** 0 **Sometimes** 1 **Quite often** 2 **Very often** 3 **Always** 4

12 What did you do for lunch yesterday?

Please tick ONE answer



- School food 0
- Ate a packed lunch from home 1
- Bought lunch from a takeaway or shop 2
- Went home for lunch..... 3
- Did not have any lunch..... 4

★1

13 Did you eat or drink anything before lessons this morning?

You may tick MORE than one answer

- No, nothing at all.....
- Yes, something at home
- Yes, something on the way to school
- Yes, something at school

✓✓



14 What did you have before lessons this morning?

Please tick everything that you had ✓

- Nothing to eat or drink
- A drink
- Toast or bread
- Sugar-coated cereals e.g. Frosties.....
- Porridge/Ready brek
- Other cereals e.g. Cornflakes
- Cooked breakfast e.g. egg on toast, pancakes etc.

- Yoghurt.....
- Breakfast bar
- Crisp-type snack.....
- Chocolate bar, sweets.....
- Biscuits/cakes.....
- Fruit
- Something else (please tick and describe below)

▼19

15 How often do you eat or drink the following?

Please tick ONE answer on each line ✓

	Rarely or never	Once a week or less	2-3 days a week	On most days
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"/>
Isotonic sports drinks (e.g. Lucozade sport, Gatorade etc.).....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Protein shakes	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"/>

★2

16 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 a maximum of one portion a day)

a dessert bowl of salad

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

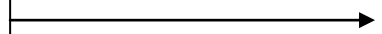
17 Is water freely available for you to drink at school?

Please tick ONE answer ✓ **No** 0 **Not Easily** 1 **Yes** 2

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

Please tick ONE answer ✓ **No** 0 **Yes** 1

If No, please tick 'No' and go to Q23 on page 6



19 On which days did you drink alcohol, in the last 7 days?

Please tick every day you drank alcohol. ✓

Sunday Monday Tuesday Wednesday
 Thursday Friday Saturday

20 On which days did you get drunk, in the last 7 days? Drunk means feeling out of control of your body.

Please tick every day you got drunk, or NONE. ✓

NONE Sunday Monday Tuesday Wednesday
 Thursday Friday Saturday

21 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 shandy

Please write on the dotted lines

I drank large cans/pints of beer or lager

I drank large cans/pints of cider

I drank cans/bottles of pre-mixed drinks (e.g. WKD, Reef)

I drank glasses of wine (a bottle is about 4 glasses)

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

I drank glasses of Baileys, Tia Maria, Martini, Cinzano, Sherry etc.

I drank measures of spirits (e.g. gin, whisky, vodka, rum, etc.)

I drank of something else (please write)

Do NOT write in the boxes

▼36

22 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

- a I bought alcohol myself from a pub/bar
- b I bought alcohol myself from an off-licence
- c I bought alcohol myself from a supermarket.....
- d I bought alcohol myself from a disco or nightclub.....
- e Parents/carers bought it for me/gave it to me.....
- f I took it from my parents/carers without their consent
- g Friends/family over 18 bought it for me/gave it to me
- h Friends/family under 18 bought it for me/gave it to me.....
- i I got adults outside shops to buy it for me
- j Other source (please write).....

→ **23 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

24 If you drink alcohol, where do you usually buy/get it?

Do not include canned shandy

Please tick all that apply

- | | | | |
|-----------------------------------|--------------------------|--|--------------------------|
| In a pub or a bar..... | <input type="checkbox"/> | From my parents..... | <input type="checkbox"/> |
| In a nightclub or a disco..... | <input type="checkbox"/> | Off the street (e.g. from a van or
someone's garage)..... | <input type="checkbox"/> |
| From an off-licence..... | <input type="checkbox"/> | From someone else..... | <input type="checkbox"/> |
| From a shop or a supermarket..... | <input type="checkbox"/> | At parties..... | <input type="checkbox"/> |
| From a friend or relative..... | <input type="checkbox"/> | I steal it..... | <input type="checkbox"/> |
| From the Internet..... | <input type="checkbox"/> | Somewhere else
(please describe.....) | <input type="checkbox"/> |
| | | None of these..... | <input type="checkbox"/> |

★3

25 Have you received any useful information about alcohol or drugs?

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

If No, please tick 'No' and go to Q28 below

26 If yes, did it help you make choices about your own behaviour?

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

27 Where did you get this useful information from? Please list the sources found useful

Please write

→ **28 How many cigarettes have you smoked during the last 7 days?**

Please write the number (If NONE, write 0)

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

Please write

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30 Which statement describes you best?

