

FIRST NATIONS REGIONAL HEALTH SURVEY



OUR VOICE, OUR SURVEY, OUR REALITY

Youth Questionnaire

May 1, 2008

(Content based on laptop-based survey)



INTRODUCTION

The First Nations Regional Longitudinal Health Survey (RHS) is the only national health survey operated by First Nations, for First Nations. The main objectives of the RHS are to provide scientifically and culturally validated information, while enhancing First Nations capacity and control over research. It is conducted across the ten regions in Canada, surveying participants in over two hundred First Nation communities.

The RHS Phase 2 (2008) is composed of three main survey components:

- **Adult** (age 18 years and over, self-reported)
- **Youth** (age 12-17 years, self-reported)
- **Child** (age 0-11 years, completed by primary care giver)

The RHS is collected using a Computer Assisted Personal Interview (CAPI) system, with over 250 laptops across the country. The data are gathered by trained local field workers, and the survey is conducted in person, within the selected communities. The final versions of the RHS Phase 2 questionnaires were reviewed and approved by the First Nations Information Governance Committee (FNIGC).

BACKGROUND

The RHS is overseen by the First Nations Information Governance Committee (FNIGC) and is coordinated by ten First Nations regional organizations and a national team housed at the Assembly of First Nations. For the complete list of the RHS Regional Coordinators and related RHS information, please visit our website at www.rhs-ers.ca

The Assembly of First Nations Chiefs Committee on Health mandated that a nation-wide First Nations health survey be implemented every four years, creating the First Nations Regional Longitudinal Health Survey (RHS). The RHS was launched as a pilot survey in 1997 and became the first stepping-stone in First Nations control over research. The RHS has played a pivotal role in the growing awareness of the importance of information and the inherent right for First Nations to exercise self-determination. The RHS collected data in 2002-03 (Phase 1), is currently in the field for data collection in 2008 (Phase 2) and will continue every four years until 2016.

**This is our story....RHS is our survey,
our voice, our future.**

Table of Contents

Personal Background Information	1
Household and Living Environment.....	1
Languages	2
Education	4
General Health	6
Food and Nutrition	7
Physical Activity	8
Health Conditions	10
Injury	11
Health Care Utilization.....	13
Alcohol and Drug Use.....	15
Smoking.....	16
Sexual Habits	18
Personal Wellness.....	20
Residential Schools	24
Community Wellness and Traditional Culture	25
Ending	26

FOR INFORMATION ONLY

Youth Phase 2

Introduction
Welcome to the First Nations Regional Longitudinal Health Survey 2007

Consent # _____

Section: Personal Info

1. What is your date of birth?

Day	Month	Year
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

2. Are you male or female?

Male Female

3. What region do you live in?

<input type="radio"/> Alberta	<input type="radio"/> Newfoundland	<input type="radio"/> Prince Edward Island
<input type="radio"/> British Columbia	<input type="radio"/> Northwest Territories	<input type="radio"/> Quebec
<input type="radio"/> Manitoba	<input type="radio"/> Nova Scotia	<input type="radio"/> Saskatchewan
<input type="radio"/> New Brunswick	<input type="radio"/> Ontario	<input type="radio"/> Yukon

4. What First Nations community do you currently live in?

Section: Household and Living Environment

5. Including yourself, how many children and youth live in this household?
*Include all children under 18 years old who reside in the household at least half of the time.
If none, mark '0'.*

0-5 years	<input type="text"/>
6-11 years	<input type="text"/>
12-18 years	<input type="text"/>

6. How many adults usually live in this household?
Include all adults, 18 years and over, who reside in the household at least half of the time.

7. Who do you live with most of the time?
 Read list and mark all that apply.

<input type="checkbox"/> Biological mother (birth mother)	<input type="checkbox"/> The father that adopted me
<input type="checkbox"/> Biological father	<input type="checkbox"/> My boyfriend/girlfriend/spouse
<input type="checkbox"/> Brother(s)/sister(s)	<input type="checkbox"/> My child(ren)
<input type="checkbox"/> Aunt/uncle/cousins	<input type="checkbox"/> Unrelated children
<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> A woman I am not related to
<input type="checkbox"/> My stepmother	<input type="checkbox"/> A man I am not related to
<input type="checkbox"/> My stepfather	<input type="checkbox"/> Don't know
<input type="checkbox"/> Step-brother(s)/step-sister(s)	<input type="checkbox"/> Refused
<input type="checkbox"/> The mother that adopted me	<input type="checkbox"/> Other:

8. Are your birth (biological) parents:
 Check the answer that best describes their situation.

<input type="checkbox"/> Living together and married	<input type="checkbox"/> One of my parents is deceased
<input type="checkbox"/> Living together but not married	<input type="checkbox"/> Both of my parents are deceased
<input type="checkbox"/> Not living together/separated	<input type="checkbox"/> Don't know
<input type="checkbox"/> Divorced	<input type="checkbox"/> Refused

9. What is the highest level of formal schooling that your parents or guardians have completed?
 Please choose one answer from the list.

