

# SURVEY

- **Please do not write your name on this paper.**
- The information you give is private and will only be seen by the researchers.
- Answer *every* question you can.
- If you can't answer a question or if you do not want to answer a question, leave it out and go on to the next one.
- You may withdraw from the survey at any time.

## HOW TO ANSWER QUESTIONS

For most questions there is a choice of answers

Pick the one that's true for you and cross the box next to it like this:  YES

Please cross ONE Box only unless otherwise indicated

If you make a mistake simply scribble it out and mark the correct answer with a cross like this:  No  YES

Some questions ask you to write a short answer in the space provided

Use a ballpoint blue or black pen (do NOT use a felt tipped pen)

### Office use only

STATE 1	SCHOOL	ID	PCODE	LEVEL	CAMPUS
PATTERN	SCHSEX	STRATA	TEACH	DAY	
ORDER 1	INITIALS		DATE	MONTH	YEAR 2011



1. (a) What suburb or town do you live in? \_\_\_\_\_

(b) What is the postcode of your address?    \_ \_ \_ \_

2. What year level are you in?

1  Year 7

3  Year 9

5  Year 11

2  Year 8

4  Year 10

6  Year 12

3. How old are you **now**?

10  10

14  14

18  18

11  11

15  15

19  19 and over

12  12

16  16

13  13

17  17

4. What sex are you?

1  Male

2  Female

5. What year were you born?    \_ \_ \_ \_

6. During a normal week, how much money do you have available to spend on yourself (eg from pocket money, part-time job)?

1  None                      4  \$21 – \$40                      7  \$81 – \$100                      10  \$131 – \$140

2  Less than \$10                      5  \$41 – \$60                      8  \$101 – \$120                      11  \$141 – \$150

3  \$11 – \$20                      6  \$61 – \$80                      9  \$121 – \$130                      12  Over \$150

7. **At school work**, do you consider yourself:

1  A lot above average?

2  Above average?

3  Average?

4  Below average?

5  A lot below average?

8. Were you at school on the last school day?

1  Yes

2  No

9. Are you of Aboriginal or Torres Strait Islander descent?

1  No

2  Yes – Aboriginal descent

3  Yes – Torres Strait Islander descent

4  Yes – both Aboriginal and Torres Strait Islander descent

10. What is the main language spoken at home? *Cross only **one** box.*

1  English only

2  Another language only (*specify which language*) \_\_\_\_\_

3  English and another language  
(*specify the other language*) \_\_\_\_\_

**THE NEXT FEW QUESTIONS ARE ABOUT DRINKING ALCOHOL – BEER, WINE, WINE COOLERS, ALCOHOLIC SODAS, SPIRITS, PREMIXED SPIRIT DRINKS, LIQUEURS, ALCOHOLIC APPLE CIDER, SHERRY OR PORT.**

11. At the present time, do you consider yourself:

1  A non-drinker?

2  An occasional drinker?

3  A light drinker?

4  A party drinker?

5  A heavy drinker?

12. Have you **ever** had even part of an alcoholic drink?

1  No

2  Yes, just a few sips

3  Yes, I have had fewer than 10 alcoholic drinks in my life

4  Yes, I have had more than 10 alcoholic drinks in my life

13. Have you had an alcoholic drink in the last **twelve months**?

1  Yes                      2  No

14. Have you had an alcoholic drink in the last **four weeks**?

1  Yes                      2  No

15. This question is about the number of alcoholic drinks you had during the last **seven days**, including yesterday.

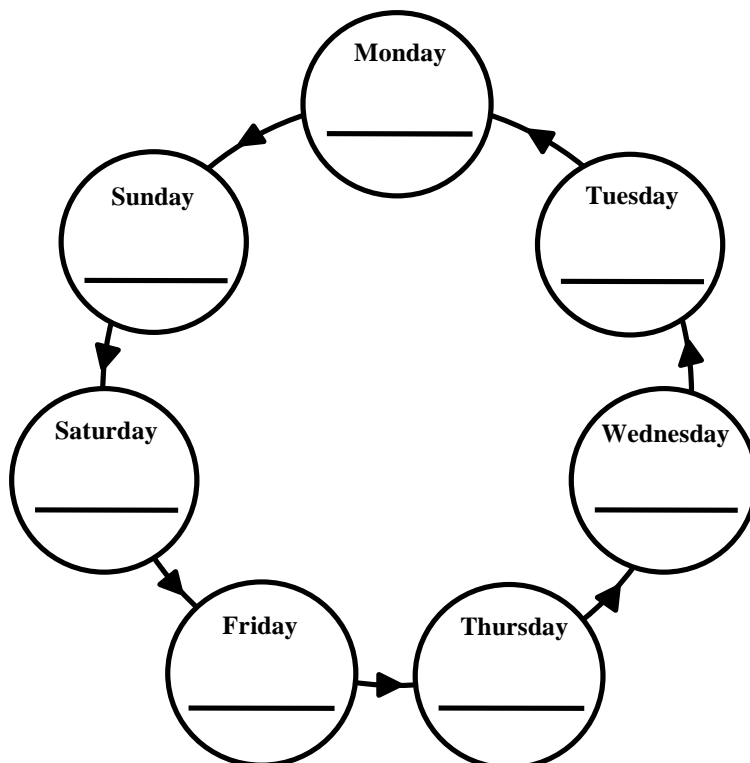
*Put a cross next to **yesterday**. Then in the space provided, write the number of alcoholic drinks you had yesterday. If you didn't have any alcoholic drinks, put in '0'.*

*Start filling in the spaces beginning with yesterday, and follow the arrows.*

**Answer for every day of the week.**

*Write the number of alcoholic drinks you had each day in the circle.*

*Put '0' for each day you didn't drink any alcoholic drinks.*



**QUESTIONS 16 TO 20 ARE FOR ANYONE WHO HAS HAD AN ALCOHOLIC DRINK.**

**IF YOU HAVE NEVER HAD AN ALCOHOLIC DRINK, GO TO QUESTION 21.**

16. What alcoholic drink do you usually have?

*Cross the box next to the drink you **usually** have. If that drink is not listed here, cross the box next to 'Other' and write the name of the drink in the space provided.*

- 01  Ordinary beer
- 02  Low alcohol beer
- 03  Wine (Goon)
- 04  Wine Cooler (eg West Coast Coolers)
- 05  Champagne or sparkling wine (eg Spumante, Passion Pop)
- 06  Alcoholic Cider (eg Apple, Pear, Strongbow, Magners, Woodchuk)
- 07  Alcoholic Sodas (eg Elevate Alcoholic Soda/Cola)
- 08  Premixed spirits (eg Bacardi Breezer, Lemon Ruski, Vodka Mudshake, Jim Beam and Cola, Wild Turkey and Cola, Bundaberg Rum and Cola, etc)
- 09  Spirits (eg rum, brandy, whisky, gin, vodka)
- 10  Liqueurs including premixed liqueurs (eg Tia Maria, Kahlua, Midori, Glide, Illusion etc)
- \*\*  Other (*specify*) \_\_\_\_\_

*You should have crossed only **one** box.*

17. (a) Where, or from whom, **did you get** your **last** alcoholic drink?

