

[Raw data coding](#)



Twin Report

TEDS-21 Study

Part Two

Please answer all questions as best you can even if you are unsure or if the question seems repetitive.

Please indicate your answers with a cross

If you make a mistake, shade out and cross the appropriate box, e.g. →

Please remember to complete this questionnaire using BLACK ink only.

Thank you for taking part in this study. Your contribution is very important to us.

Confidentiality

We understand that your thoughts and feelings are private. Please be assured that all responses will remain confidential, and will only be read by the researcher. All responses will be kept in accordance with the Data Protection Act 1998.

TEDS21 Phase 2 Twin Questionnaire: Raw Data Coding

This document shows response value coding for all items in the raw data from the TEDS21 phase 2 twin questionnaire. The layout and ordering of the questions are based on the paper booklet version. However, the formatting has been modified in order to accommodate value codes; for example, font sizes and table layouts have been changed, and page numbering has been removed.

Raw data were collected in three ways: on paper, in the app (CMS) and via the web (backup).

The raw data from the paper questionnaire are stored in tables in the Access database and are exported as csv files for dataset construction.

The original raw data files from the app and web servers have now been cleaned and aggregated together into a single csv file for dataset construction. As part of the cleaning process, item variable coding was changed where necessary so that the coding now matches that used in the paper data.

The raw item data coding is shown in this blue font, and this coding is identical in all versions (paper, app, web).

This red font is used to show the corresponding value coding in the dataset. Another document shows the dataset variable names in addition to value codes for every item, but for reasons of space the variable names are not duplicated here.

In the electronic (app and web) versions, the ordering of sections of questions differed slightly and the wording of introductions was sometimes different. However, the wording of actual questions and responses was the same as in the paper version.

Many measures are tabulated and have a consistent response value coding for all items, and in these cases the coding is shown in the table heading and not for every single item. If the coding differs for different items within the same table, then the code values are shown for each item within the body of the table.

In the backup and CMS versions, many items in this questionnaire had an explicitly coded "prefer not to answer" response option. These have been recoded to missing in the raw data (and hence in the dataset) for compatibility with the paper version.

Relationships

The questions on this page and the next are about the frequency of contact that you have with your parent-figures. Please note that they do not have to be biologically related to you (for example they could be step-parents).

The following 4 questions are about your mother or mother-figure. If you do not want to answer questions about your mother, please skip to the next page.

Approximately how close does your mother live to you?

Live together	<input type="checkbox"/>	1	1
Walking distance	<input type="checkbox"/>	2	2
Under an hour	<input type="checkbox"/>	3	3
A few hours' drive away	<input type="checkbox"/>	4	4
More than 5 hours' drive away	<input type="checkbox"/>	5	5
Lives in a different country	<input type="checkbox"/>	6	6
I do not know	<input type="checkbox"/>	7	7

If you answered "live together", then please skip questions 2 to 4.

1. When did you last see your mother?

Within the last 12 months 1	One year ago 2	Two to five years ago 3	Six or more years ago 4	Never met her 5
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

2. During the last 12 months, about how often did you see your mother? (Skip this question if you have not seen your mother within the last 12 months).

Every day 1	More than once a week 2	About once a week 3	1-3 times a month 4	Several times 5	About once 6
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

3. During the last 12 months, about how often have you communicated with your mother (in person, by phone, email, Skype, etc.)?

Every day 1	More than once a week 2	About once a week 3	1-3 times a month 4	Several times 5	About once 6	Not at all 7
<input type="checkbox"/> 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

The following 4 questions are about your father or father-figure. If you do not want to answer questions about your father, please skip to the next page.

1. Approximately how close does your father live to you?

Live together	<input type="checkbox"/>	1	1
Walking distance	<input type="checkbox"/>	2	2
Under an hour	<input type="checkbox"/>	3	3
A few hours' drive away	<input type="checkbox"/>	4	4
More than 5 hours' drive away	<input type="checkbox"/>	5	5
Lives in a different country	<input type="checkbox"/>	6	6
I do not know	<input type="checkbox"/>	7	7

If you answered "live together", then please skip questions 2 to 4.

2. When did you last see your father?

Within the last 12 months	One year ago	Two to five years ago	Six or more years ago	Never met him
1	2	3	4	5
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

3. During the last 12 months, about how often did you see your father? (Skip this question if you have not seen your father within the last 12 months).

Every day	More than once a week	About once a week	1-3 times a month	Several times	About once
1	2	3	4	5	6
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

4. During the last 12 months, about how often have you communicated with your father (in person, by phone, email, Skype, etc.)?

