

FIRST NATIONS REGIONAL HEALTH SURVEY



OUR VOICE, OUR SURVEY, OUR REALITY

Adult Questionnaire

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FOR INFORMATION ONLY

Adult Phase 3

Introduction

Welcome to the First Nations Regional Health Survey Phase 3

RUID # _____

Section: Personal Information

First are some basic questions about you.

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"/>
DK, RF		

2. Are you [#derived age] years old?

- Yes
- No

3. Are you male or female?

- Male
- Female

4. What is your marital status? Are you... ?

- Married
- Living common-law
- Widowed
- Separated
- Divorced
- Single/never married
- Don't know
- Refused

5. 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"/> Québec
<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

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

Section: Household

The following questions are about your household situation.

7. How many children or youth under the age of 18 live in your household the majority of the time?
If none, please enter "0".

0-5 years old	<input type="text"/>
6-11 years old	<input type="text"/>
12-17 years old	<input type="text"/>

MIN: 0 MAX: 25
DK, RF

8. Including yourself, how many adults 18 years and over currently live in your household the majority of the time?

MIN: 1 MAX: 25

DK, RF

9. How many rooms are there in your home?

Include kitchen, bedrooms, living rooms and finished basement rooms.

Do not count bathrooms, halls, laundry rooms and attached sheds.

<input type="radio"/> 1	<input type="radio"/> 5	<input type="radio"/> 9	<input type="radio"/> 13 or more
<input type="radio"/> 2	<input type="radio"/> 6	<input type="radio"/> 10	<input type="radio"/> Don't know
<input type="radio"/> 3	<input type="radio"/> 7	<input type="radio"/> 11	<input type="radio"/> Refused
<input type="radio"/> 4	<input type="radio"/> 8	<input type="radio"/> 12	

10. For the [previous year (ending December 31, 2014)], please think of your **total household income** from all sources, before deductions. We are asking for the total sum of all the money you and the other earners in your household made in the past year. Please include income from social assistance, child tax benefits, disability benefits, workers' compensation, etc.

Which income range does it fall into?

<input type="radio"/> No income	<input type="radio"/> \$15,000-\$19,999	<input type="radio"/> \$40,000-\$49,999	<input type="radio"/> \$80,000-\$89,999	<input type="radio"/> Don't know <input type="radio"/> Refused
<input type="radio"/> \$1-\$4,999	<input type="radio"/> \$20,000-\$24,999	<input type="radio"/> \$50,000-\$59,999	<input type="radio"/> \$90,000-\$99,999	
<input type="radio"/> \$5,000-\$9,999	<input type="radio"/> \$25,000-\$29,999	<input type="radio"/> \$60,000-\$69,999	<input type="radio"/> \$100,000 and over	
<input type="radio"/> \$10,000-\$14,999	<input type="radio"/> \$30,000-\$39,999	<input type="radio"/> \$70,000-\$79,999		

Section: Language

Now a few questions about languages.

11. Which language do you use most often in your daily life?

We are asking about the main language you use to talk with your friends, family, coworkers, etc.

- English → if English used most, go to question 13
- French → if French used most, go to question 13.
- First Nations language → If First Nations language used most, go to question 14
- More than one of the above
- Other (Specify): → if other language used most, go to question 13.
- Don't know
- Refused

12. Which languages do you use most often in your daily life?

- English and French
- English and First Nations language → Go to question 14
- French and First Nations language → Go to question 14
- French, English and First Nations language → Go to question 14
- Don't know
- Refused

13. Do you have any knowledge of a First Nations language (even if only a few words)?

- Yes
- No → If no, go to General Health section
- Don't know
- Refused

14. Which First Nations language do you know the best (even if only a few words)?

DK, RF

15.

How well can you understand [pipe in language from question 14]?				
A few words: Can understand a few words (hello, goodbye, thank you, etc.)				
Basic: Can understand basic phrases and vocabulary (e.g., time, simple directions)				
Intermediate: Able to understand main ideas in everyday speech (i.e., TV, radio)				
Fluent: No difficulty understanding spoken word in a variety of contexts				
Cannot understand	A few words	Basic	Intermediate	Fluent
How well can you speak [pipe in language from question 14]?				
A few words: Can speak a few words (hello, goodbye, thank you, etc.)				
Basic: Can ask simple questions (e.g., "Where am I?") and use basic vocabulary				
Intermediate: Able to engage in casual conversation and use short sentences				
Fluent: Can carry on complex conversations in varied situations				
Cannot speak	A few words	Basic	Intermediate	Fluent
How well can you read [pipe in language from question 14]?				
A few words: Can recognize letters/syllabics and read a few words (hello, goodbye, thank you, etc.)				
Basic: Able to read many common words (e.g., numbers, place names) and simple sentences				
Intermediate: Can read everyday explanations, descriptions, and straightforward stories				
Fluent: Able to read virtually any document				
Cannot read	A few words	Basic	Intermediate	Fluent
How well can you write [pipe in language from question 14]?				
A few words: Can write letters/syllabics and a few words (hello, goodbye, thank you, etc.)				
Basic: Able to write many common words (e.g., numbers, place names) and simple sentences				
Intermediate: Can write paragraphs and text in everyday language				
Fluent: Able to write complex reports, letters, etc. using specialized language				
Cannot write	A few words	Basic	Intermediate	Fluent

DK, RF

Section: General Health

The following questions ask about your general health status.

16. In general, would you say that your health is...?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

17. 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 (than 1 year ago)
- About the same as 1 year ago
- Somewhat worse now (than 1 year ago)
- Much worse now (than 1 year ago)
- Don't know
- Refused

18. What things help make you healthy (that is, physically, emotionally, mentally, and spiritually healthy)?

Mark all that apply.