<i>Parents Education</i>	Mother (or guardian)	Father (or guardian)
Some elementary school		
Elementary school		
Some high school		
High school diploma		
Diploma/certificate from trade or vocational school		
Diploma/certificate from community college, CEGEP		
Professional Degree		
University Degree		
Masters Degree		
Earned Doctorate (PhD)		
Not applicable		

Section: Languages

11. Which language(s) do you use most often in your daily life?
 Mark all that apply.

- English
- French
- First Nation language
- Other

12. Can you understand or speak a First Nations language?

- Yes
- No → If no, go to question 15.
- Don't know
- Refused

13. Please list all First Nation languages:

14. How well can you understand and speak the language?

A few words: understand or can speak a few words (hello, goodbye, etc)

Basic: understand basic phrases, ask simple questions ('where am i?'), and write basic sentences

Intermediate: understand main idea of everyday speech (TV, radio), engaged in conversations, write paragraphs/text

Fluent: no difficulty understanding spoken word, can read virtually any document, carrying on complex conversations, write complex reports/letters/etc.

First Nation Language	Understand					Speaking				
	Fluent	Intermediate	Basic	A few words	N/A	Fluent	Intermediate	Basic	A few words	N/A

15. How important is it to you to speak your First Nations language?

<input type="radio"/> Very important	<input type="radio"/> Not important
<input type="radio"/> Somewhat important	<input type="radio"/> Don't know
<input type="radio"/> Not very important	<input type="radio"/> Refused

16. How important are traditional cultural events in your life?

Traditional cultural events vary, but may include powwows, sweat lodges, and community feasts.

<input type="radio"/> Very important	<input type="radio"/> Not important
--------------------------------------	-------------------------------------

<input type="radio"/> Somewhat important	<input type="radio"/> Don't know
<input type="radio"/> Not very important	<input type="radio"/> Refused

17. Do you take part in your local community's cultural events?

<input type="radio"/> Always/almost always	<input type="radio"/> Never
<input type="radio"/> Sometimes	<input type="radio"/> Don't know
<input type="radio"/> Rarely	<input type="radio"/> Refused

18. Who helps you in understanding your culture?

Check all that apply.

<input type="radio"/> Grandparents	<input type="radio"/> Community elders
<input type="radio"/> Parents (mother and/or father)	<input type="radio"/> Other community members
<input type="radio"/> Aunts and uncles	<input type="radio"/> No one
<input type="radio"/> Other relatives (siblings, cousins, etc.)	<input type="radio"/> Don't know
<input type="radio"/> My friends	<input type="radio"/> Refused
<input type="radio"/> School teachers	<input type="radio"/> Other:

Section: Education

19. Are you currently attending school?

- Yes
- No → If no, go to question 21.
- Don't know
- Refused

20. What grade are you currently in?

<input type="radio"/> Grade 4	<input type="radio"/> Grade 11
<input type="radio"/> Grade 5	<input type="radio"/> Grade 12
<input type="radio"/> Grade 6	<input type="radio"/> Grade 13
<input type="radio"/> Grade 7	<input type="radio"/> Other:
<input type="radio"/> Grade 8	<input type="radio"/> Don't know
<input type="radio"/> Grade 9	<input type="radio"/> Refused
<input type="radio"/> Grade 10	

21. How do you feel about school?

<input type="radio"/> I like school very much	<input type="radio"/> I dislike school somewhat
<input type="radio"/> I like school somewhat	<input type="radio"/> I dislike school very much
<input type="radio"/> Unsure	<input type="radio"/> Refused

22. Up to now, what is the highest level of schooling you have completed?

For example, if you are currently in grade 8, then the last grade you completed was grade 7.

<input type="radio"/> Less than grade 4	<input type="radio"/> Grade 10
<input type="radio"/> Grade 4	<input type="radio"/> Grade 11
<input type="radio"/> Grade 5	<input type="radio"/> Grade 12
<input type="radio"/> Grade 6	<input type="radio"/> Grade 13
<input type="radio"/> Grade 7	<input type="radio"/> Other
<input type="radio"/> Grade 8	<input type="radio"/> Don't know
<input type="radio"/> Grade 9	<input type="radio"/> Refused

23. Have you ever skipped or advanced a grade, as a result of academic performance?

- Yes
- No
- Don't know
- Refused

24. Have you ever repeated a grade?

- Yes
- No
- Don't know
- Refused

25. Have you had any problems learning in school?

- Yes
- No → If no, go to question 26.
- Don't know
- Refused

26. What kind(s) of problems have you had?

Check all that apply.