Every day	More than once a week	About once a week	1-3 times a month	Several times	About once	Not at all
1	2	3	4	5	6	7
<input type="checkbox"/> 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

To what extent do you agree with the following statements?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	1	2	3	4	5
	1	2	3	4	5
1. It is important to me to feel I am or will be an effective parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I expect my job/career to give me more real satisfaction than anything else I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Having a comfortable and attractive home is of great importance to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I devote (or expect to devote) a significant amount of my time and energy to the rearing of my children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would value being involved in a career and expect to devote the time and effort needed to develop it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I want a place to live, but I do not really care how it looks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Although parenthood requires many sacrifices, the love and enjoyment of children of one's own are worth it all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Having work/a career that is interesting and exciting to me is an important life goal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Having a nice home is something to which I am very committed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am (or expect to be) very involved in the day-to-day matters of rearing my children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. This is a quality control item, please select 'Disagree'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I expect to devote a significant amount of my time to building my career and developing the skills necessary to advance in my career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. To have a well-run home is one of my life goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions ask about negative experiences in your childhood. We know that this is a sensitive subject, but it is important to ask as some of these experiences are not uncommon. You may find answering some of these questions distressing. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

For the items below, the CMS and backup versions also had a "prefer not to answer" response option but this has been recoded to missing.

	Never	Rarely	Sometimes	Often	Very often
	0	1	2	3	4
	1	2	3	4	5
When you were a child, how often did an adult in your family shout at you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult say hurtful or insulting things to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is a quality control question, please select 'Rarely'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult push, grab or shove you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult smack you for discipline?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult punish you in a way that seemed cruel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult threaten to kick, punch, or hit you with something that could hurt you, or physically attack you in another way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult actually kick, punch, or hit you with something that could hurt you, or physically attack you in another way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, how often did an adult hit you so hard it left you with bruises or marks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you would like to talk to a trained professional about any of the issues raised on this page, you can call the **Samaritans** for free on 116 123 (24 hours a day, 365 days a year) from any phone.

Life Experiences

To what extent do you identify with the following statements?

	Not at all like me	Not much like me	Somewhat like me	Mostly like me	Very much like me
	0	1	2	3	4
	1	2	3	4	5
I aim to be the best in the world at what I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am ambitious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Achieving something of lasting importance is the highest goal in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think achievement is overrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am driven to succeed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hassles are irritants or things that annoy or bother you. This table lists things that can be hassles in day-to-day life. Please think about how much of a hassle each item is for you on a typical day.

	None or not applicable	Not very	Somewhat	Quite a bit	A great deal
	0	1	2	3	4
	1	2	3	4	5
Inner concerns (inner conflicts, regrets, physical appearance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finances (financial security, bills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time management (responsibilities, social events)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work (promotion, job satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environment (pollution, crime, traffic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family (children, parents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health (physical, mental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Listed below are a number of events that may have brought substantial changes in your life, both positive and negative.

Have any of these occurred since you were 16 years of age, and did they affect you?

Since you were 16 years of age ...	No, did not happen	Yes, but didn't affect me at all	Yes, mildly affected me	Yes, moderately affected me	Yes, affected me a lot
	0	1	2	3	4
	1	2	3	4	5
1. You became homeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. You or your partner became pregnant or had a baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. You lost your job or got into serious financial problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. You were divorced or separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. You were admitted to hospital or became seriously ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. You were in trouble with the law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You were the victim of a serious crime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Someone close to you died	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. This is a quality control question, please select 'Yes, but didn't affect me at all'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. You attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. You or your partner had an abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Your parents divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you would like to talk to a trained professional about any of the issues raised on this page, you can call the **Samaritans** for free on 116 123 (24 hours a day, 365 days a year) from any phone.

Behaviour

To what extent do the following statements accurately describe you?

	Not true at all	Somewhat true	Mainly true	Definitely true
	0	1	2	3
	1	2	3	4
1. It is hard for me to pay attention to details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I make mistakes by accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have trouble keeping my mind on what I am doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have trouble keeping my mind on what other people are saying to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have trouble following instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have trouble finishing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have trouble keeping myself organised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I do not like doing things that make me think hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I lose stuff that I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I get distracted by things that are going on around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I forget stuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. This is a quality control item, please select 'Mainly true'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. It is hard for me to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I get out of my seat when I am not supposed to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I am restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I have trouble doing things quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I like to be on the go rather than being in one place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I talk too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I blurt out the answer before a question is finished	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I have trouble waiting for my turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I interrupt other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each of the following statements, please indicate how often you have had the thought or feeling described.