*Fill in the space beside 'Other' if you can't find your answer.*

*Cross only **one** box.*

**I didn't buy it ...**

**OR**

**I bought it ...**

- 01  My parent(s) gave it to me
- 02  My brother or sister gave it to me
- 03  I took it from home without my parent(s) permission
- 04  Friends gave it to me
- 05  I got someone to buy it for me → **Go to Question 17(b)**
- \*\*  Other (*specify*)
- \_\_\_\_\_

- 51  At a hotel, pub, bar, tavern, RSL Club
- 52  At a licensed liquor store or supermarket
- 53  At a walk-in bottle-shop at a pub or hotel
- 54  At a drive-in bottle-shop
- 55  At a restaurant
- 56  At a dance venue/dance party
- 57  At a nightclub
- 58  At a sporting event
- 59  At a sports club (eg Leagues, surfing, football)
- 60  Through the Internet
- 61  By phone, fax, mail order
- \*\*  Other (*specify*) \_\_\_\_\_

*You should have crossed only **one** box.*

(b) If someone else bought alcohol for you, who was this person?

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Friend who is 18 or over                           | 4 <input type="checkbox"/> Brother/sister or other relative who is not yet 18 |
| 2 <input type="checkbox"/> Brother/sister or other relative who is 18 or over | 5 <input type="checkbox"/> Stranger who was able to buy alcohol               |
| 3 <input type="checkbox"/> Friend who is not yet aged 18                      | 6 <input type="checkbox"/> Other ( <i>please specify</i> )                    |
- \_\_\_\_\_

18. (a) **Where** did you drink your **last** alcoholic drink?

*Fill in the space beside 'Other' if you can't find your answer.*

*Cross only **one** box.*

**I drank it ...**

- |                             |  |                             |  |
|-----------------------------|--|-----------------------------|--|
| 01 <input type="checkbox"/> | At a beach, park or recreation area      | 08 <input type="checkbox"/> | At a sports club (eg Leagues, surfing, football) |
| 02 <input type="checkbox"/> | At a hotel, pub, bar, tavern or RSL club | 09 <input type="checkbox"/> | At my school                                     |
| 03 <input type="checkbox"/> | At a dance venue/dance party             | 10 <input type="checkbox"/> | At my home                                       |
| 04 <input type="checkbox"/> | At a nightclub                           | 11 <input type="checkbox"/> | At my friend's home                              |
| 05 <input type="checkbox"/> | At a party                               | 12 <input type="checkbox"/> | In a car   |
| 06 <input type="checkbox"/> | At a restaurant                          | ** <input type="checkbox"/> | Other ( <i>specify</i> )                         |
| 07 <input type="checkbox"/> | At a sporting event                      |                             | _____  |

*You should have crossed only **one** box.*

(b) Was an adult supervising you and/or your friends when you had this drink?

- 1  Yes                      2  No

19. How often on an occasion that you drink alcohol, do you intend to get drunk?

- |                            |             |                            |            |
|----------------------------|-------------|----------------------------|------------|
| 1 <input type="checkbox"/> | Never       | 4 <input type="checkbox"/> | Most times |
| 2 <input type="checkbox"/> | A few times | 5 <input type="checkbox"/> | Every time |
| 3 <input type="checkbox"/> | Sometimes   | 6 <input type="checkbox"/> | Don't know |



20. In the past 12 months, after drinking alcohol have you?

- |  |  |
|--|--|
| 01 <input type="checkbox"/> Created a public disturbance or nuisance | 10 <input type="checkbox"/> Had to go to a Hospital Emergency department     |
| 02 <input type="checkbox"/> Stolen something                         | 11 <input type="checkbox"/> Been admitted to hospital overnight              |
| 03 <input type="checkbox"/> Caused damage to property                | 12 <input type="checkbox"/> Had an injury that needed to be seen by a Doctor |
| 04 <input type="checkbox"/> Driven a motor vehicle                   | 13 <input type="checkbox"/> Been taken home by police                        |
| 05 <input type="checkbox"/> Verbally abused someone                  | 14 <input type="checkbox"/> Missed school                                    |
| 06 <input type="checkbox"/> Physically threatened someone            | 15 <input type="checkbox"/> Been sick (vomited)                              |
| 07 <input type="checkbox"/> Hit someone or had a fight               | 16 <input type="checkbox"/> Tried any drugs                                  |
| 08 <input type="checkbox"/> Attended work or school                  | 17 <input type="checkbox"/> Been in trouble with the police                  |
| 09 <input type="checkbox"/> Had an argument                          |  |
- OR**
- 18  Other (please specify) \_\_\_\_\_
- OR**
- 19  None of the above

*You should have **crossed** all that apply.*

**THE NEXT QUESTIONS ARE FOR EVERYONE AND ARE ABOUT SMOKING CIGARETTES.**

21. At the present time, do you consider yourself:

- 1  A heavy smoker?
- 2  A light smoker?
- 3  An occasional smoker?
- 4  An ex-smoker?
- 5  A non-smoker?