<input type="radio"/> Reading	<input type="radio"/> Difficulty understanding the teacher
<input type="radio"/> Writing	<input type="radio"/> Don't know
<input type="radio"/> Math	<input type="radio"/> Refused
<input type="radio"/> Short attention span	<input type="radio"/> Other:
<input type="radio"/> Too many distractions	

27. What is the highest level of education you would like to get?

(e.g what are your plans for the future in terms of education?)

<input type="radio"/> High school diploma	<input type="radio"/> Doctorate degree (PhD)
<input type="radio"/> College/CEGEP diploma	<input type="radio"/> Not sure
<input type="radio"/> Trade or vocational certificate	<input type="radio"/> Refused

<input type="radio"/> University degree	<input type="radio"/> Don't know
<input type="radio"/> Professional degree	<input type="radio"/> Other:
<input type="radio"/> Masters degree	

Section: General Health

28. In general, would you say that your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

29. Compared to one year ago, how would you say your health is now?
Is it:

- Much better now than 1 year ago
- Somewhat better now
- About the same as a year ago
- Somewhat worse now
- Much worse now than 1 year ago

30. What things help make you healthy? **If fair or poor health, please go to next section**
Do not read list. Check all that apply.

<input type="radio"/> Good diet (low fat, fruits and vegetables etc.)	<input type="radio"/> Regular exercise / Active in sports
<input type="radio"/> Reduced stress	<input type="radio"/> In balance (physical, emotional, mental, spiritual)
<input type="radio"/> Good social supports (family, friends, co-workers)	<input type="radio"/> Other:
<input type="radio"/> Good sleep / Proper rest	<input type="radio"/> Don't know
<input type="radio"/> Happy, content	<input type="radio"/> Refused

31. How would you rate your mental health?

- Excellent
- Very good
- Good
- Fair
- Poor

32. How tall are you without your shoes on?
Approximate if necessary.

	Feet		Inches
--	------	--	--------

33. How much do you weigh (lbs)?
Approximate if necessary

Pounds

34. How satisfied are you with your weight?

<input type="radio"/> Very satisfied	<input type="radio"/> Very dissatisfied
<input type="radio"/> Somewhat satisfied	<input type="radio"/> Don't know
<input type="radio"/> Neither satisfied nor dissatisfied	<input type="radio"/> Refused
<input type="radio"/> Somewhat dissatisfied	

Section: Food and Nutrition

35. On average, how often do you eat or drink the following foods?
Choose the answer that best describes the way you normally eat.

	Several Times a Day	Once a Day	A few times a week	About once a week	Never/hardly ever
Milk and milk products (e.g. yogurt, cheese)					
Protein (beef, chicken, pork, fish, eggs, beans, tofu)					
Vegetables					
Fruit (excluding fruit juice)					
Bread, pasta, rice and other grains					
Water					
Juice					
Soft drinks/pop					
Fast food (e.g. burgers, pizza, hotdogs, French fries)					
Sweets (e.g. candy, cookies, cake)					

36. In the past 12 months, how often have you eaten the following traditional foods?

	Not at all	A few times	Often
Land-based animals (moose, caribou, bear, deer, bison, etc.)			
Fresh water fish			
Salt water fish			
Other water based foods (shellfish, eels, clams, seaweed, etc.)			
Sea-based animals (whale, seal, etc.)			

Game birds (goose, duck, etc.)			
Small game (rabbit, muskrat, etc.)			
Berries or other wild vegetation			
Bannok/Fry bread			
Wild rice			
Corn soup			

37. Do you eat a nutritious balanced diet?

- Always / almost always
- Sometimes
- Rarely
- Never
- Don't know
- Refused

38. In the past 12 months, how often did someone share traditional food with your household?

- Often
- Sometimes
- Never
- Don't know
- Refused

Section: Physical Activity

39. In the past 12 months, which of the following have you participated in?

Mark all that apply.

<input type="checkbox"/> Walking	<input type="checkbox"/> Weights, exercise equipment
<input type="checkbox"/> Hunting, trapping	<input type="checkbox"/> Aerobics/Fitness classes
<input type="checkbox"/> Fishing	<input type="checkbox"/> Canoeing/Kayaking
<input type="checkbox"/> Berry picking or other food gathering	<input type="checkbox"/> Swimming
<input type="checkbox"/> Running or jogging	<input type="checkbox"/> Bowling
<input type="checkbox"/> Hiking	<input type="checkbox"/> Golf
<input type="checkbox"/> Bicycling riding/Mountain biking	<input type="checkbox"/> Snowshoeing
<input type="checkbox"/> Dancing (aerobic, traditional, modern, etc.)	<input type="checkbox"/> Martial Arts
<input type="checkbox"/> Skating	<input type="checkbox"/> Gardening, yard work
<input type="checkbox"/> Skiing/Snowboarding	<input type="checkbox"/> None
<input type="checkbox"/> Competitive or team sports (e.g hockey, basketball, baseball, lacrosse, tennis)	<input type="checkbox"/> Other:

40. In the past 12 months, how many times did you participate in the activity?

Note: Some examples of annual estimates:

Daily= 365 times per year

Three times a week = 156 times per year

Twice a month = 24 times per year

Activity (insert all checked above)	Number of times participated

41. How much time (in minutes) do you generally spend doing the activity in the average session?

½ hour = 30 minutes 1 hour = 60 minutes 1 ½ hour = 90 minutes

Activity (insert all checked above)	Average length of time participated

42. During the past week, how much time in an average day did you spend watching TV, working at your computer, reading or playing video games?

	Less than 30 minutes	30 minutes to an hour	1 hour to 1 ½ hours	More than 1 ½ hours	Don't know	Refused
Watching TV						
Working at a computer						
Reading						
Playing video games						

43. Which best describes your routine in a typical day?

<input type="radio"/> You spend most of a typical day sitting (watching TV, playing video games, going to school). You are rarely active.	<input type="radio"/> Your daily routing involves walking or other moderate activities (swimming, bicycling, outdoor gardening) at least 60 minutes every day (either in work, errands, or through other activities).
<input type="radio"/> You spend most of your day sitting (watching TV, playing video games, going to school) but you do at least 30 minutes of physical activity at least once a week.	<input type="radio"/> Refused
<input type="radio"/> Your daily routing involves walking or other moderate activities (swimming, bicycling,	

outdoor gardening) 30 – 59 minutes a day (either in work, errands, or through other activities).	
--	--

Section: Health Conditions

44. Have you been told by a health care professional that you have any of the following health conditions?

45. If yes, what age were you diagnosed?

46. If yes, are you currently undergoing treatment(s) or taking medication(s) for these condition(s)?

Read through the entire list of conditions and answer 'yes' or 'no'.

Yes = Y

No = N

Don't know = DK

Refused = R

Conditions	44. Told that you have:				If Yes: →	45. Age when diagnosed	46. If yes, Undergoing treatment			
	Yes	No	DK	R			Yes	No	DK	R
Asthma	Y	N	DK	R			Y	N	DK	R
→ Have you had an asthma attack in the past 12 months? O Yes O No										
Chronic back pain, excluding arthritis	Y	N	DK	R			Y	N	DK	R
Allergies	Y	N	DK	R			Y	N	DK	R
Blindness or serious vision problems (can't be corrected with glasses)	Y	N	DK	R			Y	N	DK	R
Hearing impairment										
Epilepsy	Y	N	DK	R			Y	N	DK	R
Emphysema	Y	N	DK	R			Y	N	DK	R
Psychological or nervous disorders	Y	N	DK	R			Y	N	DK	R
Cognitive or Mental disability	Y	N	DK	R			Y	N	DK	R
Attention Deficit Disorder / Attention Deficit-Hyperactivity Disorder (ADD/ADHD)	Y	N	DK	R			Y	N	DK	R
Learning Disability	Y	N	DK	R			Y	N	DK	R
Stomach and intestinal problems	Y	N	DK	R			Y	N	DK	R

HIV/AIDS	Y	N	DK	R
Hepatitis	Y	N	DK	R
→ If yes, what type of hepatitis do you have? O Type A O Type B O Type C O Don't know	Y	N	DK	R
Tuberculosis	Y	N	DK	R
→ If yes, is your tuberculosis active or inactive? O Active O Inactive O Don't know	Y	N	DK	R
Diabetes	Y	N	DK	R
Anemia	Y	N	DK	R
Fetal Alcohol Symptom Disorder (FASD)	Y	N	DK	R
Chronic ear infections	Y	N	DK	R
Liver disease (excluding hepatitis)	Y	N	DK	R
Dermatitis, atopic eczema	Y	N	DK	R

	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R
	Y	N	DK	R

47. Which type(s) of diabetes have you been diagnosed with in your lifetime? Include all diagnosis that you have received.

Type 1 typically occurs in childhood or adolescence and requires multiple daily injections for survival.

Type 2 usually begins after age 30 and is more common in First Nation populations. This type can be prevented and effectively managed by eating healthy foods and engaging in regular exercise.

Gestational diabetes occurs only during pregnancy.

- Type 1
- Type 2
- Gestational
- Don't know
- Refused

48. What kind of treatment or measure are you using to manage your diabetes (all types)?

Ask about treatment type. Check all that apply.