Please tick ONE answer

- | | | |
|---|---|--------------------------|
| I have never smoked at all, not even a puff | 0 | <input type="checkbox"/> |
| I have tried smoking once or twice..... | 1 | <input type="checkbox"/> |
| I used to smoke, but I don't now | 2 | <input type="checkbox"/> |
| I smoke occasionally (less than 1 cigarette a week) | 3 | <input type="checkbox"/> |
| I smoke regularly but would like to give it up | 4 | <input type="checkbox"/> |
| I smoke regularly and don't want to give it up | 5 | <input type="checkbox"/> |

Please tick ONE answer on each line ✓

31a) Do your parents/carers smoke?..... **No** 0 **Yes** 1

b) Does anyone smoke indoors at home in rooms that you use?..... **No** 0 **Yes** 1

c) Does anyone smoke in a car when you are in it too?..... **No** 0 **Yes** 1

32 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 only outside 1
 - Smoking happens only in certain rooms 2
 - Smokers can smoke anywhere 3

33 Do your parents/carers use e-cigarettes (vape)? No 0 Don't know 1 Yes 2

34 E-cigarettes - which statement describes you best?

- Please tick ONE answer ✓
- I have never heard of e-cigarettes (vaping) 0
 - I have never used an e-cigarette (vaped) 1
 - I have only used an e-cigarette once or twice 2
 - I use an e-cigarette occasionally - a few times a year 3
 - I use an e-cigarette occasionally – at least once a month 4
 - I use an e-cigarette regularly at least once a week 5
 - I use an e-cigarette every day 6

35 Do you know anyone personally who you think takes any drugs to get high?

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Fairly sure** 2 **Certain** 3

36a Have you ever been offered drugs to get high? No 0 Don't know 1 Yes 2

b If yes, what drugs were you offered?

▼20

Please write below

✍	
✍	

37a Have you ever taken drugs to get high? No 0 Don't know 1 Yes 2

If No, please tick 'No' and go to Q39 on next page →

b If yes, what drugs have you taken?

Please write below

✍	
✍	

▼38

38 If you take drugs, do your parents/carers know?

Please tick ONE answer. ✓

- I don't take drugs 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

→ **39 How much do you worry about the issues listed below?**

Tick ONE answer on each line ✓

	Never	Hardly ever	A little	Quite a lot	A lot
a School-work problems	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b Exams and tests	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c Bullying.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d Your physical health	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e Your mental health.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f 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"/>
g Problems with friends.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h Family problems	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i Money problems/family finances	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j The way you look	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k Relationships	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l Sexually transmitted infections	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m 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"/>
n Drugs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
o The environment	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
p Wars and terrorism	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
q Crime	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
r Gambling	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
s The future	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

If you worry about other things please write what they are in the box

✍	
✍	

40 If you were worried about something, do you know an adult you trust that you can talk to about this?

Please tick ONE answer ✓ **No** 0 **Maybe** 1 **Yes** 2

41 When you have a problem that worries you, how do you cope?

Please tick ONE answer on each line ✓

	Never	Rarely	Sometimes	Often	Always
Talk to an adult about the problem	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Talk to a friend or brother/sister about the problem.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Rest or sleep more.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Smoke cigarettes	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Think carefully about the problem by yourself.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Drink alcohol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Keep busy.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Exercise	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Self-harm/hurt yourself	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Go out with friends/socialise.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Stop going out	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Watch TV	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Seek help from books/magazines/Internet.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Listen to music.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Eat more	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Eat less.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Do nothing.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

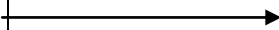
▼18

42 Have you ever self-harmed?

"Self-harm is where someone does something to deliberately hurt themselves when they find things difficult to cope with. It can include things like cutting or burning yourself, or overdosing (self-poisoning)"

Please tick one answer ✓ No 0 Yes 1 Don't want to say 2

If no, tick 'no' and go to Question 45 (page 11).