22. Have you ever smoked even part of a cigarette?

- 1  No
- 2  Yes, just a few puffs
- 3  Yes, I have smoked fewer than 10 cigarettes in my life
- 4  Yes, I have smoked more than 10 but fewer than 100 cigarettes in my life
- 5  Yes, I have smoked more than 100 cigarettes in my life

23. Have you smoked cigarettes in the last **twelve months**?

1  Yes

2  No

24. Have you smoked cigarettes in the last **four weeks**?

1  Yes

2  No

25. This question is about the number of cigarettes you had during the last **seven days**, including yesterday.

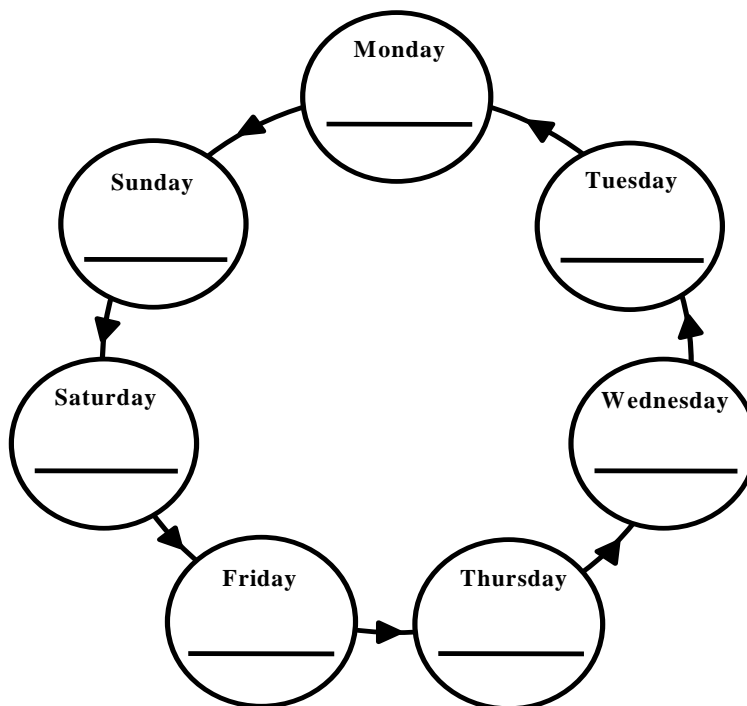
*Put a cross next to **yesterday**. Then in the space provided, write the number of cigarettes you had yesterday. If you didn't smoke any cigarettes, put in '0'.*

*Start filling in the spaces beginning with yesterday, and follow the arrows.*

**Answer for every day of the week.**

*Write the number of cigarettes you smoked each day in the circle.*

*Put '0' for each day you didn't smoke any cigarettes.*



26. Do you think you will be smoking cigarettes this time next year?

- 1  Certain **not** to be smoking
- 2  Very **unlikely** to be smoking
- 3  **Unlikely** to be smoking
- 4  Can't decide how likely
- 5  Likely to be smoking
- 6  Very likely to be smoking
- 7  Certain to be smoking

27. At most shops in the area where you live and go to school, how easy or difficult would it be: (*Cross only **one** box for **each** question*)

- |  | Very<br>easy               | Easy                       | Neither<br>easy nor<br>difficult | Difficult                  | Very<br>difficult          |
|--|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------|
| (i) for you to buy cigarettes?                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/>       | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| (ii) for you to get someone else<br>to buy cigarettes for you? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/>       | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

**QUESTIONS 28, 29 AND 30 ARE ONLY FOR THOSE WHO HAVE SMOKED A CIGARETTE IN THE PAST WEEK.  
IF YOU HAVE NOT SMOKED A CIGARETTE IN THE PAST WEEK, GO TO QUESTION 31.**

28. (a) What brand of cigarettes do you usually smoke?

*Cross the box near the brand you **usually** smoke. If that brand is not listed here, cross the box next to 'Other' and write the name of the brand in the space provided.*

- |   |  |
|---|--|
| 01 <input type="checkbox"/> Alpine          | 10 <input type="checkbox"/> Peter Jackson            |
| 02 <input type="checkbox"/> Benson & Hedges | 11 <input type="checkbox"/> Sterling                 |
| 03 <input type="checkbox"/> Dunhill         | 12 <input type="checkbox"/> Stradbroke               |
| 04 <input type="checkbox"/> Escort          | 13 <input type="checkbox"/> Vogue                    |
| 05 <input type="checkbox"/> Fortune         | 14 <input type="checkbox"/> Wills Super Mild         |
| 06 <input type="checkbox"/> Holiday         | 15 <input type="checkbox"/> Winfield                 |
| 07 <input type="checkbox"/> Horizon         | 16 <input type="checkbox"/> Freedom                  |
| 08 <input type="checkbox"/> Longbeach       | ** <input type="checkbox"/> Other ( <i>specify</i> ) |
| 09 <input type="checkbox"/> Marlboro        | _____  |

*You should have crossed only **one** box.*

(b) Do the cigarettes you usually smoke come from packets of ...?

1  20s?

2  25s?

3  30s?

4  35s?

5  40s?

6  50s?

*Remember: you should have crossed only **one** box.*

29. (a) Where, or from whom, **did you get** the **last** cigarette that you smoked?

*Fill in the space beside 'Other' if you can't find your answer.*

*Cross only **one** box.*

**I didn't buy it ...**

**OR**

**I bought it ...**

01  My parent(s) gave it to me

02  My brother or sister gave it to me

03  I took it from home without my  
parent(s) permission

04  Friends gave it to me

05  I got someone to buy it for  
me → **Go to Question 27(b)**

\*\*  Other (*specify*)  
\_\_\_\_\_

51  At a hotel, pub, bar, tavern, RSL Club

52  At a supermarket

53  At a newsagency

54  At a milk bar or delicatessen

55  At a convenience store (eg Food Plus or 7  
eleven)

56  At a tobacconist/tobacco shop

57  At a take-away food shop

58  At a petrol station

59  Through the Internet

\*\*  Other (*specify*) \_\_\_\_\_

*You should have crossed only **one** box.*

(b) If someone else bought cigarettes for you, who was this person?

1  Friend who is 18 or over

2  Brother/sister or other relative  
who is 18 or over

3  Friend who is not yet aged 18

4  Brother/sister or other relative  
who is not yet 18

5  Stranger who was able to buy  
cigarettes

6  Other (*please specify*)  
\_\_\_\_\_

30. Sometimes people break open a packet of cigarettes and sell single cigarettes. In the last **four weeks**, have you **bought** cigarettes that were **not in a full packet** (for example, buying one or more cigarette(s) at a time)?

1  Yes

2  No

**THE NEXT QUESTIONS ARE FOR EVERYONE AND ARE ABOUT OTHER THINGS YOU MIGHT USE.**

For **each** substance, cross the box which shows how many times you have used the substance during the specified time period. There should only be **one** cross for **each** line of boxes.

31. (a) How many times, if ever, have you used or taken painkillers/analgesics such as Disprin, Panadol or Aspro, **for any reason**:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NEVER used or taken painkiller/analgesics, go to QUESTION 32.*

(b) Last time you used a painkiller/analgesic, did you use it because you ...?