<input type="checkbox"/> Good diet	<input type="checkbox"/> Regular exercise / Active in sports
<input type="checkbox"/> Reduced stress	<input type="checkbox"/> In balance (physical, emotional, mental, spiritual)
<input type="checkbox"/> Spiritual and/or religious practices	<input type="checkbox"/> Cultural/traditional activities
<input type="checkbox"/> Work	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Good social supports (family, friends, co-workers)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Good sleep / Proper rest	<input type="checkbox"/> Refused
<input type="checkbox"/> Happiness, contentment	

19. In general, would you say your mental health is...?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

20. Do you prefer to report your height in...?

- Feet/inches
- Centimetres → if centimetres, go to question 22.
- DK, RF

21. How tall are you without your shoes on?

Feet Inches

(MIN: 3) (MAX: 7) (MIN: 0) (MAX: 11)
DK, RF

If feet/inches for question 20, go to question 23.

22. How tall are you without your shoes on?

Centimetres

MIN: 100 MAX: 241
DK, RF

23. Do you prefer to report your weight in pounds or kilograms?

- Pounds
- Kilograms → if Kilograms, go to question 25.
- DK, RF

24. How much do you weigh?

Pounds

MIN: 1 MAX: 575 (warning if <60 or > 500)
DK, RF

If pounds for question 23, go to question 26.

25. How much do you weigh?

Kilograms

MIN: 1.0 MAX: 261 (warning if < 27 or > 227)
DK, RF

26. How many children have you **[given birth to/fathered]**?
If none, please enter '0'.

MIN: 0 MAX: 70 (warning after 15)

DK, RF

If you answered "0" to question 26 and are female, please proceed to question 28.

If you answered "0" to question 26 and are male, please proceed to Health Conditions section.

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

MIN: 5 MAX: 70, Warning if < 10

DK, RF

If male, please proceed to Health Conditions section

28. Are you currently pregnant?

Yes

No → If "No", please go to Health Conditions section.

Don't know

Refused

29. If yes, how many weeks pregnant are you?

Number of weeks

MIN: 1 MAX: 50 (Warning after 40)

DK, RF

Section: Health Conditions

The next set of questions asks about some health conditions you may have. You will need to answer 'yes' or 'no' for each condition. If yes, we will ask what age you were diagnosed and if you are currently undergoing treatment.

Note: Y= Yes, N=No, DK = Don't Know, R= Refused.

30. Have you been told by a health care professional that you have any of the following health conditions? We are interested in "long-term conditions" which are expected to last or have already lasted 6 months or more and that have been **diagnosed by a health professional**.

31. If yes, at what age were you diagnosed?

32. 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'.

Conditions	30. Told that you have:				If Yes: →	31. Age when diagnosed	32. If yes, are you undergoing treatment?			
	Yes	No	DK	R			Yes	No	DK	R
Allergies	Y	N	DK	R			Y	N	DK	R
Alzheimer's Disease or any other dementia	Y	N	DK	R			Y	N	DK	R
Anemia (chronic)	Y	N	DK	R			Y	N	DK	R
Anxiety disorder such as a phobia, obsessive-compulsive disorder or a panic disorder	Y	N	DK	R			Y	N	DK	R
Arthritis (excluding fibromyalgia)	Y	N	DK	R			Y	N	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 O DK O RF										
Attention Deficit Disorder / Attention Deficit-Hyperactivity Disorder (ADD/ADHD)	Y	N	DK	R			Y	N	DK	R
Autism Spectrum Disorder (ASD)	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
Cancer	Y	N	DK	R			Y	N	DK	R
<p>→ If yes, what type of cancer were you diagnosed with?</p> <ul style="list-style-type: none"> • Breast • Prostate • Lung • Colon • Bladder • Leukemia • Lymphoma • Malignant melanoma • Ovarian • Pancreatic • Other (Specify) • Don't Know • Refused 										
Cataracts	Y	N	DK	R			Y	N	DK	R
Chronic back pain, excluding arthritis	Y	N	DK	R			Y	N	DK	R
Dermatitis/atopic eczema	Y	N	DK	R			Y	N	DK	R
Diabetes	Y	N	DK	R			Y	N	DK	R
Effects of Stroke (brain hemorrhage)	Y	N	DK	R			Y	N	DK	R
Emphysema, Chronic bronchitis, or Chronic Obstructive Pulmonary Disease (COPD)	Y	N	DK	R			Y	N	DK	R
Epilepsy	Y	N	DK	R			Y	N	DK	R
Glaucoma	Y	N	DK	R			Y	N	DK	R
Hearing impairment	Y	N	DK	R			Y	N	DK	R
Heart Disease	Y	N	DK	R			Y	N	DK	R
Hepatitis	Y	N	DK	R			Y	N	DK	R
<p>→ If yes, what type of hepatitis do you have?</p> <p>O Type A O Type B O Type C O Don't know O RF</p>										
High Blood Pressure	Y	N	DK	R			Y	N	DK	R
<p>→ If yes, was the high blood pressure related to pregnancy?</p> <p>O Yes O No O Don't know O Refused</p>										
High Cholesterol	Y	N	DK	R			Y	N	DK	R
HIV/AIDS	Y	N	DK	R			Y	N	DK	R
Kidney Problem	Y	N	DK	R			Y	N	DK	R
Learning disorder	Y	N	DK	R			Y	N	DK	R
Liver Disease (excluding hepatitis)	Y	N	DK	R			Y	N	DK	R
Mood disorder such as depression, bipolar disorder, mania or dysthymia	Y	N	DK	R			Y	N	DK	R
Neurological disease, excluding Alzheimer's and dementia (e.g., Parkinson's, Huntington's, multiple sclerosis, etc.)	Y	N	DK	R			Y	N	DK	R
Osteoporosis	Y	N	DK	R			Y	N	DK	R
Speech or Language difficulties	Y	N	DK	R			Y	N	DK	R
Stomach and Intestinal problems	Y	N	DK	R			Y	N	DK	R
Thyroid problems	Y	N	DK	R			Y	N	DK	R
Tuberculosis	Y	N	DK	R			Y	N	DK	R
<p>→ If yes, is your tuberculosis active or inactive?</p> <p>O Active O Inactive O Don't know O Refused</p>										
Other (Specify) :	Y	N	DK	R			Y	N	DK	R

If no diabetes, please proceed to Disability section.

Section: Diabetes

If male, please proceed to question 35.