43 If yes, did you tell anyone?

Please tick one answer on each line ✓

No-one	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
Friend	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
Parents/carers.....	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
Teachers	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
Counsellor	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
CAMHS	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>
Other (please write in the box below)	No 0 <input type="checkbox"/>	Yes 1 <input type="checkbox"/>

44 Did you receive any support/help?

Please tick one answer ✓

No 0 Yes 1

→ **45 Which of these is your main source of information about relationships and sexual health?**

Please tick ONE answer ✓

My parents/carers 01 <input type="checkbox"/>	School lessons 02 <input type="checkbox"/>	School lessons delivered by Brook 03 <input type="checkbox"/>
Friends 04 <input type="checkbox"/>	School nurse 05 <input type="checkbox"/>	Doctor 06 <input type="checkbox"/>
Brothers, sisters, other close relations 07 <input type="checkbox"/>	Advice centre e.g. Family Planning Clinic 08 <input type="checkbox"/>	Posters, leaflets, reference books 09 <input type="checkbox"/>
TV, films 10 <input type="checkbox"/>	Magazines 11 <input type="checkbox"/>	Advisers/tutors 12 <input type="checkbox"/>
Internet 13 <input type="checkbox"/>	Telephone helpline 14 <input type="checkbox"/>	Youth workers 15 <input type="checkbox"/>
Other (please write)		16 <input type="checkbox"/>

46 Who would you like to talk to about relationships and sexual health?

Please tick all that apply

✓✓

No-one	<input type="checkbox"/>	Visitors in school lessons	<input type="checkbox"/>
Young people	<input type="checkbox"/>	School Nurse	<input type="checkbox"/>
Parents/carers	<input type="checkbox"/>	Doctor	<input type="checkbox"/>
Teachers, in school lessons	<input type="checkbox"/>	Social worker/family worker	<input type="checkbox"/>
		Someone else	<input type="checkbox"/>

▼41

47 Here is a list of sexually transmitted infections (STIs). For each one, please choose the answer that describes best what you know about them.

Please tick ONE answer on each line ✓

	Never heard of it	Have heard of it
A Genital herpes	0 <input type="checkbox"/>	1 <input type="checkbox"/>
B Human papilloma virus (HPV, Genital warts)....	0 <input type="checkbox"/>	1 <input type="checkbox"/>
C Gonorrhoea	0 <input type="checkbox"/>	1 <input type="checkbox"/>
D HIV/AIDS	0 <input type="checkbox"/>	1 <input type="checkbox"/>
E Chlamydia	0 <input type="checkbox"/>	1 <input type="checkbox"/>
F Syphilis	0 <input type="checkbox"/>	1 <input type="checkbox"/>
G Pubic lice (crabs).....	0 <input type="checkbox"/>	1 <input type="checkbox"/>

48a) Do you know where to get help if you had an STI?

Please tick ONE answer ✓ **No** 0 **Yes** 1

b) If yes, please write where

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49 Do you know how to prevent getting an STI?

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Yes** 2

50 Have you heard of the C-card scheme?

Please tick ONE answer ✓ **No** 0 **Yes** 1

51a) 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

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52a) 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

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53 What do you know about the Savvy website?

Please tick ONE answer ✓



- Never heard of this website before 0
- Heard of it but know little or nothing about it 1
- Know what it is but haven't seen it 2
- Know what it is and have used it 3

54 What do you know about the Rise Above website?

Please tick ONE answer ✓



- Never heard of this website before 0
- Heard of it but know little or nothing about it 1
- Know what it is but haven't seen it 2
- Know what it is and have used it 3

55 What do you know about the Young Minds website?

Please tick ONE answer ✓



- Never heard of this website before 0
- Heard of it but know little or nothing about it 1
- Know what it is but haven't seen it 2
- Know what it is and have used it 3

★5

56 How much have your RSE lessons helped you make decisions about the following?

Please tick ONE answer on each line ✓

		Not at all	A little	Quite a lot	A lot
a	Deciding when you are ready to have sex	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b	Using contraception.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c	The relationships you have.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d	Resisting pressure.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e	Accessing sexual health services	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

57 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.....).....