	Not at all	Rarely	Once a month	Once a week	Several times a week	Daily
	0	1	2	3	4	5
	1	2	3	4	5	6
1. Someone has bad intentions towards me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bad things are being said about me behind my back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. People are being hostile towards me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. People are trying to upset me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Someone has it in for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. People are looking at me in an unfriendly way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. There might be negative comments being spread about me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People might be conspiring against me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am under threat from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. People are laughing at me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. People would harm me if given an opportunity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. People are deliberately trying to irritate me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I need to be on my guard against others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I might be being observed or followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I can detect coded messages about me in the press/TV/internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I hear sounds or music that people near me don't hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I see things that other people cannot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I feel that someone is touching me, but when I look nobody is there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I hear noises or sounds when there is nothing about to explain them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I detect smells which don't seem to come from my surroundings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I see shapes, lights, or colours even though there is nothing really there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I notice smells or odours that people next to me seem unaware of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I experience unusual burning sensations or other strange feelings in or on my body that can't be explained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. This is a quality control question, please select 'Once a month'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I hear voices commenting on what I'm thinking or doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are affected by any of the issues raised on this page, you may wish to contact the mental health charity **Mind** on 0300 123 3393 or visit their website: www.mind.org.uk.

Substance Use

The questions on this and the next page are about drinking **alcohol** (this includes beer, wine, alcopops, cider, and spirit drinks like vodka).

If you prefer not to answer these questions, please skip them and move on to page 12.

1. Have you ever had a whole drink? (For example: a small bottle or half a pint of beer, a small glass of wine, or a shot of whisky, gin or vodka).

A "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

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

If **Yes**, please answer questions 2-14 below.

If **No**, please skip these questions and go to page 12.

2. How old were you the first time you had a whole drink?

Less than 10	10-12	13-15	16-18	Over 18
1	2	3	4	5
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

3. Think about the occasion on which you drank the most alcohol you've **ever had in a 24-hour period**. On that occasion, how many of each of the following did you drink? (Choose from the options below, for example: 3-5 pints of beer and 1-2 shots).

	0	1-2	3-5	6-10	11-15	16-20	21-25	26 or more
	1	2	3	4	5	6	7	8
	0	1	2	3	4	5	6	7
Standard glass of wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pint of lager/beer/cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcopop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Single shot of spirit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How often do you have a drink containing alcohol?

Never / almost never	Monthly or less	2-4 times a month	2-3 times per week	4 or more times per week
1	2	3	4	5
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

5. Thinking about a typical day when you are drinking how many of the following do you drink?

	0	1-2	3-5	6-10	11-15	16-20	21-25	26 or more
	1	2	3	4	5	6	7	8
	0	1	2	3	4	5	6	7
Standard glass of wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pint of lager/beer/cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcopop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Single shot of spirit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions about your drinking **in the past year**.

	Never / almost never	Less than monthly	Monthly	Weekly	Daily / almost daily
	1	2	3	4	5
	0	1	2	3	4
6. During the past year, how often have you had six or more units of alcohol on one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past year, how often have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, how often have you failed to do what was normally expected of you because of drinking (e.g., go to college/university/work, play sport or go out with family and friends)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. This is a quality control question, please select 'Less than monthly'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. During the past year, how often have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past year, how often have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. During the past year, how often have you been unable to remember what happened the night before because you had been drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions about your drinking **in the past year**.

	No	Yes, but not in the past year	Yes, once	Yes, a couple of times	Yes, frequently
	1	2	3	4	5
	0	1	2	3	4
13. During the past year have you, or has someone else, been injured as a result of your drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. During the past year has anyone (e.g., a relative, friend or doctor) been concerned about your drinking or suggested you cut down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For confidential advice and information about drinking, **Drinkline** runs a free helpline. Their number is: 0300 123 1110 (weekdays 9am-8pm, weekends 11am-4pm).

The next 12 questions are about **smoking**. If you prefer not to answer these questions, please skip them.

1. Have you ever smoked a cigarette (including roll-ups)?

A "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

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

If **Yes**, please answer the questions below.

If **No**, please skip these questions and go to question 10.

2. How many cigarettes have you smoked altogether in your lifetime?

1-10	11-50	51-100	101-250	251-500	501-1000	Over 1000
1	2	3	4	5	6	7
<input type="checkbox"/> 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

3. How old were you when you first smoked a whole cigarette?

10 or younger	11	12	13	14	15	16 or older
1	2	3	4	5	6	7
<input type="checkbox"/> 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

Please answer questions 4 to 9 if you currently smoke.