33. Were you pregnant when you were first diagnosed with diabetes?

- Yes
- No
- Don't know
- Refused

34. Other than during pregnancy, has a health professional ever told you that you have diabetes?

- Yes
- No
- Don't know
- Refused

35. When you were first diagnosed with diabetes, how long was it before you were started on insulin?

- Less than 1 month
- 1 month to less than 2 months
- 2 months to less than 6 months
- 6 months to less than 1 year
- 1 year or more
- Never
- Don't know
- Refused

36. What kind of treatment or measure are you using to manage your diabetes?

Mark all that apply.

<input type="checkbox"/> Diet	<input type="checkbox"/> Traditional medicine
<input type="checkbox"/> Exercise	<input type="checkbox"/> Traditional ceremonies/help from healer
<input type="checkbox"/> Insulin	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Pills	<input type="checkbox"/> No treatment or measure

DK, RF

37. In the past two weeks, how often have you checked your blood sugar levels?

<input type="checkbox"/> More than once a day	<input type="checkbox"/> 2 – 5 times in the past two weeks
<input type="checkbox"/> Once a day	<input type="checkbox"/> Not at all in the past two weeks
<input type="checkbox"/> 10 – 13 times in the past two weeks	<input type="checkbox"/> Don't know
<input type="checkbox"/> 6 – 9 times in the past two weeks	<input type="checkbox"/> Refused

38. Has your diabetes...

<i>Impacts of Diabetes</i>	Yes	No	Don't know	Refused
Prompted you to adopt a healthier lifestyle, which includes a good diet and/or exercise?				
Affected your vision (e.g., retinopathy)?				
Affected your kidney function?				
Affected your circulation (e.g., blood vessels, heart)?				
Affected the feeling in your hands and feet (e.g., neuropathy)?				
Affected your lower limbs?				
Resulted in infections?				
Resulted in amputation?				

39. Are you currently attending a diabetes clinic or seeing someone (medical doctor, nurse, etc.) for diabetes education?

- Yes → If yes, please go to Disability section
- No

- Don't know
- Refused

40. If you are not currently attending a diabetes clinic or seeing someone for diabetes education, why is that?
 Mark all that apply.

<input type="radio"/> No longer require diabetes education, I already have the information I need.	<input type="radio"/> Transportation costs
<input type="radio"/> I don't have sufficient information about where to go	<input type="radio"/> Childcare costs
<input type="radio"/> A diabetes clinic is not available in my area	<input type="radio"/> Felt the health service for diabetes would be inadequate
<input type="radio"/> A diabetes health specialist is not available in my area	<input type="radio"/> Felt the health service for diabetes would be culturally inappropriate
<input type="radio"/> Does not fit my schedule	<input type="radio"/> Chose not to attend
<input type="radio"/> Direct health care costs	<input type="radio"/> Other (Specify) :

DK, RF

Section: Disability

The following questions are about any activity limitations or disability you have to cope with in your day-to-day living.

41. Do you have difficulties with any of the following activities due to a long-term physical condition, mental condition, or health problem?

	No	Sometimes	Often	Always	Don't know	Refused
Seeing/reading newsprint (with glasses or contacts if normally used)						
Hearing normal conversation (with hearing aid if normally used)						
Having your speech understood by those who speak the same language						
Lifting or carrying 10 lbs						
Walking for 5 minutes without resting						
Climbing a flight of stairs without resting						
Bending down and picking up an object from the floor						
Reaching in any direction, for example, above your head						
Using your fingers to grasp small objects, such as a pencil or scissors						
Eating, bathing, dressing, using toilet						
Learning						
Remembering						
Concentrating						
Other (Specify) :						

42. Do you have a physical or mental condition that causes you to be limited in the kinds or amount of activity you can do at home, work, or otherwise?

Note: We are interested in long-term conditions or health problems that have already lasted or are expected to last 6 months or more.

Mark all that apply.

- Yes, physical condition
- Yes, mental condition
- No
- Don't know
- Refused

Section: Injury

Now some questions about injuries which occurred in the past 12 months and were serious enough to limit your normal activities the day after the injury occurred. For example, a broken bone, a bad cut, a burn or a sprain.

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

- Yes, once
- Yes, more than once
- No → If no, please go to Home Health Care section.
- Don't know
- Refused

If "Yes, more than once" for question 43, then please note: For the following injury questions, please think about your most serious injury only.

44. What type of injury did you have?

<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"/> Scrape(s), bruise(s), blister(s) (including multiple minor injuries)	<input type="radio"/> Repetitive strain
<input type="radio"/> Major cut, puncture, animal bite (open wound)	<input type="radio"/> Multiple serious injuries at the same time
<input type="radio"/> Electrocutation	<input type="radio"/> Other (Specify):
<input type="radio"/> Concussion or other brain injury	

DK, RF

45. What month did it happen?

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December
- Don't know
- Refused

46. What part of your body was injured?

<input type="radio"/> Hand	<input type="radio"/> Torso (collarbone, chest, abdomen, pelvis)
<input type="radio"/> Wrist	<input type="radio"/> Eye(s)
<input type="radio"/> Elbow, lower arm	<input type="radio"/> Head (includes face, teeth and mouth)
<input type="radio"/> Shoulder, upper arm	<input type="radio"/> Back or Spine
<input type="radio"/> Neck	<input type="radio"/> Multiple sites
<input type="radio"/> Foot	<input type="radio"/> Other (Specify):
<input type="radio"/> Ankle	<input type="radio"/> Don't know
<input type="radio"/> Knee, lower leg	<input type="radio"/> Refused
<input type="radio"/> Hip, upper thigh	

47. Where did the injury occur?

<input type="radio"/> Home or in someone else's home	<input type="radio"/> Industrial or construction area
<input type="radio"/> School, college, university (non-sport related)	<input type="radio"/> Office
<input type="radio"/> Sports fields/facilities	<input type="radio"/> Countryside, forest, woodlot
<input type="radio"/> Street, highway, sidewalk	<input type="radio"/> Lake, river, ocean
<input type="radio"/> Commercial area (e.g., store, restaurant)	<input type="radio"/> Other (Specify):
<input type="radio"/> Community buildings (community centre, band office)	