<input type="radio"/> Diet	<input type="radio"/> Traditional medicines
<input type="radio"/> Exercise	<input type="radio"/> Traditional ceremonies, help from healer
<input type="radio"/> Insulin	<input type="radio"/> No treatment or medicine
<input type="radio"/> Pills	<input type="radio"/> Other:

Section: Injury

49. Have you been injured in the past 12 months?

- Yes
- No → If no, go to question 57.
- Don't know
- Refused

50. What type of injury(ies) did you have?
For example, was it a burn, a broken bone, etc.
Please select all that apply.

<input type="radio"/> Broken or fractured bones	<input type="radio"/> Poisoning
<input type="radio"/> Burns or scalds	<input type="radio"/> Injury to internal organ
<input type="radio"/> Dislocation	<input type="radio"/> Dental injury
<input type="radio"/> Major sprain or strain	<input type="radio"/> Hypothermia, frost bite
<input type="radio"/> Minor cuts, scrapes or bruises	<input type="radio"/> Repetitive strain
<input type="radio"/> Concussion	<input type="radio"/> Other:

51. What part(s) of your body was injured?
Mark all that apply.

<input type="radio"/> Hand	<input type="radio"/> Torso
<input type="radio"/> Wrist	<input type="radio"/> Eye(s)
<input type="radio"/> Arm	<input type="radio"/> Head
<input type="radio"/> Foot	<input type="radio"/> Multiple sites
<input type="radio"/> Ankle	<input type="radio"/> Other:
<input type="radio"/> Knee	<input type="radio"/> Don't know
<input type="radio"/> Leg	<input type="radio"/> Refused

52. Where did the injury(ies) occur?

<input type="radio"/> Home	<input type="radio"/> Industrial or construction area
<input type="radio"/> School, college, university	<input type="radio"/> Office
<input type="radio"/> Sports fields/facilities of schools	<input type="radio"/> Countryside, forest, woodlot
<input type="radio"/> Street, highway, sidewalk	<input type="radio"/> Lake, river, ocean
<input type="radio"/> Community buildings (community centre, band office)	<input type="radio"/> Other:

53. What were you doing when the injury(ies) occurred?

<input type="radio"/> Sports or physical exercise	<input type="radio"/> Unpaid work/ chores around the house
<input type="radio"/> Leisure or hobby	<input type="radio"/> Travel to and from work/school
<input type="radio"/> Working at a job or business	<input type="radio"/> Other (specify):

54. What caused the injury(ies)?

<input type="radio"/> Motor vehicle collision	<input type="radio"/> Contact with a machine, tool, etc.
---	--

→ Were you wearing a seat belt? O Yes O No O Don't know O Refused	
O ATV collision	O Smoke, fire, flames
→ Were you wearing a helmet? O Yes O No O Don't know O Refused	
O Snowmobile collision	O Contact with HOT liquid, object, etc.
→ Were you wearing a helmet? O Yes O No O Don't know O Refused	
O Hunting accident	O Extreme weather or natural disaster (i.e. flood)
O Boating accident	O Thin ice
→ Were you wearing a life jacket? O Yes O No O Don't know O Refused	
O Accidental contact with another person or animal	O Overexertion or strenuous movement
O Fall	O Suicide attempt or other self-inflicted injury
O Domestic/family violence	O Riding a bike
	→ Were you wearing a helmet? O Yes O No O Don't know O Refused
O Other physical assault	O Other. (Specify):

55. Where did you get medical treatment for your injury(ies)?

Mark all that apply.

O Doctors office	O At home
O Hospital emergency room	O Traditional healer
O Walk-in clinic	O By telephone
O Community Health Centre/Nursing station	O Didn't seek any medical treatment
O At school	O Other (specify):
O At work	

56. When the injury(ies) happened, did any of the following have an influence in your injury?

- O Alcohol
- O Marijuana
- O Not under the influence
- O Other substances
- O Don't know
- O Refused

Section: Health Care Utilization

57. When did you last:

	Never	Within the last 12 months	1-2 years ago	Over 2 years ago	I don't remember	Refused
Consult a traditional						

healer						
Visit a doctor or community health nurse						
Have counseling, psychological testing or any other mental health service						

58. In the past 12 months, have you had any of the following tests or examinations?
Please check a response for each.

Tests and Examinations	Yes	No	Don't know	Refused
Cholesterol Test				
Vision/Eye exam				
Blood Pressure Test				
Blood Sugar Test				
Complete physical examination				

If you are male, please proceed to question 61.

59. When was your last PAP smear?

<input type="radio"/> Never had one	<input type="radio"/> 3 years to less than 5 years ago
<input type="radio"/> Less than 6 months ago	<input type="radio"/> More than 5 years ago
<input type="radio"/> 6 months to less than 1 year ago	<input type="radio"/> Don't know
<input type="radio"/> 1 year to less than 3 years ago	<input type="radio"/> Refused

60. Have you received the HPV vaccine?

Note: The HPV vaccine is available to females in grade 8, for the prevention of the human papillomavirus and cervical cancer.