If you do not currently smoke, skip these questions and go to question 10 on the next page.

4. Which cigarette would you most hate to give up?

A "not applicable" response was included in the app and web versions, to enable branching away from the following questions. This response has been recoded to missing.

The first one in the morning	Any others
1	2
<input type="checkbox"/> 1	<input type="checkbox"/> 2

5. How soon after you wake up do you smoke your first cigarette?

Within 5 minutes	6-30 minutes	31-60 minutes	More than an hour
1	2	3	4
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

6. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, buses, trains, the library, cinemas)?

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

7. How many cigarettes a day do you smoke?

10 or less	11-20	21-30	31 or more
1	2	3	4
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

8. Do you smoke more frequently during the first hours after waking than during the rest of the day?

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

9. Do you smoke if you are so ill that you are in bed most of the day?

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

10. Have you ever vaped/used an electronic cigarette

(also known as e-cigarettes or e-cigs)?

A "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

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

If Yes, please answer questions 11-12 below.

If No, please skip these questions.

11. How long have you used electronic cigarettes for?

The "not applicable" response is recoded to missing in the dataset.

Less than one month 1 <input type="checkbox"/> 1	1-3 months 2 <input type="checkbox"/> 2	3-6 months 3 <input type="checkbox"/> 3	6 months - 1 year 4 <input type="checkbox"/> 4	1-2 years 5 <input type="checkbox"/> 5	More than 2 years 6 <input type="checkbox"/> 6	Not applicable 0 <input type="checkbox"/>
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12. How often do you use electronic cigarettes?

I've only tried once/a few times 1 <input type="checkbox"/> 1	Less than once a month 2 <input type="checkbox"/> 2	At least once a month 3 <input type="checkbox"/> 3	At least once a week 4 <input type="checkbox"/> 4	At least once a day 5 <input type="checkbox"/> 5	Every few hours 6 <input type="checkbox"/> 6
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For confidential advice and information on smoking, including giving up smoking, **Smokefree National Helpline** can be reached on 0300 123 1044 (weekdays 9am-8pm, weekends 11am-4pm).

Questions 1 to 5 below are about **cannabis**. Please remember that your answers to all these questions are confidential. If you prefer not to answer these questions, please skip them.

1. Have you ever tried cannabis (also called marijuana, hash, dope, pot, blow, skunk, puff, grass, draw, ganja, spliff, joint, smoke, weed)?

A "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

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

If Yes, please answer questions 2-5 below.

If No, please skip these questions and go to the next page.

2. How old were you when you first tried cannabis?

11 or younger 1 <input type="checkbox"/> 1	12 2 <input type="checkbox"/> 2	13 3 <input type="checkbox"/> 3	14 4 <input type="checkbox"/> 4	15 5 <input type="checkbox"/> 5	16 6 <input type="checkbox"/> 6	17 or older 7 <input type="checkbox"/> 7
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3. When you smoke cannabis, on a typical day, how many joints/spliffs/pipes or bongs would you have?

The "not applicable" response is recoded to missing in the dataset.

1 1 <input type="checkbox"/> 1	2-3 2 <input type="checkbox"/> 2	4-5 3 <input type="checkbox"/> 3	6-10 4 <input type="checkbox"/> 4	More than 10 5 <input type="checkbox"/> 5	Not applicable 0 <input type="checkbox"/>
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4. In the last 12 months how often have you used cannabis?

Not in the last 12 months 1	Once or twice 2	Less than monthly 3	Monthly 4	Weekly 5	Daily or almost daily 6
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

5. The questions below are about your use of cannabis in the **past 12 months**. If you haven't used cannabis in the past 12 months, please skip these questions and go to the next set of questions.

	Never / almost never 1	Rarely 2	From time to time 3	Fairly often 4	Often 5
	0	1	2	3	4
a) During the past 12 months, how often have you used cannabis before midday?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the past 12 months, how often have you used cannabis when you were alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the past 12 months, how often have you had memory problems when you've used cannabis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) During the past 12 months, how often have friends or members of your family told you that you ought to reduce your cannabis use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) During the past 12 months, how often have you tried to reduce or stop your cannabis use without succeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) During the past 12 months, how often have you had problems because of your use of cannabis (an argument, fight, accident, bad result at college/university, or other problems)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following 5 questions are about **cognitive enhancers**. A cognitive enhancer is defined as any drug taken specifically for the purpose of improving cognitive performance (memory, attention, thinking speed, etc.). If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