DK, RF

48. What were you doing when the injury occurred?

<input type="checkbox"/> Sports or physical exercise	<input type="checkbox"/> Unpaid work/ chores around the house
<input type="checkbox"/> Leisure or hobby	<input type="checkbox"/> Riding a bicycle
<input type="checkbox"/> Sleeping, eating, personal care	<input type="checkbox"/> Driver or passenger in/on road motor vehicle (including motorcycles, trucks)
<input type="checkbox"/> Driver or passenger in/on off-road motor vehicle (including boat, ATV, snowmobile)	<input type="checkbox"/> Walking
<input type="checkbox"/> Working at a job or business	<input type="checkbox"/> Other (Specify):

DK, RF

49. What caused the injury?

<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Contact with a machine, tool, etc.
→ Were you wearing a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	
<input type="checkbox"/> ATV accident	<input type="checkbox"/> Smoke, fire, flames
→ Were you wearing a helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	
<input type="checkbox"/> Snowmobile accident	<input type="checkbox"/> Contact with HOT liquid, object, etc.
→ Were you wearing a helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	
<input type="checkbox"/> Hunting accident	<input type="checkbox"/> Extreme weather or natural disaster (e.g., flood)
<input type="checkbox"/> Boating accident	<input type="checkbox"/> Falling through thin ice
→ Were you wearing a life jacket? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused	
<input type="checkbox"/> Accidental contact with another person or animal	<input type="checkbox"/> Overexertion or strenuous movement
<input type="checkbox"/> Fall → go to question 50	<input type="checkbox"/> Suicide attempt or other self-inflicted injury
<input type="checkbox"/> Domestic/ Family violence	<input type="checkbox"/> Bicycle accident
	→ Were you wearing a helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
<input type="checkbox"/> Accidentally struck or crushed by object(s)	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Other physical assault	

DK, RF

If injury was not the result of a fall, proceed to question 51

50. How did you fall?

- While skating, skiing or snowboarding
- While engaged in other sport or physical exercise (including school activities and running)
- Going up or down stairs / steps (icy or not)
- Slip, trip, stumble or loss of balance while walking on ice or snow
- Slip, trip, stumble or loss of balance while walking on any other surface
- From furniture or while rising from furniture (e.g., bed, chair)
- From elevated position (e.g., ladder, tree, scaffolding)
- Due to health problems (e.g., faint, weakness, dizziness, hip/knee gave out, seizure)
- Other (**Specify**):
- Don't know
- Refused

51. Where did you get medical treatment for your injury?

Mark all that apply.

<input type="checkbox"/> Doctor's office	<input type="checkbox"/> At school
<input type="checkbox"/> Physiotherapist or massage therapist's office	<input type="checkbox"/> At work
<input type="checkbox"/> Chiropractor's office	<input type="checkbox"/> At home
<input type="checkbox"/> Hospital emergency room	<input type="checkbox"/> By Internet/telephone/e-health
<input type="checkbox"/> Walk-in clinic	<input type="checkbox"/> Traditional healer
<input type="checkbox"/> Community Health Centre/Nursing Station	<input type="checkbox"/> Other (Specify):

Dental practitioner Didn't receive any medical treatment

DK, RF

52. When the injury happened, did any of the following substances have an influence? *Mark all that apply.*

- Yes, alcohol
- Yes, marijuana
- Yes, other substance (Specify)
- No
- Don't know
- Refused

Section: Home Health Care

The next section focuses on home health care services.

53. Do you believe you currently need any of the following services at home because of a physical or mental condition or health problem?

54. If yes, do you currently receive the service?
Mark a response for each.

Home Care	53. NEED the service?				54. If yes, RECEIVE the service?			
	Yes	No	DK	RF	Yes	No	DK	RF
Light housekeeping								
Home maintenance								
Care from a nurse								
Palliative care (terminally ill)								
Personal care (grooming, washing, etc.)								
Meals prepared or delivered								
Running errands								
Paying bills								
Long term care								
Other (Specify):								

The following questions ask about services you may give or provide to others.

55. Do you help with home care (e.g., dressing, bathing, meals, housekeeping, travel) for a family member or friend because he/she has a chronic condition or a disability?

- Yes
- No
- Don't know
- Refused

If you do not help with home care, please proceed to question 58.

56. What type of care do you provide? *Mark all that apply.*

<input type="checkbox"/> Housekeeping (cleaning, laundry, etc.)	<input type="checkbox"/> Home maintenance (e.g., minor repair, shoveling driveway)
<input type="checkbox"/> Personal care (grooming, washing, etc.)	<input type="checkbox"/> Running errands
<input type="checkbox"/> Driving	<input type="checkbox"/> Administer medication
<input type="checkbox"/> Paying bills	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Food preparation	

DK, RF

57. How many hours a week do you provide care?

Hours
 (MIN: 1) (MAX: 168)

DK, RF

58. Do you have any immediate family members that have been placed in a long-term care facility?

- Yes, in a facility on reserve/in my community
- Yes, in a facility off reserve/outside my community
- No
- Don't know
- Refused

Section: Health Care Access

The next section concerns your access to health, well-being, and dental services.

59. Overall, how would you rate the quality of the health care services that are available in your community?

- Excellent
- Good
- Fair
- Poor
- Don't know
- Refused

60. Over the past 12 months, how often has your primary health care provider (family physician/RN/nurse practitioner) changed?

- Two times or more
- Once
- Stayed the same
- I don't have a primary health care provider
- Don't know
- Refused

61. When did you last...?

	Never	Within the past 12 months	1-2 years ago	Over 2 years ago	Don't know	Refused
Consult a traditional healer						
Visit a doctor or community health nurse						
Access a mental health service (e.g., counseling, psychological testing)						

62. In the past 12 months, did you use traditional medicine?

Note: Traditional medicine can include herbal remedies, spiritual therapies, assistance from healers, or other practices indigenous to your culture.

- Yes
- No
- Don't know
- Refused

63. Have you had any of the following difficulties when trying to access traditional medicine?

Mark all that apply.