*Cross only **one** box.*

- 1  Had a headache or migraine
- 2  Had a cold or 'flu?
- 3  Had a toothache or pains associated with dental procedure
- 4  Had pains associated with playing sport (eg, injury, strain)
- 5  Had other types of pain (*please specify*) \_\_\_\_\_
- 6  Wanted to – there was no medical reason for using it
- 7  Other (*please specify*) \_\_\_\_\_

(c) Where, or from whom, **did you get** your **last** painkiller/ analgesic?

- 1  My parent(s) gave it to me
- 2  My brother or sister gave it to me?
- 3  I took it from home without my parent(s) permission
- 4  Friends gave it to me
- 5  A member of staff at my school gave it to me
- 6  A member of staff at my sporting club gave it to me
- 7  I bought it
- \*  Other (*please specify*) \_\_\_\_\_

32.(a) How many times, if ever, have you used or taken sleeping tablets, tranquillisers or sedatives, such as Valium, Mogadon, Diazepam, Temazepam (Vallies, Moggies, Jellies), Serepax or Rohypnol (rohies, barbs)? **other than for medical reasons:**

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

***If you have NEVER used or taken benzodiazepines sleeping tablets/sedatives, go to QUESTION 33.***

- (b) In the last year, did you use any other substance or substances on the same occasion that you used benzodiazepines sleeping tablets, tranquillisers or sedatives, such as Valium, Mogadon, Diazepam, Temazepam (Vallies, Moggies, Jellies), Serepax or Rohypnol (rohies, barbs)?

*Cross **all** that apply.*

- |                            |  |                            |  |
|----------------------------|--|----------------------------|--|
| 1 <input type="checkbox"/> | I did not use any other substance on the same occasion | 6 <input type="checkbox"/> | Alcohol  |
| 2 <input type="checkbox"/> | Ecstasy (XTC, E, MDMA, ecci, X, bickies)               | 7 <input type="checkbox"/> | Amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice) |
| 3 <input type="checkbox"/> | Hallucinogens (eg LSD, acid, trips, magic mushrooms)   | 8 <input type="checkbox"/> | Marijuana/cannabis   |
| 4 <input type="checkbox"/> | Painkillers/analgesics                                 | 9 <input type="checkbox"/> | Other (what substance?)  |
| 5 <input type="checkbox"/> | Tobacco  |                            |  |
- 

*You should have crossed **all** that apply.*

- (c) Where, or from whom, do you usually get sedatives/ tranquillisers from?  
Fill in the space beside other if you can't find your answer

*Cross **only one** box.*

- 1  My parent(s) gave it to me
  - 2  I am prescribed sedatives/tranquillisers by my doctor/paediatrician, or psychiatrist
  - 3  My brother or sister gave it to me
  - 4  I took it from home without parent(s) permission
  - 5  I buy them from someone
  - 6  I am given them by someone
  - 7  I trade or swap something for them with someone
  - 8  Other (please specify) \_\_\_\_\_
-

33. (a) How many times, if ever, have you smoked or used marijuana/cannabis (grass, hash, dope, weed, mull, yarndi, ganga, pot, a bong, a joint):

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used marijuana/cannabis in the last year, go to QUESTION 34.*

(b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** marijuana/cannabis?

*Cross all that apply.*

- 1  Tobacco
- 2  Alcohol
- 3  Painkillers/analgesics
- 4  Sedatives/tranquillisers/sleeping tablets
- 5  Hallucinogens (eg LSD, acid, trips, magic mushrooms)
- 6  Amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)
- 7  Ecstasy (XTC, E, MDMA, ecci, X, bickies)
- \*\*  Other (*what substance?*) \_\_\_\_\_
- 8  I did not use any other substance on the same occasion

*You should have crossed all that apply.*

(c) When you use cannabis (marijuana) do you usually:

*Cross only one box.*

- 1  Smoke it as a joint (reefer, spliff)?
- 2  Smoke it from a bong or a pipe?
- 3  Eat it (eg in hash cookies)?
- 4  Other (*specify*) \_\_\_\_\_

*You should have crossed only one box.*



(d) Do you usually use cannabis (marijuana) by yourself or with others?

- 1  By myself
- 2  With others
- 3  By myself and with others about equally often

(e) **Where** did you last use cannabis?

*Fill in the space beside 'Other' if you can't find your answer.*

**I used it ...**

- 01  At a hotel, pub, bar, tavern or RSL club
- 02  At a dance venue, dance party, rave
- 03  At a nightclub
- 04  At a party
- 05  At my home
- 06  At my friend's home
- 07  At a sports club (eg Leagues, surfing, football)
- 08  At the beach
- 09  In a park
- 10  In a car
- 11  At my school
- \*\*  Other (*specify*) \_\_\_\_\_

*You should have crossed only **one** box.*

34. How many times, if ever, have you used or taken steroids (muscle, roids, or gear) **without a doctor's prescription** in an attempt to make you better at sport, to increase muscle size or to improve your general appearance:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

35. How many times, if ever, have you deliberately sniffed (inhaled) from spray cans or deliberately sniffed things like glue, paint, petrol or thinners in order to get high or for the way it makes you feel:

**This does not include sniffing white-out, liquid paper, textas, markers or pens.**

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

36. (a) How many times, if ever, have you used or taken amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice) other than for medical reasons:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used amphetamines in the last year, go to QUESTION 37 (a).*

- (b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)?

*Cross **all** that apply.*

- 1  Tobacco
- 2  Alcohol
- 3  Painkillers/analgesics
- 4  Sedatives/tranquillisers/sleeping tablets
- 5  Hallucinogens (eg LSD, acid, trips, magic mushrooms)
- 6  Marijuana/cannabis
- 7  Ecstasy (XTC, E, MDMA, ecci, X, bickies)
- \*  Other (*what substance?*) \_\_\_\_\_
- 8  I did not use any other substance on the same occasion

*You should have crossed **all** that apply.*

37. (a) How many times, if ever, have you used or taken ecstasy or XTC (E, MDMA, ecci, X, bickies):

	None	Once or twice	3–5 times	6–9 times	10–19 times	20–39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

***If you have NOT used ecstasy in the last year, go to QUESTION 38.***

(b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** ecstasy (XTC, E, MDMA, ecci, X, bickies)?