In each of these questions, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

	No, never	Yes, once or twice	Yes, 3-5 times	Yes, 6-10 times	Yes, more than 10 times
	1	2	3	4	5
	0	1	2	3	4
1. Have you ever tried to enhance your cognitive performance by using over-the-counter products? Examples of such products are caffeine tablets, caffeinated drinks or energy drinks and ginkgo biloba.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. This is a quality control question, please select 'Yes, 3-5 times'.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever tried to enhance your cognitive performance by using drugs that are normally prescribed for other purposes? Examples of such drugs are Ritalin, Adderall, Modafinil, antidepressants, sedatives, beta-blockers and anti-dementia agents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If Yes, were you prescribed this drug yourself, or did you obtain it by other means?		Prescribed <input type="checkbox"/> 1 1		Other means <input type="checkbox"/> 2 2	
5. Have you ever tried to enhance your cognitive performance by using illicit or illegal drugs? Examples of such drugs are ecstasy, MDMA, crystal meth, cocaine, speed, GHB or GBL.	No, never <input type="checkbox"/> 0	Yes, once or twice <input type="checkbox"/> 1	Yes, 3-5 times <input type="checkbox"/> 2	Yes, 6-10 times <input type="checkbox"/> 3	Yes, more than 10 times <input type="checkbox"/> 4
	1	2	3	4	5

The remaining questions on this page are about **illicit or illegal drugs**. Please remember that your answers to all questions are confidential. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

In each of these questions about drugs, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

1. Have you ever taken any illicit/illegal drugs?

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

If Yes, please answer questions 2-8 below.

If No, please skip these questions and go to the next page.

	No, not at all	Just once	2-5 times	6-10 times	More than 10 times
	1	2	3	4	5
	0	1	2	3	4
2. Have you ever taken cocaine (charlie, 'c', coke, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever taken crack (rock, stone, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken amphetamine-type stimulants (ecstasy, MDMA, speed, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken inhalants (nitrous, glue, petrol, paint thinner, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken sedatives or sleeping pills (Valium, etc.) recreationally, without a prescription?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken hallucinogens (LSD, acid, mushrooms, PCP, Ketamine ('Special K'), etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken opioids (heroin, morphine, methadone, codeine, etc.) recreationally, without a prescription?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For confidential advice and information on drug use, you can call the drug advice helpline **FRANK** on 0300 123 6600 (24 hours a day 365 days a year).

Conflict

The following questions are about your actions **in the past 12 months**.

During the last year ...	Not in the last year (or never)	Once	2-5 times	6-10 times	More than 10 times
	1	2	3	4	5
	0	1	2	3	4
1. How often have you been rowdy or rude in a public place, so that people complained or you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often have you stolen something from a shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often have you bought something that you knew or suspected was stolen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often have you broken into a car or van to try to steal something out of it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often have you taken and/or driven a vehicle without the owner's permission?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often have you broken into a house or building to try to steal something?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often have you stolen any money or property that someone was holding, carrying or wearing at the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If you have stolen in this way , on how many of these occasions did you use threats or actual force or violence against the other person? (skip if not applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How often have you hit, kicked or punched someone else on purpose, with the intention of really hurting them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How often have you deliberately damaged or destroyed property that did not belong to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How often have you hurt or injured animals or birds on purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. This is a quality control question, please select '6-10 times'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often have you carried a knife or other weapon with you for protection, or in case it was needed in a fight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. If you have carried a weapon in this way , did you actually use this weapon against somebody? (skip if not applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the last year ...	Not in the last year (or never)	Once	2-5 times	6-10 times	More than 10 times
	1	2	3	4	5
	0	1	2	3	4
15. How often have you used a cheque book, credit card or cash point card which you knew or suspected to be stolen, to get money out of a bank account or to purchase something?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. How many times did you sell an illegal drug to someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. How many times did you set fire or try to set fire to something on purpose (e.g., a school, bus shelter, house, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following 6 questions are about criminality. As always, all of your responses are confidential. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

In these questions about criminality, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

1. Have you ever been cautioned by the police?

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

2. Have you ever been arrested?

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

If Yes, please answer questions 3-6 below.

If No, please skip these questions and go to the next page.

3. How many times have you been arrested?

Once	2-4 times	5-7 times	8-10 times	More than 10 times
1	2	3	4	5
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

4. How many nights have you spent in a police cell?

None	1 night	2-4 nights	5-7 nights	8 or more nights
1	2	3	4	5
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

5. Have you ever been sentenced to prison?

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

If Yes, please answer question 6.