If you didn't experience any difficulties or are not interested in using traditional medicine, please mark the appropriate option and proceed to the next question.

<input type="radio"/> Not interested in using traditional medicine	<input type="radio"/> Do not know enough about it
<input type="radio"/> No difficulties in accessing traditional medicine	<input type="radio"/> Not available in health care setting
<input type="radio"/> Do not know where to get it	<input type="radio"/> Not covered by Non-Insured Health Benefits (Health Canada)
<input type="radio"/> Restrictions/regulations	<input type="radio"/> Child care
<input type="radio"/> Can't afford it	<input type="radio"/> Other (Specify) :
<input type="radio"/> Too far to travel	<input type="radio"/> Don't know
<input type="radio"/> Concerned about effects	<input type="radio"/> Refused

64. During the past 12 months, did you require any health care (e.g., from a doctor, nurse, or other health professional)?

- Yes, and I received all the health care I needed
- Yes, but I did not receive all the health care I needed
- No → If no, please go to question 66
- Don't know
- Refused

65. During the past 12 months, have you experienced any of the following barriers to receiving health care?

Please read each item and mark your answer.

Note: NIHB, or Non-Insured Health Benefits, is the Health Canada program that provides support to help cover health care costs - medications, dental care, vision care, medical supplies/equipment, etc.

Access Barriers	Yes	No	Don't know	Refused
Doctor or nurse not available in my area				
Health facility not available in my area (e.g., community health centre/nursing station or hospital)				
Service was not available in my area				
Unable to arrange transportation				
Difficulty in getting traditional care (e.g., healer, medicine person, or Elder)				
Not covered by Non-Insured Health Benefits (NIHB)				
Did not know if it was covered by NIHB				
Prior approval of Non-Insured Health Benefits was denied				
Could not afford direct cost of care/services				
Could not afford transportation costs				
Could not afford childcare costs				
Felt health care provided was inadequate				
Felt service was not culturally appropriate				
Chose not to see health care professional				
Waiting list is too long				
Other (Specify):				

DK, RF

66. Have you ever had any difficulties accessing any of the health services provided through the Non-Insured Health Benefits Program (NIHB) provided to status First Nations people through Health Canada?

Note: NIHB, or Non-Insured Health Benefits, is the Health Canada program that provides support to help cover health care costs - medications, dental care, vision care, medical supplies/equipment, etc.

Mark all that apply.

<input type="checkbox"/> Not applicable (didn't need service / didn't try to access)	<input type="checkbox"/> Ambulance Services
<input type="checkbox"/> No difficulties	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Medication	<input type="checkbox"/> Escort travel
<input type="checkbox"/> Dental care	<input type="checkbox"/> Transportation services or costs (air or road)
<input type="checkbox"/> Vision care (e.g., glasses)	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Don't know
<input type="checkbox"/> Other medical supplies (e.g., walker, crutches)	<input type="checkbox"/> Refused

Section: Preventative Health Care

The next section asks questions on preventative health care measures.

67. 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 71.

68. Other than a mammogram, when was the last time you had your breasts examined for lumps (tumours, cysts) by a doctor or other health professional?

<input type="radio"/> Never	<input type="radio"/> 2 years to less than 5 years ago
<input type="radio"/> Less than 6 months ago	<input type="radio"/> 5 or more 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 2 years ago	<input type="radio"/> Refused

69. When was the last time you had a mammogram?

<input type="radio"/> Never had one	<input type="radio"/> 3 years to less than 5 years ago
<input type="radio"/> Less than 1 year ago	<input type="radio"/> 5 or more years ago
<input type="radio"/> 1 year to less than 2 years ago	<input type="radio"/> Don't know
<input type="radio"/> 2 years to less than 3 years ago	<input type="radio"/> Refused

70. 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 1 year ago	<input type="radio"/> 5 or more years ago
<input type="radio"/> 1 year to less than 2 years ago	<input type="radio"/> Don't know
<input type="radio"/> 2 years to less than 3 years ago	<input type="radio"/> Refused

71. Have you ever been screened for colorectal cancer (e.g., FOBT, sigmoidoscopy, colonoscopy)?

- Yes
- No
- Don't know
- Refused

If you are female, please proceed to question 73

72. Have you ever had a physical prostate check (rectal exam) or PSA Test?

Note: A PSA test is the Prostate-specific antigen blood test. It is used to screen for cancer of the prostate.

- Yes
- No
- Don't know
- Refused

Section: Dental Care

The next section asks questions about your dental health.

73. In general, would you say the health of your teeth and mouth is...?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

74. 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

75. Do you have one or more of your own teeth?

We are referring to your permanent adult teeth, not including false teeth or dentures.

- Yes
- No
- Don't know
- Refused

76. Do you wear full or partial dentures, false teeth, bridges, or dental plates to replace missing permanent teeth?

- Yes
- No
- Don't know
- Refused

77. Have you had any of the following difficulties accessing dental care?

Note: NIHB, or Non-Insured Health Benefits, is the Health Canada program that provides money to help cover health care costs – medications, dental care, vision care, medical supplies/equipment, etc.

Mark all that apply

- Not applicable (No dental care was needed) No difficulties
- Dental services not available in my area
- Waiting list is too long
- Service not covered by Non-Insured Health Benefits (NIHB)
- Prior approval for services under NIHB was denied
- Direct cost of dental care
- Transportation costs
- Childcare costs
- Other costs
- Felt dental services were inadequate
- Other (Specify):
- Don't know
- Refused

78. Do you currently need any of the following dental treatments?

Mark all that apply.

<input type="checkbox"/> Cavities filled or other restorative work (e.g., fillings, crowns, bridge)	<input type="checkbox"/> Orthodontics (e.g., braces)
<input type="checkbox"/> Maintenance (e.g., checkups or teeth cleaning)	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Extractions (taking teeth out)	<input type="checkbox"/> None
<input type="checkbox"/> Fluoride treatment	<input type="checkbox"/> Don't know
<input type="checkbox"/> Periodontal (gum) work	<input type="checkbox"/> Refused
<input type="checkbox"/> Prosthetics (e.g., denture, including repair and maintenance)	

Section: Food and Nutrition

The following questions ask about your eating habits.