58 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
- I can sometimes say no 1
- I can rarely say no 2
- I can never say no 3

59 Please think about each of the following statements. Please say whether you disagree, are not sure or agree.

Please tick ONE answer on each line ✓

		Disagree	Not sure	Agree
a	There is pressure on young people to have sex	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b	It is ok to wait to have sex.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c	It is important to be in a serious relationship before having sex.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d	There is no need to use contraception when you are in a serious relationship	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e	If you or your partner are ‘on the pill’ you don’t need to use a condom	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
f	Getting pregnant or getting a partner pregnant now would ruin my future plans.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

60 How long ago did you last visit the doctor?

Please tick ONE answer ✓

In the past week 0 **In the past month** 1 **In the past 3 months** 2 **In the past 6 months** 3 **In the past year** 4 **More than a year ago** 5 **61 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 **62 How long ago did you last visit the dentist?**

Please tick ONE answer ✓

In the past week 0 **In the past 3 months** 1 **In the past 6 months** 2 **In the past year** 3 **More than a year ago** 4 **I have never been to the dentist** 5

These questions are about STAYING SAFE.

63 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 **64 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 **65 Have you bullied someone else at school in the last 12 months?**

Please tick ONE answer ✓

No 0 **Don't know** 1 **Yes** 2 **66 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 **67 Do you think your school takes bullying seriously?**

Please tick ONE answer ✓

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

68 Have any of the following happened to you in the last month?

Please tick any that apply

✓ ✓

- a Been teased/made fun of.....
- b Called nasty names.....
- c Received nasty/threatening text message
- d Received nasty/threatening e-mail
- e Received nasty/threatening message in a chatroom
- f Seen nasty things written about you online

- g Pushed/hit for no reason.....
- h Had belongings taken/broken.....
- i Been threatened for no reason.....
- j Been threatened for money.....
- k Been forced to do things you didn't want to do.....
- l Been ganged up on.....
- m Other (please write)

If you have ticked none in Q68 please go on to Question 72

▼ 44

69 Where did they happen?

Please tick any that apply

✓ ✓

- a At or near home.....
- b On the way to or from school.....
- c During lesson time.....
- d In a classroom (playtime/lunchtime)
- e In the toilets.....
- f In the corridors.....
- g Outside at school (playtime/lunchtime)
- h Online via my phone tablet etc during the day
- i Online via my phone tablet etc at night
- j Other (please write)

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

Please tick all that apply

✓ ✓

- a Teacher.....
- b Friend.....
- c Mum or Dad/carer
- d Other trusted adult.....
- e Brother or sister.....
- f Someone else.....
- g No one.....

71 ... and did the problem stop?

Please tick ONE answer ✓

No 0

Don't know 1

Yes 2

★5

→ **72 Do you think you have been picked on or bullied for any of the following?**

- Please tick any that apply ✓✓
- I've never been picked on or bullied
 - 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
 - Your family background
 - Your health
 - Because you are a young carer
 - Other (please write)

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

- Please tick ONE answer on each line
- | | Very
poor | Poor | Adequate | Good | Very
good |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a Your safety when going out after dark | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b Your safety when going out during the day | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c Your safety at school | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d Your safety when going to and from school | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

74a) In the last 12 months, have you been the victim of violence or aggressive behaviour? ▼ 19

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Yes** 2

If no, please tick no and go to Q75

→

b) If yes, where did the incident take place?

Please tick ONE answer ✓ **In the street/park** 01 **School grounds** 02 **At a club** 03
At home 04 **Somewhere else (please write below)** 05

(please write)

c) If yes, did you report it to anyone?

Please tick ONE answer ✓ **No** 01 **The police** 02 **Parent/carer** 03
A teacher 04 **Somewhere else (please write below)** 05

(please write)

d) If yes, was a weapon used/threatened?

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Yes** 2

e) If yes, what weapon was it?

(please write)

--	--



75a) Has there been any shouting and arguing between adults at home in the last month that frightened you?

Please tick ONE answer ✓ **No** 0 **Once or twice** 1 **Once a week** 2
Every day/almost every day 3

b) Has there been any violence between adults (e.g. hitting, punching, slapping) at home in the last month?