6. How much time were you sentenced to spend in prison?

1-6 days	1	1	<input type="checkbox"/>	1-2 years	5	5	<input type="checkbox"/>
1-4 weeks	2	2	<input type="checkbox"/>	2-5 years	6	6	<input type="checkbox"/>
1-5 months	3	3	<input type="checkbox"/>	5-10 years	7	7	<input type="checkbox"/>
6-11 months	4	4	<input type="checkbox"/>	More than 10 years	8	8	<input type="checkbox"/>

The questions on the next two pages are about victimisation and bullying. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

How often during the last year has someone (**excluding family and partner**) done these things to you? **In each of these questions, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.**

	Not at all	Once	More than once
	1	2	3
	0	1	2
1. Punched me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Tried to get me into trouble with my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Called me names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sent me nasty texts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Kicked me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tried to turn my friends against me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Made fun of me because of my appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Said something mean about me on social media (e.g., Facebook, Instagram)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Hurt me physically in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Refused to talk to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Made fun of me for some reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Written spiteful things about me in a chat room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Beaten me up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Made other people not talk to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Sworn at me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Written nasty things to me using instant messenger (e.g., Facebook Messenger, Whatsapp, Snapchat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For confidential advice and information on bullying, the **National Bullying Helpline** can be reached on 0845 22 55 787 or 07734 701221.

Below is a list of things that you might have done to another person.

How often during the last year have you done these things to someone (excluding family and partner)?
 In each of these questions, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

	Not at all	Once	More than once
	1	2	3
	0	1	2
1. Punched another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Tried to get somebody in trouble with their friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Called another person names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sent a nasty text to somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Kicked another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tried to turn another person's friends against them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Made fun of another person because of their appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Said something mean about somebody on social media (e.g., Facebook, Instagram)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Hurt someone physically in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Refused to talk to another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Made fun of another person for some reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Written spiteful things about somebody in a chat room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Beaten another person up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. This is a quality control question, please select 'Once'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Made other people not talk to another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Sworn at somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Written nasty things to somebody using instant messenger (e.g., Facebook Messenger, Whatsapp, Snapchat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For confidential advice and information on bullying, the **National Bullying Helpline** can be reached on 0845 22 55 787 or 07734 701221.

Wellbeing

How much do you agree with the following statements about your fun and recreation?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	1	2	3	4	5
	1	2	3	4	5
I have lots of interesting things to do in my leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have plenty of opportunities for socialising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find my leisure time fulfilling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have at least one engaging hobby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure time is important to my quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about **the past 7 days**.

During the past 7 days ...	Never	Occasionally	Half of the time	Most of the time	All of the time
	1	2	3	4	5
	0	1	2	3	4
I have felt moments of sudden terror, fear, or fright	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt anxious, worried, or nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt a racing heart, sweaty, trouble breathing, faint, or shaky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have avoided, or did not approach or enter situations about which I worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have left situations early or participated only minimally due to worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have spent a lot of time making decisions, putting off making decisions, or preparing for situations, due to worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have sought reassurance from others due to worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have needed help to cope with anxiety (e.g., alcohol or medications, superstitious objects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next nine questions are repeated from the first phase of TEDS21, so you may recognise them. This repetition is deliberate because we would like to see whether some behaviours change over time. Thinking about how you have been feeling or acting in the **past two weeks**, how much do you agree with the following statements?

During the past two weeks ...	Not true	Quite true	Very true
	1	2	3
	0	1	2
I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is a quality control question, please select 'Quite true'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I thought I could never be as good as other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are affected by any of the issues raised in the questions above, you may wish to contact the mental health charity **Mind** on 0300 123 3393 or visit their website: www.mind.org.uk.

The following section is about (thoughts of) suicide and hurting yourself on purpose, also sometimes referred to as deliberate self-harm. We know this is a sensitive subject, but it is important to ask about it now, as it is not uncommon. By finding out about self-harm we can try to find ways of helping people. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

We have asked about this subject more generally before, but the following questions are specifically about **the past year**.

In each of the self-harm questions on these two pages, a "prefer not to answer" response was included in the app and web versions but not the paper version. This has been recoded to missing.

	No	Yes, once or twice	Yes, 3-5 times	Yes, 6-10 times	Yes, more than 10 times
	1	2	3	4	5
	0	1	2	3	4
1. In the past year, have you ever thought about killing yourself, even if you would not really do it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past year, have you ever hurt yourself on purpose in any way (e.g. by taking an overdose of pills, or by cutting yourself)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **yes** to the last question (have you hurt yourself on purpose in the past year), please answer questions 3-14 below. Otherwise, skip ahead to the next page.