79. On average, how often do you eat or drink the following foods?

Choose the answer that best describes the way you normally eat/drink.

	Two or more times a day	Once a Day	A few times a week	About once a week	Never/hardly ever
Milk, yogurt, cheese or fortified soy beverage.					
Meat and alternatives (e.g., beef, chicken, pork, fish, seafood, deer, moose, eggs, beans, tofu)					
Vegetables (fresh, frozen, or canned)					
Fruit (excluding fruit juice)					

Bread, pasta, rice and other grains					
Water					
100% fruit juice (e.g., orange, grapefruit, tomato)					
Soft drinks/pop/artificially flavoured juice					
Fast food (e.g., burgers, pizza, hotdogs, French fries)					
Sweets (e.g., candy, cookies, cake)					
Energy drinks (e.g, Red Bull, Monster, RockStar)					

DK, RF

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

Please note that some of these foods may not be considered traditional for all individuals or regions.

Traditional Foods	Not Applicable (not a local traditional food)	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				
Bannock or Fry bread				
Wild rice				
Corn soup				
Meat, fish, or vegetable broth				
Other (<i>Specify</i>):				

DK, RF

81. In the past 12 months, how often did you eat nutritious balanced meals?

Note: Balanced meals contain a variety of food groups, for example a selection of protein, grains, vegetables and fruits, and dairy products.

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

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

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

Section: Food Security

Here are a few statements that may be used to describe the food situation for a household. Please indicate if the statement was often true, sometimes true, or never true for you and your family in the past 12 months.

83. The first statement is, "*The food that we bought just didn't last and we didn't have the money to get more*". Was that statement often, sometimes or never true for your household in the past 12 months?

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

Refused

84. Next statement: "*We couldn't afford to eat balanced meals*".

Was that statement often, sometimes, or never true for your household in the past 12 months?

Note: Balanced meals contain a variety of food groups, for example a selection of protein, grains, vegetables and fruits, and dairy products.

Often true

Sometimes true

Never true

Don't know

Refused

85. In the past 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

Yes

No → If you answered no, go to question 87.

Don't know

Refused

86. If you answered yes to skipping meals, how often did this happen – almost every month, some months but not every month, or in only 1 or 2 months in the past year?

Almost every month

Some months but not every month

Only one or two months

Don't know

Refused

87. In the past 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

Yes

No

Don't know

Refused

88. In the past 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?

Yes

No

Don't know

Refused

89. Next are a few statements that may describe the food situation for households with children. ***If you do not have any children in your household, please skip to the Physical Activity section.***

Please indicate if the statement was often true, sometimes true, or never true for you and your family in the past 12 months.

The first statement is, "*You had to rely on only a few kinds of low-cost food (e.g., macaroni, rice) to feed your child/children because you were running out of money to buy food*".

Was that statement often, sometimes or never true for your household in the past 12 months?

Often true

Sometimes true

Never true

Don't know

Refused

90. The next statement is, "*You couldn't feed your child/children a balanced meal, because you couldn't afford it*".

Was that statement often, sometimes or never true for your household in the past 12 months?

Note: Balanced meals contain a variety of food groups, for example a selection of protein, grains, vegetables and fruits, and dairy products.

Often true

Sometimes true

- Never true
- Don't know
- Refused

91. The final statement: "The child was not eating enough because you (the primary care giver) just couldn't afford enough food".

Was that statement often, sometimes or never true for your household in the past 12 months?

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

Section: Physical Activity

Next are some questions about your physical activities, beginning with physical activities NOT related to work; that is, leisure time activities.

92. Have you done any of the following activities in the past 3 months?

Mark all that apply.

<input type="checkbox"/> Aerobics/Fitness classes	<input type="checkbox"/> Skateboarding
<input type="checkbox"/> Berry picking or other food gathering	<input type="checkbox"/> Skating
<input type="checkbox"/> Bicycle riding/Mountain biking	<input type="checkbox"/> Skiing/Snowboarding
<input type="checkbox"/> Bowling	<input type="checkbox"/> Snowmobiling
<input type="checkbox"/> Boxing	<input type="checkbox"/> Snowshoeing
<input type="checkbox"/> Canoeing/Kayaking	<input type="checkbox"/> Swimming
<input type="checkbox"/> Competitive or team sports (e.g., hockey, basketball, baseball, lacrosse, tennis)	<input type="checkbox"/> Traditional dancing
<input type="checkbox"/> Dancing (aerobic, modern, etc.)	<input type="checkbox"/> Trapping
<input type="checkbox"/> Fishing	<input type="checkbox"/> Walking for exercise
<input type="checkbox"/> Outdoor gardening, yard work	<input type="checkbox"/> Weights, exercise equipment
<input type="checkbox"/> Golf	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Hiking	<input type="checkbox"/> None
<input type="checkbox"/> Hunting	<input type="checkbox"/> Don't know
<input type="checkbox"/> Martial arts	<input type="checkbox"/> Refused
<input type="checkbox"/> Running or jogging	

If you answered "None" to question 92 please proceed to question 95.

93. In the past 3 months, how many times did you participate in the activity?

Note: If you need help calculating the number of times, please ask the Field Worker.

Some examples of 3 month estimates:

Daily= 90 times

Three times a week = 39 times

Twice a month = 6 times

Activity (insert all checked above)	Number of times participated

DK, RF

MIN: 1 MAX: 300

94. How many minutes do you generally spend doing each activity in the average session?

Note: Some examples of time estimates:

½ hour = 30 minutes 1 hour = 60 minutes 1 ½ hours = 90 minutes 2 hours = 120 minutes

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

DK, RF

MIN: 1 MAX: 480 (8 hrs) Warning if < 10 or > 240 (4 hrs)

95. Thinking of a **typical week**, which best describes your amount of physical activity?

*Note: Please include only physical activity that is **at least moderate-intensity**; that is, activity that makes you sweat a little and breathe harder than normal.*

*This may **include any activities you do as part of your everyday life** - at work/school, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.*

Some examples of time estimates:

1 hour = 60 minutes 1 ½ hours = 90 minutes 2 hours = 120 minutes 2 ½ hours = 150 minutes

<input type="radio"/> You spend at least 60 minutes on physical activity every day .	<input type="radio"/> In total, you spend between 60 and 149 minutes on physical activity during the week .
<input type="radio"/> You spend 30-59 minutes on physical activity every day .	<input type="radio"/> In total, you spend from 0 to 59 minutes on physical activity during the week .
<input type="radio"/> In total, you spend at least 150 minutes on physical activity during the week (but less than 30 minutes every day).	