- Yes
- No
- Don't know
- Refused

61. Approximately when was the last time you had any dental care?

<input type="radio"/> Less than six months ago	<input type="radio"/> More than five years ago
<input type="radio"/> Between six months and one year ago	<input type="radio"/> Never
<input type="radio"/> Between one and two years ago	<input type="radio"/> Don't know
<input type="radio"/> Between two and five years ago	<input type="radio"/> Refused

62. What type of dental treatment do you currently need?

Mark all that apply.

<input type="checkbox"/> None	<input type="checkbox"/> Prosthetics (e.g denture, including repair and maintenance)
<input type="checkbox"/> Cavities filled or other restorative work (e.g. fillings, crowns, bridge)	<input type="checkbox"/> Urgent care (dental problems requiring immediate attention)
<input type="checkbox"/> Maintenance (e.g. check ups or teeth cleaning)	<input type="checkbox"/> Orthodontics (e.g. braces)
<input type="checkbox"/> Extractions (taking teeth out)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Fluoride treatment	<input type="checkbox"/> Refusal
<input type="checkbox"/> Periodontal (gum) work	<input type="checkbox"/> Other:

63. Have you experienced problems with your teeth or experienced any dental pain in the past month?

- Yes
- No
- Don't know
- Refused

Section: Alcohol and Drug Use

64. Have you had any of the following substances in the last 12 months (without a prescription)? For each substance, please select the answer that best describes your usage.

	Never	Once or twice	Monthly	Weekly	Daily or almost daily	Don't know	Refused
Cannabis (marijuana, pot, grass, hash, etc)							
Cocaine (coke, crack, etc)							
Amphetamine type stimulants (crystal meth, speed, ecstasy, etc)							
Inhalants (solvents, glue, petrol, paint thinner, etc)							
Sedatives or sleeping pills (Valium, Serenax, Rohypnol, etc)							
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc)							
Opioids (heroin, morphine, methadone, codeine, etc)							

65. Have you ever sought treatment for substance abuse/addiction?

- Yes
- No
- Don't know
- Refused

66. During the past 12 months, have you had a drink of beer, wine, liquor or any other alcoholic beverage?

- Yes
- No → If no, go to question 69.
- Don't know
- Refused

67. During the past 12 months, how often did you drink alcoholic beverages?
Please select one that best describes your habits.

<input type="radio"/> Once a day	<input type="radio"/> About 2 – 3 times a week
<input type="radio"/> About 2 – 3 times a month	<input type="radio"/> About once a month
<input type="radio"/> About 2 – 3 times a year	<input type="radio"/> Refused

68. During the past 12 months, how often have you had 5 or more alcoholic drinks on one occasion?
One drink includes one beer, one glass of wine, or one shot of hard liquor.

<input type="radio"/> Never	<input type="radio"/> Less than once a month
<input type="radio"/> Once per month	<input type="radio"/> 2-3 times per month
<input type="radio"/> Once per week	<input type="radio"/> More than once per week
<input type="radio"/> Every day	<input type="radio"/> Refused

Section: Smoking

69. At the present time, do you smoke cigarettes?

- Not at all → If no, go to question 71.
- Daily
- Occasionally
- Refused

70. On average, how many cigarettes do you currently smoke each day?
Approximate if necessary

--	--

71. At what age did you begin smoking cigarettes?
(Age in years)

--	--

72. Have you ever smoked cigarettes?
(Current non-smokers only)

- Yes, daily
- Yes, occasionally
- No → If no, go to question 78.
- Don't know
- Refused

73. In the past 12 months, how many times have you tried to quit smoking?

- 0 (never tried to quit)
- 1 – 2 tries
- 3 – 4 tries
- 5 or more tries
- Don't know
- Refused

74. At what age did you begin smoking cigarettes?
(age in years)

--	--

75. At what age did you quit smoking cigarettes?
(age in years)

--	--

76. What were the reasons for quitting smoking?
Mark all that apply.

<input type="checkbox"/> Respect for the cultural and traditional significance of tobacco	<input type="checkbox"/> Greater awareness/education about the ill effects of cigarettes on my health
<input type="checkbox"/> Chose a healthier lifestyle	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Health condition	<input type="checkbox"/> Don't know
<input type="checkbox"/> Doctor's orders	<input type="checkbox"/> Refused
<input type="checkbox"/> Peer pressure from friends and co-workers	<input type="checkbox"/> Other:
<input type="checkbox"/> Out of respect of loved ones	

77. What method(s) did you use to quit smoking?
Mark all that apply.

<input type="checkbox"/> Cold turkey/will power alone	<input type="checkbox"/> Other prescribed medications
---	---

<input type="radio"/> With help from spirituality	<input type="radio"/> Traditional methods
<input type="radio"/> With assistance from family	<input type="radio"/> Self help/support program
<input type="radio"/> Nicotine replacement patch	<input type="radio"/> Don't know
<input type="radio"/> Nicotine replacement gum	<input type="radio"/> Refused
<input type="radio"/> Zyban (bupropion)	<input type="radio"/> Other:

78. Do you have a smoke free home?

- Yes
- No
- Don't know
- Refused

Section: Sexual Habits

The following questions are about sexual behaviours. These questions are being asked of everyone, regardless of age, gender or situation. They may not apply to you. Remember anything you say will remain confidential.