*Cross **all** that apply.*

- 1  Tobacco
- 2  Alcohol
- 3  Painkillers/analgesics
- 4  Sedatives/tranquillisers/sleeping tablets
- 5  Hallucinogens (eg LSD, acid, trips, magic mushrooms)
- 6  Amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)
- 7  Marijuana/cannabis
- \*\*  Other (*what substance?*) \_\_\_\_\_
- 8  I did not use any other substance on the same occasion

*You should have crossed **all** that apply.*

38. How many times, if ever, have you used or taken cocaine:

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

39. How many times, if ever, have you used or taken heroin (smack, horse, skag, hammer, H), or other opiates (narcotics) such as methadone, morphine or pethidine **other than for medical reasons:**

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

40. (a) How many times, if ever, have you used or taken hallucinogens (eg LSD, acid, trips, magic mushrooms, datura, angel's trumpet):

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
(i) In the <b>last week</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(ii) In the <b>last four weeks</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iii) In the <b>last year</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
(iv) In your <b>lifetime</b> ?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

*If you have NOT used hallucinogens in the last year, go to QUESTION 41.*

(b) In the **last year**, did you use any other substance or substances **on the same occasion that you used** hallucinogens (eg LSD, acid, trips, magic mushrooms, datura, angel's trumpet)?

*Cross **all** that apply.*

- 1  Tobacco
- 2  Alcohol
- 3  Painkillers/analgesics
- 4  Sedatives/tranquillisers/sleeping tablets
- 5  Marijuana/cannabis
- 6  Amphetamines (eg speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice)
- 7  Ecstasy (XTC, E, MDMA, ecci, X, bickies)
- \*\*  Other (*what substance?*) \_\_\_\_\_
- 8  I did not use any other substance on the same occasion

*You should have crossed **all** that apply.*

**THESE QUESTIONS ARE FOR EVERYONE.**

41. **During 2010** (last year), did you have any lessons or parts of lessons at school that were about **smoking cigarettes**?

- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

42. **During 2010** (last year), did you have any lessons or parts of lessons at school that were about **drinking alcohol**?

- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

43. **During 2010** (last year), did you have any lessons or parts of lessons at school that were about **illicit drugs** such as marijuana, ecstasy, heroin, amphetamines (speed, uppers, goey, crystal methamphetamine, base, dex, dexies, dexamphetamines, ox blood, methamphetamine, ice), hallucinogens, cocaine?

- 1  No, not even part of a lesson
- 2  Yes, part of a lesson
- 3  Yes, one lesson
- 4  Yes, more than one lesson

*Remember: last year was 2010.*

**These questions are for everyone and are additional questions about SMOKING**

44. How hard do you think it would be for someone to give up smoking? (Cross one box only)

Impossible	Very hard	Fairly hard	Not too hard	Easy
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

45. Do you think you will smoke cigarettes sometime in the next 6 months?

1 <input type="checkbox"/> Definitely no	3 <input type="checkbox"/> Probably yes
2 <input type="checkbox"/> Probably no	4 <input type="checkbox"/> Definitely yes

46. Would you like to quit smoking?

1 <input type="checkbox"/> Yes	3 <input type="checkbox"/> I am not sure
2 <input type="checkbox"/> No	4 <input type="checkbox"/> I don't smoke

↳ **GO to Question 48**

47. Have you tried to quit smoking in the last 12 months?

1 <input type="checkbox"/> Yes have tried to give up <input type="text"/> times	2 <input type="checkbox"/> I smoke but have not tried to quit in the last 12 months
---	---

48. Have you seen any cigarette advertising in the last 6 months?

(You may cross *more than one* box)

1 <input type="checkbox"/> No	5 <input type="checkbox"/> Yes, on billboards
2 <input type="checkbox"/> Yes, in magazines or newspapers	6 <input type="checkbox"/> Yes, at a sports event
3 <input type="checkbox"/> Yes, on the Internet	7 <input type="checkbox"/> Yes, while watching TV coverage of a sports event
4 <input type="checkbox"/> Yes, in shops or tobacconists	8 <input type="checkbox"/> Yes, at a festival or other event





54. Have you seen any advertisements about quitting smoking in the last 6 months?  
(You may cross **more than one** box)

- |                            |                                 |                            |                        |
|----------------------------|---------------------------------|----------------------------|------------------------|
| 1 <input type="checkbox"/> | No                              | 5 <input type="checkbox"/> | Yes, on billboards     |
| 2 <input type="checkbox"/> | Yes, in magazines or newspapers | 6 <input type="checkbox"/> | Yes, at a sports event |
| 3 <input type="checkbox"/> | Yes, on the Internet            | 7 <input type="checkbox"/> | Yes, on TV             |
| 4 <input type="checkbox"/> | Yes, in shops or tobacconists   | 8 <input type="checkbox"/> | Unsure                 |

**These questions are for everyone and are additional questions about ALCOHOL**

55. Have you ever tried to buy alcohol at a hotel, pub, club, restaurant, and nightclub or bottle shop?

- |                            |                          |                            |                          |
|----------------------------|--------------------------|----------------------------|--------------------------|
| 1 <input type="checkbox"/> | No                       | 2 <input type="checkbox"/> | Yes                      |
|                            | ↳                        |                            | ↳                        |
|                            | <b>Go to QUESTION 60</b> |                            | <b>Go to QUESTION 56</b> |

56. How often have you been refused service in a hotel, club, pub, restaurant, nightclub or bottle shop? (Please cross one box in each line)

	Never	1-4 times	5 or more times
Hotel, pub or club	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Restaurant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Nightclub or dance venue	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Bottle shop	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

57. How often have you been asked for proof of your age or identification (ID) when entering and/or asking for alcohol at a hotel, pub, club, restaurant, nightclub or bottle shop? (Please cross **one** box in each line)

	Never	1-4 times	5 or more times
Hotel, pub or club	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Restaurant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Nightclub or dance venue	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Bottle shop	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

58. How often have you used someone else's identification (ID) or fake identification (ID) to enter and or ask for alcohol at a hotel, club, restaurant, nightclub or bottle shop?