Please tick ONE answer ✓ **No** 0 **Once or twice** 1 **Once a week** 2
Every day/almost every day 3

76 Have any of these things happened to you in a relationship with a boyfriend/girlfriend?

Please tick one answer on each line ✓	No, never	Yes, in the past	Yes, with my current boy/girlfriend
Used hurtful or threatening language to me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Was angry or jealous when I wanted to spend time with friends	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Kept checking my phone	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Put pressure on me to have sex or do other sexual things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Threatened to tell people things about me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Threatened to hit me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Hit me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

77 If any of those things were to happen to you...?

Please tick ONE answer

I'd know what to do for myself..... ✓ **No** 0 **Not sure** 1 **Yes** 2

I have an adult I trust I could talk to..... ✓ **No** 0 **Not sure** 1 **Yes** 2

I could get some help ✓ **No** 0 **Not sure** 1 **Yes** 2

78 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 **Sometimes** 1 **Usually** 2 **Whenever possible** 3

These questions are about SCHOOL and LEISURE TIME.

79 How many lessons do you enjoy at school?

Please tick ONE answer ✓ **All of them** 0 **Most of them** 1 **About half of them** 2
Less than half of them 3 **Hardly any of them** 4

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

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

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

Please tick all that apply ✓ ✓

- | | | | | | |
|---|---|--------------------------|---|----------------------------------|--------------------------|
| a | Illness or injury | <input type="checkbox"/> | f | Worries about school | <input type="checkbox"/> |
| b | Caring for family members | <input type="checkbox"/> | g | Worries about bullying | <input type="checkbox"/> |
| c | Medical/dental appointments | <input type="checkbox"/> | h | Effects of my social life | <input type="checkbox"/> |
| d | Day trips or holiday in term time | <input type="checkbox"/> | i | Other (please describe below) .. | <input type="checkbox"/> |
| e | Shopping | <input type="checkbox"/> | | | |

82 If you have been absent from the school in the last 12 months, did your parents/carers know?

Please tick ONE answer I have not been absent in the last 12 months 0
 My parents/carers always know 1
 My parents/carers sometimes know 2
 My parents/carers never know 3

83 How much do you enjoy physical activities?

Please tick ONE answer ✓ **Not at all** 0 **A little** 1 **Quite a lot** 2 **A lot** 3

84 How many times last week did you exercise and have to breathe harder and faster?

Please tick ONE answer ✓
None at all 0 **Once** 1 **Twice** 2 **3 times** 3 **4 times** 4 **5 times or more** 5

85 On average, how long are you active each day, enough that it makes you breathe harder and faster?

Never 0
 Less than 30 minutes (or less than half an hour each day) 1
 About 30 minutes (or half an hour each day) 2
 About 60 minutes (or an hour each day) 3
 More than 60 minutes (or more than an hour each day) 4



86 Please tick one answer on each line. ✓

- a Have you ever chatted on the Internet?** No 0 Yes 1
 If YES: Do you use a webcam to chat online, e.g. Skype? No 0 Yes 1
 If YES: Do you chat to **just** your friends or family? No 0 Yes 1
 If YES: Do you chat to friends of friends? No 0 Yes 1
 If YES: Do you chat to other people who you don't know? No 0 Yes 1
- b Have you ever got a message or picture that scared you or made you upset?.** No 0 Yes 1
- c Have any of these things ever happened to you online?**
- Received a hurtful, unwanted or nasty message online No 0 Yes 1
 Hurtful comments were posted about you on a social networking site No 0 Yes 1
 Someone used your identity/password to post false or hurtful things online No 0 Yes 1
 Someone posted private information about you (including pictures) No 0 Yes 1
 Someone used/changed a picture to humiliate you No 0 Yes 1
 An offensive video clip was taken or posted about you No 0 Yes 1
 Someone had voted for you in an insulting online poll No 0 Yes 1
 A nasty webpage was set up about you No 0 Yes 1
 Other (please tick an answer then describe in the box) No 0 Yes 1
- d Has anyone you don't know in person, asked to meet with you?** No 0 Yes 1
 If YES, was this person (as far as you know) quite a bit older than you? No 0 Yes 1
- e Have you ever been told how to stay safe while online?** No 0 Yes 1
 If YES, do you always follow the advice you have been given? No 0 Yes 1
- f Have you ever sent personal information or images to someone which then you wished you hadn't done or had thought more about?** No 0 Yes 1