DK, RF

96. During the past week, how much time in an **average day** did you spend watching TV, reading, playing bingo/seated video games, using the Internet including social media, or working at your computer? (Do not include time spent at work or school.)

____ hours
____ minutes

Hours: MIN 0 MAX 24 (warning after 16) Minutes: MIN 0 MAX 59

DK, RF

Section: Smoking

The following group of questions is about your personal habits.

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

- Yes, daily → Go to question 99
- Yes, occasionally → Go to question 100
- No
- Don't know
- Refused

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

- Yes, daily → Go to question 102
- Yes, occasionally → Go to question 102
- No → If you answered no, go to question 107.
- Don't know
- Refused

99. On average, how many cigarettes do you currently smoke each day?
(Current daily smokers) *Approximate if necessary*

MIN: 1 MAX: 99

DK, RF

100. At what age did you begin smoking cigarettes?

(Current smokers)

Age in years

MIN: 5 MAX: 121

DK, RF

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

(For current smokers only)

0 (didn't try to quit)

1 – 2 tries

3 – 4 tries

5 or more tries

Don't know

Refused

If you currently smoke daily or occasionally, please proceed to question 107.

102. When did you stop smoking? Was it ...?

(For ex-smokers only)

Less than one year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

3 or more years ago

Don't know

Refused

103. At what age did you begin smoking cigarettes?

(ex-smokers only)

Age in years

MIN: 5 MAX: 121

DK, RF

104. At what age did you quit smoking cigarettes?

(ex-smokers only)

Age in years

MIN: 5 MAX: 121

DK, RF

105. What were your reasons for quitting smoking?

Mark all that apply.

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

106. 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="checkbox"/> With help from spirituality	<input type="checkbox"/> Traditional methods
<input type="checkbox"/> With assistance from family	<input type="checkbox"/> Self-help/support program
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Electronic cigarette
<input type="checkbox"/> Nicotine replacement patch	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Nicotine replacement gum	<input type="checkbox"/> Don't know

<input type="radio"/> Zyban (bupropion)	<input type="radio"/> Refused
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107. Including both household members and regular visitors, does anyone smoke inside your home, every day or almost every day?

(Include cigarettes, cigars and pipes)

(For non-smokers, ex-smokers, and current smokers)

- Yes
- No
- Don't know
- Refused

108. In the past month, were you exposed to second-hand smoke, every day or almost every day, in a car or other private vehicle?

(Include cigarettes, cigars and pipes).

- Yes
- No
- Don't know
- Refused

Section: Alcohol and Drug Use

109. 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 113
- Don't know
- Refused

110. During the past 12 months, how often did you drink alcoholic beverages?

Please select one that best describes your habits.

- Daily
- About 2 – 3 times a week
- About 2 – 3 times a month
- About once a month
- About 2 – 3 times a year or less
- Don't know
- Refused

111. During the past 12 months, how often have you had 5 or more alcoholic drinks on one occasion?

Note: One drink includes one beer, one glass of wine, or one shot of hard liquor.

- Never
- Less than once a month
- Once per month
- 2-3 times per month
- Once per week
- More than once per week
- Every day
- Don't know
- Refused

112. In the past 12 months, have you sought treatment for alcohol abuse/alcohol addiction?

- Yes, and I completed the treatment
- Yes, but I didn't complete the treatment
- Yes, but no treatment was available
- No
- Don't know
- Refused

113. Have you had any of the following substances in the past 12 months?

For each substance, please select the answer that best describes your usage.

Substances	Never	Once or twice	Monthly	Weekly	Daily or almost daily	Don't know	Refused
Cannabis (marijuana, pot, grass, hash, etc.)							
Cocaine (coke, crack, etc.)							
Amphetamines (speed, etc.)							
Methamphetamine or Crystal Meth							
Ecstasy (MDMA, E, Xtc, X, etc.)							
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, mescaline, angel dust, etc.)							
Inhalants (solvents, glue, petrol, paint thinner, etc.)							
Heroin (H, horse, junk, smack)							
Salvia (Divine Sage, Magic Mint, Sally D)							
Other (Specify): (not including drugs normally prescribed by a doctor or dentist)							

If never used Cannabis, proceed to question 115

114. In the past 12 months, have you used Cannabis (marijuana, pot, grass, hash, etc.) for medical purposes?

- Yes
- No
- Don't know
- Refused

115. Have you had any of the following substances in the past 12 months?

For each substance, please select the answer that best describes your usage. Note: We are not interested in over-the-counter medications that are available without a prescription.

Substances	Never	Once or twice	Monthly	Weekly	Daily or almost daily	Don't know	Refused
Pain relievers that contain opioids such as Oxycodone (Percocet, Percodan, OxyContin), Codeine (Tylenol 3, 292s, 222s), or Hydromorphone (Morphine, Dilaudid, Hydromorph Contin, Demorol), etc.							
Stimulants (Ritalin, Concerta, Adderall, Dexedrine, etc.)							
Sedatives (Valium, Ativan, Xanax, Rivotril, etc.)							

If never used pain relievers, stimulants or sedatives, proceed to question 119

116. Thinking about all the pain relievers, stimulants, and/or sedatives you have used in the past 12 months, were they prescribed?

- Yes, all prescribed
- No, none prescribed
- Some prescribed, some not prescribed
- Don't know
- Refused

If No (none prescribed), proceed to question 118

117. If prescribed, sometimes people do not take pills as directed by a doctor or pharmacist. Thinking about all the pain relievers, stimulants, and/or sedatives you have used in the past 12 months, did you ever take more pills or take them for a longer period than you were supposed to?