	No, not in the past year	Yes, once or twice	Yes, 3-5 times	Yes, 6-10 times	Yes, more than 10 times
	1	2	3	4	5
	0	1	2	3	4
3. In the past year, have you ever hurt yourself on purpose without intending to kill yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past year, on any of the occasions you have hurt yourself on purpose, have you ever seriously wanted to kill yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past year, did you hurt yourself because you wanted to show how desperate you were feeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past year, did you hurt yourself because you wanted to die?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past year, did you hurt yourself because you wanted to punish yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past year, did you hurt yourself because you wanted to frighten someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, did you hurt yourself because you wanted to get relief from a terrible state of mind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, have you swallowed pills or something poisonous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, have you cut yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past year, have you burnt yourself (e.g., with a cigarette)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. In the past year, have you scratched yourself, pulled your hair, head-butted or punched something to the point of feeling pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. If you have harmed yourself in any other way not mentioned in questions 10-13, you can give details in the space below:

Text responses here have not been retained, but have been recoded into numeric categories for use in the dataset:

1=harm to skin (scratching, biting, piercing, etc);

2=other physical harm (hitting, bruising, banging, etc);

3=food-related harm (binge-eating, vomiting, starving);

4=heat-related harm (burning, scalding, freezing);

5=chemical harm (poisoning, stopping medication, overdose).

If you would like to talk to a trained professional about any of the issues raised in this section, you can call the **Samaritans** for free on 116 123 (24 hours a day, 365 days a year) from any phone.

Health

The questions on the next few pages are about aspects of your health. If you find that you prefer not to answer a particular question, please leave it and move on to the next question.

In questions most health questions below, a "prefer not to answer" response was included in the app and web versions but not the paper version. This response has been recoded to missing.

1. Have you been diagnosed with a medical disorder with serious life-long physical effects on your health, such as cerebral palsy, epilepsy or Down's syndrome?

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

If Yes, please answer questions 2 and 3 below.

If No, please skip these questions and go to question 4 below.

2. Please specify which, if any, of the following conditions you have been diagnosed with (select all that apply).

Dataset: all coded 1=yes if ticked or 0=no if not ticked.

Paper and backup data: all coded 1=yes, 0=no as in the dataset.

Cerebral palsy	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	Tourette's syndrome	<input type="checkbox"/>
Down's syndrome	<input type="checkbox"/>	Fragile X	<input type="checkbox"/>

3. If you have any other serious medical order that you have been diagnosed with, and which is not in the list above, please tell us about it in the space below:

Text responses here have not been retained. Where appropriate, they have been recoded into category responses for other questions in this Health section.

.....

4. Have you ever been diagnosed with a mental health disorder by a medical professional (for example depression, schizophrenia, autism, Asperger's syndrome)?

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

If Yes, please answer questions 5 to 11 below.

If No, please skip these questions and go to question 12 on page 25.

5. Please specify which, if any, of the following conditions you have been diagnosed with (select all that apply).

Dataset: all coded 1=yes if ticked or 0=no if not ticked.

Paper and backup data: all coded 1=yes, 0=no as in the dataset.

Depression	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>
Anxiety Disorders	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>
Obsessive-Compulsive Disorder (OCD)	<input type="checkbox"/>	Autism	<input type="checkbox"/>
Post-traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	Asperger's syndrome	<input type="checkbox"/>

6. If you have any other mental health disorder that you have been diagnosed with, and which is not in the list above, please tell us about it in the space below:

Text responses here have not been retained. Where appropriate, they have been recoded into category responses for other questions in this Health section.

.....

7. Have you ever taken medication for a diagnosed mental health problem?

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

If Yes, please answer questions 8 and 9 below.

If No, please skip these questions and go to question 10 below.

8. Do you **currently** take any medication for a diagnosed mental health problem?

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

If Yes, please answer question 9 below.

If No, please skip this question and go to question 10 below.

9. How long have you been taking medication for a diagnosed mental health problem?

1-4 weeks	1	1	<input type="checkbox"/>
1 month - 4 months	2	2	<input type="checkbox"/>
5 months - 1 year	3	3	<input type="checkbox"/>
1 year - 2 years	4	4	<input type="checkbox"/>
2 years - 5 years	5	5	<input type="checkbox"/>
More than 5 years	6	6	<input type="checkbox"/>

10. Have you ever been admitted to a psychiatric hospital?

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

If Yes, please answer question 11 below.