79. Are you sexually active?

- Yes
- No
- Prefer not to answer/refused

80. Have you had sexual intercourse in the last 12 months?

- Yes
- No → If no, go to question 86.
- Don't know
- Refused

81. How many people have you had sexual intercourse with in the past 12 months?

- None
- 1 partner
- 2 partners
- 3 partners
- 4 partners or more
- Don't know
- Refused

82. Which of the following birth control or protective methods do you and/or your partner(s) use?

Check all that apply.

<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Surgery (hysterectomy, vasectomy, tubes tied)
<input type="checkbox"/> Condoms	<input type="checkbox"/> None
<input type="checkbox"/> Birth control pills	<input type="checkbox"/> Don't know
<input type="checkbox"/> Depo Provera (injection)	<input type="checkbox"/> Refused
<input type="checkbox"/> Rhythm (natural family planning)	<input type="checkbox"/> Other:

83. What is the main purpose of that/those methods?

- Birth control (avoid pregnancy)
- Protection from sexually transmitted diseases
- Both (birth control and STD protection)
- Other
- Don't know
- Refused

84. How often do you use condoms?

- Always → If always, go to question 86.
- Most of the time
- Occasionally
- Never
- Refused

85. What is the main reason for not always using condoms?

Check the answer that best describes your situation.

<input type="checkbox"/> Your partner didn't want to use one	<input type="checkbox"/> You were with your steady partner
<input type="checkbox"/> You were under the influence of alcohol or drugs	<input type="checkbox"/> You didn't have a condom at the time
<input type="checkbox"/> Your partner doesn't have HIV/AIDS	<input type="checkbox"/> You thought you were safe
<input type="checkbox"/> You or your partner wanted to get pregnant	<input type="checkbox"/> You didn't think of using a condom
<input type="checkbox"/> You couldn't afford to buy condoms	<input type="checkbox"/> Other:

86. Have you ever been pregnant or got someone pregnant?

- Yes
- No
- Don't know
- Refused

87. How many children have you given birth to or fathered?

If none, write '0'.

--	--

88. At what age did you have your first child?

--	--

89. Have you ever been tested for Sexually Transmitted Diseases (STDs) or Sexually Transmitted Infections (STIs)?

Some examples of STD/STIs include chlamydia, herpes, gonorrhea, syphilis.

- Yes
- No
- Refused

90. Without revealing the test result, have you ever been tested for HIV/AIDS?

- Yes
- No
- Refused

Section: Personal Wellness

91. Outside of school hours, how often do you:

	Never	Less than once per week	1-3 times per week	4 times or more a week	Not applicable
Take part in sport teams or lessons					
Take part in art or music groups or lessons					
Take part in traditional singing, drumming, or dancing groups or lessons					
Have a job such as baby-sitting, working at a store, tutoring					

92. How often do you feel that you are in balance in the four aspects of your life? (Physical, emotional, mental and spiritual)

	All of the time	Most of the time	Some of the time	Almost none of the time
Physical				

Emotional				
Mental				
Spiritual				

93. Please indicate how strongly you agree or disagree with the following statements:

Please check a response for each phrase.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
In general, I like the way I am					
Overall, I have a lot to be proud of					
A lot of things about me are good					
When I do something, I do it well					

94. Please indicate your level of agreement with the following statements:

Please check a response for each phrase.

	Not at all	A little	Moderately	Quite a bit	A lot	Don't know	Refused
Do you feel lonely?							
Do you feel loved?							
Do you feel stressed?							

95. Below is a list of statements dealing with your feelings of control over your life.

Please indicate how strongly you agree or disagree with each statement.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I can solve the problems that I have					
No one pushes me around in life					
I have control over the things that happen to me					
I can do just about anything I really set my mind to					
I often feel helpless in dealing with the problems in life					
What happens to me in the future mostly depends					

on me					
There is little I can do to change many of the important things in my life					

96. In the past 12 months, have you seen or talked on the telephone about your emotional or mental health to any of the following?

Answer 'yes' or 'no' for each person/professional.