▼21

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

		No time at all	Up to 1 hour	Up to 2 hours	Up to 3 hours	More than 3 hours
Please tick ONE answer on each line ✓						
a	Watching TV programmes or films/DVDs etc.....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b	Doing homework	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c	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"/>
d	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"/>
e	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"/>

88 Please think about each of the following statements.

		Disagree	Not sure	Agree
Please tick ONE answer on each line ✓				
a	“I feel happy talking to other pupils at school.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b	“There are lots of things about myself that I would like to change.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c	“When I have something to say in front of teachers in class, I usually feel uneasy.” ...	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d	“I often fall out with other pupils at school.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
e	“I often feel lonely at school.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
f	“I think other pupils usually say nasty things about me.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
g	“When I want to tell a teacher something I usually feel shy.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
h	“I often have to find new friends because my old ones are with somebody else.”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
i	“I usually feel foolish when I have to talk to my parents/carers”	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

★8

These questions are about MAKING a POSITIVE CONTRIBUTION.

89a) Do you feel that your views and opinions are listened to in your school?

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Yes** 2

b) If you answered yes, in what ways do you think they are listened to?

Please tick all that apply ✓✓

School/class council.....

Suggestion box

Circle time

Talking to teachers

Talking to other adults in school.....

Talking to trained pupils (e.g. playground pals/buddies; peer mediator; bullying counsellor).....

Other (please write)

90 Please think about each of the following statements.

Please tick one answer on each line ✓

Disagree **Not sure** **Agree**

The school cares whether I am happy or not 0 1 2

My work is marked so I can see how to improve it..... 0 1 2

I set my own targets and I am helped to meet them 0 1 2

My achievements in and out of school are recognised..... 0 1 2

The school teaches me to deal with my feelings positively 0 1 2

The school helps me work as part of a team 0 1 2

In this school people with different backgrounds are valued 0 1 2

▼19

The school encourages everyone to take part in decisions, e.g. class discussions or school council..... 0 1 2

The school encourages me to contribute to community events..... 0 1 2

The school prepares me for when I leave this school..... 0 1 2

These questions are about YOUR FUTURE.

91 When you leave school, do you want to:

Please tick one answer on each line ✓

No **Don't know** **Yes**

Continue in full-time education (e.g. college/university)? 0 1 2

Find a job as soon as you can? 0 1 2

Get training for a skilled job (e.g. apprenticeship)? 0 1 2

Start a family? 0 1 2

Other (please describe.) 0 1 2

If you are in Year 8 you have now finished, thank you!

If you are in Year 10 please go on to the next page Q92



→ **YEAR 10 and older ONLY**

92 Nationally, we know that most young people under 16 have not had sex (only 25% of under 16s report having sex).

Which of the following best describes you? ✓

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

93 If you have had sex, did you always use a method of protection or contraception? ✓

No 0

Not sure 1

Yes 2

94 Have you ever taken risks with sex (infection or pregnancy) after drinking alcohol or drug use? ✓

No 0

Not sure 1

Yes 2

95 Which of the following best describes how you think about yourself? ✓✓

Straight/heterosexual

Gay/Lesbian

Bisexual

Trans

Questioning/don't know

Other (please tick then describe below)

Prefer not to say



96 Do you think there are good advice and support services in Cornwall for Lesbian, Gay, Bisexual or Transgender (LGBT) young people which are easy to access?

Please tick ONE answer ✓ **No** 0 **Not sure** 1 **Yes** 2



THE END!

▼36

★9

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.

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 **Female** 1

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

Which drinks did you have yesterday?
 Please tick all that apply ✓✓

Water..... 01

Juice 01

Fizzy drinks..... 01

Milk..... 01

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

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


When you finish school, do you want to: ?
 Please tick one answer on each line ✓

	No	Don't know	Yes
Continue in full-time education e.g. college/university?	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 e.g. apprenticeship?	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:).....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

4. Some questions just 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 Yes 1

If no, tick no and go to Question X (next page)



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