- └─▶ **Go to QUESTION 60**      └─▶ **Go to QUESTION 59**      └─▶ **Go to QUESTION 59**
- 1  No                      2  Yes, Once or twice                      3  Yes, Frequently

59. If you have used someone else's identification (ID) or fake identification (ID), what type of document was it? (You may cross more than one box)

- 1  Someone else's proof of age card or driver's licence  
2  A fake proof of age card  
3  A fake learner's or driver's licence  
4  A genuine learner's or driver's licence that has been altered (eg date of birth)  
5  A stolen proof of age card  
6  A stolen learner's or driver's licence  
7  Other document (please specify) \_\_\_\_\_

60. Have you ever bought alcohol over the Internet or by phone, fax or mail order? (You may cross more than one box)

- 1  No      2  Yes, over the Internet      3  Yes, by phone, fax or mail order

61. In the last 12 months, have you been in a car when the driver appeared to be under the influence of alcohol?

- 1  Yes                      2  No

**These questions are for everyone and are questions about SUN PROTECTION**

62. Please read the following statements and indicate your agreement on the scale.

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Don't Know
There is little chance that I will get skin cancers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Skin cancer can be easily treated because it can be cut out	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
You only get skin cancer if you get sun burnt often	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
A suntan protects you against skin cancers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

63. Over the last summer, did you get sunburn that was sore or tender the next day?

- |  |   |
|--|---|
| 1 <input type="checkbox"/> Yes, just once    | 3 <input type="checkbox"/> Yes, 4 or more times |
| 2 <input type="checkbox"/> Yes, 2 or 3 times | 4 <input type="checkbox"/> No, not at all       |

64. How many times have you used a solarium (sun bed) in the past 12 months?

- |                                 |  |
|---------------------------------|--|
| 1 <input type="checkbox"/> None | 3 <input type="checkbox"/> 2-5 times       |
| 2 <input type="checkbox"/> Once | 4 <input type="checkbox"/> 6 or more times |

65. Do you like to get a suntan?

- |  |   |
|--|---|
| 1 <input type="checkbox"/> No                  | 4 <input type="checkbox"/> Yes, a dark tan      |
| 2 <input type="checkbox"/> Yes, a light tan    | 5 <input type="checkbox"/> Yes, a very dark tan |
| 3 <input type="checkbox"/> Yes, a moderate tan |   |

66. Over the last summer, did you try to get a suntan?

- |  |   |
|--|---|
| 1 <input type="checkbox"/> Yes, just once    | 3 <input type="checkbox"/> Yes, 4 or more times |
| 2 <input type="checkbox"/> Yes, 2 or 3 times | 4 <input type="checkbox"/> No, not at all       |

67. Thinking about sunny days in summer, when you are outside for an hour or more between 11 am and 3 pm, how often would you:

	Never	Rarely	Sometimes	Usually	Always
Wear a hat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Wear clothes covering most of your body (including arms and legs)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Deliberately wear less or briefer clothing so as to get some sun on your skin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Wear maximum protection sunscreen (SPF 30+)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Wear sunglasses	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Stay mainly in the shade	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Spend most of the time inside	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

68. Suppose your skin was exposed to strong sunshine at the beginning of summer with no protection at all. If you stayed in the sun for 30 minutes, would your skin:

- 1  Just burn and not tan afterwards
- 2  Burn first and then tan afterwards
- 3  Not burn at all
- 4  Don't know

<b>These questions are for everyone and are questions about NUTRITION</b>
---

69. How many serves of vegetables do you usually eat each day?

(A serve is equal to ½ cup of cooked vegetables or 1 cup of salad vegetables)

- 1  1 serve or less      4  4 serves      7  I do not eat vegetables
- 2  2 serves      5  5 serves
- 3  3 serves      6  6 serves or more

70. How many serves of fruit do you usually eat each day? (A serve is equal to 1 medium piece or 2 small pieces of fruit, or 1 cup of diced pieces of fruit)

- 1 serve or less      4  4 serves      7  I do not eat fruit
- 2  2 serves      5  5 serves
- 3  3 serves      6  6 serves or more

71. How many serves of bread and/or cereal do you usually eat each day? (A serve is 1 slice of bread, ½ bread roll, ½ cup breakfast cereal, or ½ cup pasta, rice, or noodles)

- |                            |                 |                            |          |                             |                                  |
|----------------------------|-----------------|----------------------------|----------|-----------------------------|----------------------------------|
| 1 <input type="checkbox"/> | 1 serve or less | 5 <input type="checkbox"/> | 5 serves | 9 <input type="checkbox"/>  | 9 serves                         |
| 2 <input type="checkbox"/> | 2 serves        | 6 <input type="checkbox"/> | 6 serves | 10 <input type="checkbox"/> | 10 serves or more                |
| 3 <input type="checkbox"/> | 3 serves        | 7 <input type="checkbox"/> | 7 serves | 11 <input type="checkbox"/> | I do not eat bread and/or cereal |
| 4 <input type="checkbox"/> | 4 serves        | 8 <input type="checkbox"/> | 8 serves |                             |                                  |

72. How many times in the last week did you eat a fast food meal like McDonalds, Hungry Jacks, pizzas, fish and chips, hamburgers, meat pies, pasties etc?

- |                            |         |                            |         |                            |                 |
|----------------------------|---------|----------------------------|---------|----------------------------|-----------------|
| 1 <input type="checkbox"/> | One     | 4 <input type="checkbox"/> | 4 times | 7 <input type="checkbox"/> | 7 or more times |
| 2 <input type="checkbox"/> | Twice   | 5 <input type="checkbox"/> | 5 times | 8 <input type="checkbox"/> | None            |
| 3 <input type="checkbox"/> | 3 times | 6 <input type="checkbox"/> | 6 times |                            |                 |

73. How many times in the last week did you eat snacks like a chocolate bar, a piece of cake, a packet of chips/twisties/corn chips, ice cream, 3-4 sweet biscuits?

- |                            |         |                            |         |                            |                 |
|----------------------------|---------|----------------------------|---------|----------------------------|-----------------|
| 1 <input type="checkbox"/> | One     | 4 <input type="checkbox"/> | 4 times | 7 <input type="checkbox"/> | 7 or more times |
| 2 <input type="checkbox"/> | Twice   | 5 <input type="checkbox"/> | 5 times | 8 <input type="checkbox"/> | None            |
| 3 <input type="checkbox"/> | 3 times | 6 <input type="checkbox"/> | 6 times |                            |                 |

74. How many times in the last week did you drink a can soft drink (like Coke, Pepsi, lemonade, Fanta), an energy drink (like Redbull, V, Wild), fruit juice or have at least 2 glasses of cordial in a row? This does not include diet or low joule drinks.