	Yes	No	Don't know	Refused
Parents				
Other family member				
Friend				
Traditional healer				
Healthcare professional (MD, nurse, psychologist)				
Counselor				
Social worker				

97. Are you currently being bullied?

Bullying is an act that is done on purpose. Bullies use their power (physical size, age, social status, computer skills, etc.) to threaten, harass, or hurt others. Bullying happens over and over to one person or as a group of people.

- Yes
- No
- Don't know
- Refused

98. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?

- Yes
- No
- Don't know
- Refused

99. People sometimes look to others for companionship, assistance, guidance or other types of support. Could you tell me how often each of the following kinds of support is available to you when you need them?

Ask about each item. Mark one response for each.

	All of the time	Most of the time	Some of the time	Almost none of the time	Refused
--	-----------------	------------------	------------------	-------------------------	---------

Someone you can count on to listen to you talk when you need to talk					
Someone you can count on when you need help					
Someone to take you to the doctor if you needed it					
Someone who shows you love and affection					
Someone who can give you a break from your daily routines					
Someone to have a good time with					
Someone to confide in or talk about yourself or your problems					
Someone to do something enjoyable with					

100. Who would you go to **first** for help if you had a problem with:

Go to first for help:	Parent	Other family	Friend my age	Adult friend	Traditional healer	MD or nurse	Principal or teacher or counselor	N one	D.K	R
Family Problems										
Relationships boyfriend/girlfriend										
Financial problems										
Drugs/Alcohol										
Anger/feeling out of control										
Depression										
Problems with friends										
Sexual/physical assault										
Sexually transmitted diseases										
Birth Control										
Pregnancy										

101. In the past 12 months, has a close friend or family member committed suicide?

- Yes
- No
- Don't know
- Refused

102. Have you ever thought about committing suicide?

- Yes
- No → If no, go to question 104.
- Don't know
- Refused

103. When did these suicidal thoughts occur?
Check all that apply.

- During the past year.
- As an adolescent (aged 12-17).
- As a child (less than 12 years old).

104. Have you ever attempted suicide?

- Yes
- No → If no, go to question 106.
- Don't know
- Refused

105. When did the suicide attempt occur?
Check all that apply.

- During the past year.
- As an adolescent (aged 12-17).
- As a child (less than 12 years old).

Section: Residential Schools

The following questions are about Residential Schools.

For the purpose of the survey, the term "residential schools" refers to the residential school systems attended by Aboriginal students. This includes residential schools run by religious orders, industrial schools, boarding schools, student residences, hostels and billets. The last residential school shut down in 1996.

106. Did your parents or grandparents attend a residential school?

Please specify.

Parents/Grandparents Attending Residential Schools	Yes	No	Don't know	Refused
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Section: Community Wellness and Traditional Culture

107. What are the main challenges your community is currently facing?
Check all that apply.

<input type="checkbox"/> Lack of education and training opportunities	<input type="checkbox"/> Poor health
<input type="checkbox"/> Alcohol and drug abuse	<input type="checkbox"/> Lack of funding
<input type="checkbox"/> Housing	<input type="checkbox"/> Lack of control
<input type="checkbox"/> Loss of culture	<input type="checkbox"/> Gang activity
<input type="checkbox"/> Lack of employment	<input type="checkbox"/> Other:
<input type="checkbox"/> Destruction of natural environment/resources	

108. Has there been any change in those areas in the past 12 months?

Progress on Issues	Good progress/ change	Some progress/ change	No progress/ change	Worsening	Don't know	Refused
Lack of education and training opportunities						
Alcohol and drug abuse						
Housing						
Loss of culture						
Lack of employment						
Destruction of natural environment/resources						
Poor health						
Lack of funding						
Lack of control						
Gang activity						
Other						

109. What are the main strengths of your community?

Do not read list. Check all that apply.

<input type="checkbox"/> Family values	<input type="checkbox"/> Awareness of First Nations culture
<input type="checkbox"/> Social connections (community working together)	<input type="checkbox"/> Community/health programs
<input type="checkbox"/> Traditional ceremonial activities (e.g powwow)	<input type="checkbox"/> Low rates of suicide/crime/drug abuse
<input type="checkbox"/> Good leisure/recreation facilities	<input type="checkbox"/> Elders
<input type="checkbox"/> Use of First Nation language	<input type="checkbox"/> Education and training opportunities
<input type="checkbox"/> Natural environment	<input type="checkbox"/> Strong economy
<input type="checkbox"/> Strong leadership	<input type="checkbox"/> Other:

110. Can we contact you for other potential surveys in the future?

- Yes
- No

Section: Ending

Did someone interpret/translate the questions of this survey?
(in whole or in part)

- Yes
- No
- Don't know
- Refused

Thank you for participating in the RHS!

The questionnaire is now complete. Are there any issues that affect the well-being of youths in your community that we missed? What should we include in the next cycle? What questions should be dropped next time?