If No, please skip this question and go to question 12 on the next page.

11. How long did you stay at the psychiatric hospital?

1 day	1	1	<input type="checkbox"/>
2-6 days	2	2	<input type="checkbox"/>
1 - 2 weeks	3	3	<input type="checkbox"/>
2 - 8 weeks	4	4	<input type="checkbox"/>
2 - 6 months	5	5	<input type="checkbox"/>
More than 6 months	6	6	<input type="checkbox"/>

12. Have you ever been diagnosed with a learning disability, such as dyslexia, ADHD or dyspraxia?

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

If Yes, please answer questions 13 and 14 below.

If No, please skip these questions and go to the next section of questions.

13. Have you ever been diagnosed with any of the following (please select all that apply)?

Dataset: all coded 1=yes if ticked or 0=no if not ticked.
Paper and backup data: all coded 1=yes, 0=no as in the dataset.

Attention deficit hyperactivity disorder (ADHD)	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>
Dyspraxia	<input type="checkbox"/>
Dyscalculia	<input type="checkbox"/>

14. If you have any other learning disability that you have been diagnosed with, and which is not in the list above, please tell us about it in the space below:

Text responses here have not been retained. Where appropriate, they have been recoded into category responses for other questions in this Health section.

.....

The following questions are about your own health state **today**.

	None	Slight	Moderate	Severe	I am unable to do these activities
	1	2	3	4	5
	0	1	2	3	4
Do you have any problems today with walking about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems today washing or dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems today doing your usual activities (e.g., work, study, housework, family or leisure)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Slight	Moderate	Severe	Extreme
	1	2	3	4	5
	0	1	2	3	4
Do you have any pain or discomfort today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any anxiety or depression today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about your health **in the last year**.

1. How many days have you been absent from work/your studies due to illness in the past year?

None	1-6 days	7-15 days	16-30 days	Over 30 days
1	2	3	4	5
0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you had a hospital inpatient admission (**overnight stay**) in the last year?

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

If **Yes**, please answer question 3 below.

If **No**, please move on to question 4 below.

3. How many nights did you stay at the hospital (in the past year) for each of the following reasons:

	None	1-6 nights	7-15 nights	16-30 nights	Over 30 nights
	1	2	3	4	5
	0	1	2	3	4
... due to mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for physical health reasons other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for any other reasons not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you had a hospital outpatient/day patient visit (**no overnight stay**) in the last year?

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

If Yes, please answer question 5 below.

If No, please move on to question 6.

5. How many times did you attend outpatient/day patient appointments (in the past year) for each of the following reasons:

	None	1-6 times	7-15 times	16-30 times	Over 30 times
	1	2	3	4	5
	0	1	2	3	4
... due to mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for day surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for physical health reasons other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... for any other reasons not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Have you attended an accident and emergency (A&E) department **in the last year**?

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

If Yes, please answer questions 7 and 8 below.

If No, please move on to question 9 below.

In the following two questions, input responses have been converted to integer values.

7. How many times have you attended A&E **in the last year**?

8. When you attended A&E **in the last year**, how many times were you taken by ambulance?

9. How many times did you receive each of the following professional health services **in the last year**:

In the last year, how many times did you ...	None	1-3 times	4-6 times	7-10 times	More than 10 times
	1	2	3	4	5
	0	1	2	3	4
Receive professional services from a General Practitioner (GP) (at home, at the surgery, or by telephone)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a nurse, health visitor or midwife (at home, at the surgery, or by telephone)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consult a specialist doctor (e.g., allergist, oncologist, surgeon, dermatologist, cardiologist, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a social worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a day centre/drop-in centre or walk-in clinic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from an advice service (e.g., Citizens' Advice bureau, housing association)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a helpline (e.g., Samaritans, MIND)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a self-help group (e.g., Alcoholics Anonymous)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive professional services from a counsellor, psychologist or psychotherapist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Call NHS Direct?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the **past month**, how often have you had trouble sleeping because you ...

	Not during the past month	Less than once a week	Once or twice a week	Three or more times per week
	1	2	3	4
	0	1	2	3
1. Woke up in the middle of the night or early morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Had to get up to use the bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Could not breathe comfortably?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coughed or snored loudly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. This is a quality control question, please select 'Less than once a week'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Felt too cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Felt too hot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Had bad dreams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Had pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you for answering our questions.
We really appreciate your help.**

Don't forget to send back the consent form to let us know about your preferences for a reward voucher!

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