- |                            |         |                            |         |                            |                 |
|----------------------------|---------|----------------------------|---------|----------------------------|-----------------|
| 1 <input type="checkbox"/> | One     | 4 <input type="checkbox"/> | 4 times | 7 <input type="checkbox"/> | 7 or more times |
| 2 <input type="checkbox"/> | Twice   | 5 <input type="checkbox"/> | 5 times | 8 <input type="checkbox"/> | None            |
| 3 <input type="checkbox"/> | 3 times | 6 <input type="checkbox"/> | 6 times |                            |                 |

75. What type of milk do you usually have? (*Cross one box only*)

- |                            |   |                            |  |
|----------------------------|---|----------------------------|--|
| 1 <input type="checkbox"/> | Whole milk (including flavoured milk and full-cream soy milk)   | 4 <input type="checkbox"/> | Evaporated or sweetened condensed milk |
| 2 <input type="checkbox"/> | Reduced fat milk (eg. Lite White, Farmer's Best, Hi-Lite, So Good Lite, Oak and reduced fat flavoured milk) | 5 <input type="checkbox"/> | None of the above                      |
| 3 <input type="checkbox"/> | Skim milk (including Shape)   | 6 <input type="checkbox"/> | I don't know                           |

76. How many cups of water do you usually drink? (One cup=250ml or a household teacup; 1 average bottle of water=1.5 cups)

- |                            |  |                            |              |
|----------------------------|--|----------------------------|--------------|
| 1 <input type="checkbox"/> | Number of cups per day <input type="text"/> cups | 3 <input type="checkbox"/> | I don't know |
| 2 <input type="checkbox"/> | I don't drink water                              |                            |              |

77. What is your normal source of drinking water? (*Cross one box only*)

- |                            |                     |                            |  |
|----------------------------|---------------------|----------------------------|--|
| 1 <input type="checkbox"/> | Public water supply | 4 <input type="checkbox"/> | Private bore, spring or well                 |
| 2 <input type="checkbox"/> | Bottled water       | 5 <input type="checkbox"/> | Other private supply (eg. creek or farm dam) |
| 3 <input type="checkbox"/> | Rainwater           | 6 <input type="checkbox"/> | Combination of different water sources       |
|                            |                     | 7 <input type="checkbox"/> | Other [SPECIFY]<br><input type="text"/>      |

78. How tall are you without shoes:

- Centimetres or  Feet or  Inches    1  I don't know

79. How much do you weight without clothes or shoes?

- Kilograms or  Stones or  Lbs    1  I don't know

80. Do you think of yourself as being too thin, about the right weight, or too fat?

- |                            |                        |                            |                      |
|----------------------------|------------------------|----------------------------|----------------------|
| 1 <input type="checkbox"/> | Too thin (underweight) | 3 <input type="checkbox"/> | Too fat (overweight) |
| 2 <input type="checkbox"/> | About the right weight |                            |                      |

81. Which of the following are you trying to do about your weight?

- |                            |             |                            |  |
|----------------------------|-------------|----------------------------|--|
| 1 <input type="checkbox"/> | Lose weight | 3 <input type="checkbox"/> | Stay the same weight                           |
| 2 <input type="checkbox"/> | Gain weight | 4 <input type="checkbox"/> | I am not trying to do anything about my weight |

**These questions are for everyone and are questions about PHYSICAL ACTIVITY**

82. How many times in the last week did you:

			3	4	5	6 or more	
	None	Once	Twice	times	times	times	times

Do any vigorous physical activity for at least 30 minutes that made you sweat and breathe hard? (eg basketball, netball, soccer, football, running, fast bike riding, aerobics)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Do any moderate physical activity for at least 30 minutes that did not make you sweat or breathe hard? (eg slow bike riding, housework, brisk walking, pushing a lawnmower)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

83. How many days in the past week have you done any vigorous or moderate physical activity for a total of at least 60 minutes? (this could be made up of different activities during the day like cycling or walking to and from school, playing sport at lunchtime or after school, doing an exercise class, doing housework etc)

- |                            |        |                            |        |                            |                          |
|----------------------------|--------|----------------------------|--------|----------------------------|--------------------------|
| 1 <input type="checkbox"/> | 1 day  | 4 <input type="checkbox"/> | 4 days | 7 <input type="checkbox"/> | 7 days                   |
| 2 <input type="checkbox"/> | 2 days | 5 <input type="checkbox"/> | 5 days | 8 <input type="checkbox"/> | No days in the last week |
| 3 <input type="checkbox"/> | 3 days | 6 <input type="checkbox"/> | 6 days |                            |                          |

84. On an average school day, about how many hours a day do you do the following when you are not at school:

	None	1 hour or less	2 Hours	3 Hours	4 Hours	5 or more hours
Homework	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Watch TV/videos/DVDs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Use the Internet/playing computer games? (Don't include computer use for homework)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

85. Outside school time, how many hours a day on average do you usually watch TV, videos or DVDs?

a) **On Monday to Friday**  
(Cross only *one* box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day

b) **On Saturday and Sunday**  
(Cross only *one* box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day

86. Outside school time how many hours a day on average do you usually use computers for entertainment or to play video games (eg. surfing the net, Playstation, Nintendo)?

a) **On Monday to Friday**  
(Cross only *one* box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day

b) **On Saturday and Sunday**  
(Cross only *one* box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day



87. Outside school time, how many hours a day on average do you usually use computers for study or school work?

a) **On Monday to Friday**

(Cross only **one** box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day

b) **On Saturday and Sunday**

(Cross only **one** box)

- 1  Not at all
- 2  1 hour or less a day
- 3  2 hours a day
- 4  3 hours a day
- 5  4 hours a day
- 6  5 hours or more a day

**These questions are for everyone and are questions about how you have been feeling in the past 6 months.**

88. During the last six months, was there a time when you felt unhappy, sad or depressed? (*Please cross **one** box only*)

- 1  No —————> **Please go to QUESTION 92**
- 2  Yes, at home and at school
- 3  Yes, but only at home
- 4  Yes, but only at school

89. When you were feeling unhappy, sad or depressed, how bad was it for you? (*Please cross **one** box only*)

- 1  Almost more than I could take
- 2  Quite bad
- 3  Worse than usual
- 4  About usual

90. When you were feeling unhappy, sad or depressed, who did you talk to about it? (*You may cross **more than one** box*)

- 1  No one —————> **Please go to QUESTION 92**
- 2  My family
- 3  My friend/s
- 4  Teachers or school counsellors
- 5  Doctors or other health professionals
- 6  Religious advisors or groups
- 7  Helpline/ Internet etc
- 8  Other person or group (please describe)

91. If you talked to someone about feeling unhappy, sad or depressed, how helpful were they? (*Cross one box only*)

- |   |  |
|---|--|
| 1 <input type="checkbox"/> Not at all helpful | 3 <input type="checkbox"/> Quite helpful |
| 2 <input type="checkbox"/> Somewhat helpful   | 4 <input type="checkbox"/> Very helpful  |

92. During the last six months, was there a time when you felt nervous, stressed, or under pressure? (*Cross one box only*)

- |   |  |
|---|--|
| 1 <input type="checkbox"/> No → <b>Please go to QUESTION 96</b> | 3 <input type="checkbox"/> Yes, but only at home   |
| 2 <input type="checkbox"/> Yes, at home and at school           | 4 <input type="checkbox"/> Yes, but only at school |

93. When you were feeling nervous, stressed, or under pressure, how bad was it for you? (*Cross one box only*)

- |  |   |
|--|---|
| 1 <input type="checkbox"/> Almost more than I could take | 3 <input type="checkbox"/> Worse than usual |
| 2 <input type="checkbox"/> Quite bad                     | 4 <input type="checkbox"/> About usual      |

94. When you were feeling nervous, stressed, or under pressure, who did you talk to about it? (*You may cross more than one box*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> No one → <b>Please go to QUESTION 96</b> | 5 <input type="checkbox"/> Doctors or other health professionals                        |
| 2 <input type="checkbox"/> My family                                | 6 <input type="checkbox"/> Religious advisors or groups                                 |
| 3 <input type="checkbox"/> My friend/s                              | 7 <input type="checkbox"/> Helpline/ Internet etc                                       |
| 4 <input type="checkbox"/> Teachers or school counsellors           | 8 <input type="checkbox"/> Other person or group (please describe) <input type="text"/> |

95. If you talked to someone about feeling nervous, stressed, or under pressure, how helpful were they? (*Cross one box only*)

- |   |  |
|---|--|
| 1 <input type="checkbox"/> Not at all helpful | 3 <input type="checkbox"/> Quite helpful |
| 2 <input type="checkbox"/> Somewhat helpful   | 4 <input type="checkbox"/> Very helpful  |

96. During the last six months, was there a time when you were in trouble because of your behaviour? (*Cross **one** box only*)

- 1  No → **Please go to QUESTION 100**      3  Yes, but only at home  
2  Yes, at home and at school                      4  Yes, but only at school

97. When you were in trouble because of your behaviour, how bad was it for you? (*Cross **one** box only*)

- 1  Almost more than I could take                      3  Worse than usual  
2  Quite bad `    4  About usual

98. When you were in trouble because of your behaviour, who did you talk to about it? (*You may cross **more than one** box*)

- 1  No one → **Please go to QUESTION 100**                      5  Doctors or other health professionals  
2  My family    6  Religious advisors or groups  
3  My friend/s    7  Helpline/ Internet etc  
4  Teachers or school counsellors                      8  Other person or group (please describe)

99. If you talked to someone about being in trouble because of your behaviour, how helpful were they? (*Cross **one** box only*)

- 1  Not at all helpful    2  Somewhat helpful  
3  Quite helpful    4  Very helpful

**These questions are for everyone and are questions about problems that may have impact on school performance.**

100. During the last six months, was there a time when you had problems studying at home or school that affected your performance in school tests and other work? (*Cross **one** box only*)

- 1  No → **Please go to QUESTION 104**                      3  Yes, but only at home  
2  Yes, at home and at school                              4  Yes, but only at school

101. When you were having those study problems, how bad was it for you? (*Cross one box only*)

- |                            |                               |                            |                  |
|----------------------------|-------------------------------|----------------------------|------------------|
| 1 <input type="checkbox"/> | Almost more than I could take | 3 <input type="checkbox"/> | Worse than usual |
| 2 <input type="checkbox"/> | Quite bad`                    | 4 <input type="checkbox"/> | About usual      |

102. When you were having those study problems, who did you talk to about it? (*You may cross more than one box*)

- |                            |                                |  |                            |   |
|----------------------------|--------------------------------|--|----------------------------|---|
| 1 <input type="checkbox"/> | No one                         | → <b>Please go to<br/>QUESTION 104</b> | 5 <input type="checkbox"/> | Doctors or other health<br>professionals                        |
| 2 <input type="checkbox"/> | My family                      |  | 6 <input type="checkbox"/> | Religious advisors or groups                                    |
| 3 <input type="checkbox"/> | My friend/s                    |  | 7 <input type="checkbox"/> | Helpline/ Internet etc  |
| 4 <input type="checkbox"/> | Teachers or school counsellors |  | 8 <input type="checkbox"/> | Other person or group (please<br>describe) <input type="text"/> |

103. If you talked to someone about having those study problems, how helpful were they? (*Cross one box only*)

- |                            |                    |                            |                  |
|----------------------------|--------------------|----------------------------|------------------|
| 1 <input type="checkbox"/> | Not at all helpful | 2 <input type="checkbox"/> | Somewhat helpful |
| 3 <input type="checkbox"/> | Quite helpful      | 4 <input type="checkbox"/> | Very helpful     |

**These questions are for everyone and are questions about INJURY**

104. In the past 6 months have you hurt yourself or had an injury for which you had to see a doctor, physiotherapist or another health professional?

- |                            |                           |                            |                           |
|----------------------------|---------------------------|----------------------------|---------------------------|
| 1 <input type="checkbox"/> | No                        | 2 <input type="checkbox"/> | Yes                       |
|                            | └─→                       |                            | └─→                       |
|                            | <b>Go to QUESTION 106</b> |                            | <b>Go to QUESTION 105</b> |

105. What were you doing the most recent time you were hurt or injured and required medical attention from a doctor, physiotherapist or another health professional? (*You may cross **more than one** box*)

- |                            |  |                            |  |
|----------------------------|--|----------------------------|--|
| 1 <input type="checkbox"/> | School activity (including school sport)           | 5 <input type="checkbox"/> | Travelling in a vehicle                          |
| 2 <input type="checkbox"/> | Sport (playing or training; excludes school sport) | 6 <input type="checkbox"/> | Travelling on foot or on wheels                  |
| 3 <input type="checkbox"/> | Leisure or play                                    | 7 <input type="checkbox"/> | Doing any other activity<br><input type="text"/> |
| 4 <input type="checkbox"/> | Working for money                                  |                            |  |

106. Which of the following dental injuries have you ever had? (*You may cross **more than one** box*)

- |                            |   |                            |                   |
|----------------------------|---|----------------------------|-------------------|
| 1 <input type="checkbox"/> | None  | 4 <input type="checkbox"/> | A fractured tooth |
| 2 <input type="checkbox"/> | A tooth was completely knocked out                  | 5 <input type="checkbox"/> | Other (specify)   |
| 3 <input type="checkbox"/> | A tooth was loosened but not completely knocked out |                            |                   |

Thank you very much for your help  
You have completed the survey!