- Yes
- No
- Don't know
- Refused

118. Thinking about all the pain relievers, stimulants, and/or sedatives you have used in the past 12 months, did you ever tamper with the product before taking it, for example, crush tablets to swallow, snort or inject?

- Yes
- No
- Don't know
- Refused

119. In the past 12 months, have you sought treatment for substance abuse/substance addiction?

- Yes, and I completed the treatment
- Yes, but I didn't complete the treatment
- Yes, but no treatment was available
- No
- Don't know
- Refused

Section: Sexual Activities

The following questions are about sexual identity and 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.

120. Do you identify as being Two-spirited/Trans-gender?

- Yes
- No
- Don't know
- Refused

121. Do you identify as being....?

- Heterosexual
- Homosexual
- Bisexual
- Don't know
- Refused

122. Have you ever had sexual intercourse?

- Yes
- No → If no, go to question 129.
- Don't know
- Refused

123. Have you had sexual intercourse in the past 12 months?

- Yes
- No → If no, go to question 129
- Don't know
- Refused

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

- 1 partner
- 2 partners
- 3 partners
- 4 partners or more
- Don't know
- Refused

125. Which of the following birth control or protective methods do you and/or your partner(s) use?
Read the list. Mark all that apply.

<input type="radio"/> Withdrawal	<input type="radio"/> Surgery (hysterectomy, vasectomy, tubes tied)
<input type="radio"/> Patch	<input type="radio"/> Intrauterine Device (IUD)
<input type="radio"/> Condoms (male or female)	<input type="radio"/> Other (Specify):
<input type="radio"/> Birth control pills	<input type="radio"/> None → Go to question 128
<input type="radio"/> Depo Provera (injection)	<input type="radio"/> Don't know
<input type="radio"/> Rhythm (natural family planning)	<input type="radio"/> Refused

126. What is the main purpose of the method/s you use?

- Birth control (avoid pregnancy)
- Protection from sexually transmitted infections
- Both (birth control and STI protection)
- Other (Specify):
- Don't know
- Refused

127. How often do you use condoms during intercourse?

- Always → If always, go to question 129.
- Most of the time
- Occasionally
- Never
- Don't know
- Refused

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

Check the answer that best describes your situation.

<input type="radio"/> Your partner doesn't want to use one	<input type="radio"/> You are with a steady partner
<input type="radio"/> You don't want to use one	<input type="radio"/> Under the influence of alcohol or drugs
<input type="radio"/> You or your partner want to get pregnant	<input type="radio"/> Other (Specify):
<input type="radio"/> You or your partner are allergic	<input type="radio"/> Don't know
<input type="radio"/> You can't afford to buy condoms	<input type="radio"/> Refused

The following questions can help to design programs to improve health and increase the awareness of HIV and STIs.

129. Have you ever been tested for Sexually Transmitted Infections (STIs)?

Note: Some examples of STIs include chlamydia, herpes, gonorrhea, syphilis, etc.

- Yes
- No
- Don't know
- Refused

130. Have you ever been tested for HIV/AIDS?

- Yes
- No
- Don't know
- Refused

Section: Gambling

The following questions ask about gambling. These questions are being asked of everyone but they may not necessarily apply to you.

131. In the past 12 months, have you gambled (bet or spent money on bingo, card games, lottery tickets, Video Lottery Terminals (VLT), casino, sports games, Internet gambling)?

- Yes
- No → If No, please go to Personal Wellness section.
- Don't know

Refused

132. Have you ever borrowed money to gamble?

- Yes
- No
- Don't know
- Refused

133. Have you ever bet more money than you could afford to lose?

- Yes
- No
- Don't know
- Refused

134. Has your gambling caused any financial problems for you and your family?

- Yes
- No
- Don't know
- Refused

Section: Personal Wellness

This set of questions is about your personal wellness and related indicators of well-being.

135. How would you describe your sense of belonging to your local community? Would you say it is ...?

- Very strong
- Somewhat strong
- Somewhat weak
- Very weak
- Don't know
- Refused

Please indicate if you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the following statements:

136. Traditional spirituality is important to me.

<input type="radio"/> Strongly agree	<input type="radio"/> Strongly disagree
<input type="radio"/> Agree	<input type="radio"/> Don't know
<input type="radio"/> Neither agree nor disagree	<input type="radio"/> Refused
<input type="radio"/> Disagree	

137. Organized religion is important to me (e.g., Christianity, Buddhism, Islam).

<input type="radio"/> Strongly agree	<input type="radio"/> Strongly disagree
<input type="radio"/> Agree	<input type="radio"/> Don't know
<input type="radio"/> Neither agree nor disagree	<input type="radio"/> Refused
<input type="radio"/> Disagree	

138. How often do you feel in balance physically, emotionally, mentally, and spiritually?

	All of the time	Most of the time	Some of the time	Almost none of the time	None of the time	Don't know	Refused
Physically							
Emotionally							
Mentally							
Spiritually							

139. 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 or 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					

DK, RF

The following questions ask about any threats you may have experienced to your personal safety. They are being asked of everyone but may not apply to you.

140. Have you experienced any physical aggression towards you in the past 12 months?

This includes hitting, kicking, crowding, etc.

<input type="radio"/> Yes, often	<input type="radio"/> No, never
<input type="radio"/> Yes, sometimes	<input type="radio"/> Don't know
<input type="radio"/> Yes, rarely	<input type="radio"/> Refused

141. Have you experienced any verbal aggression towards you in the past 12 months?

Verbal aggression includes threats, insults, name calling, etc.

<input type="radio"/> Yes, often	<input type="radio"/> No, never
<input type="radio"/> Yes, sometimes	<input type="radio"/> Don't know
<input type="radio"/> Yes, rarely	<input type="radio"/> Refused

If answered "No, never" to both physical and verbal aggression, proceed to question 143

142. Where did the aggression occur? *Mark all that apply.*

- At home
- At work/school
- In the community
- Online
- Other (**Specify**):
- Don't know
- Refused

143. Have you experienced any cyber-bullying towards you in the past 12 months?

Note: "Cyber-bullying" refers to the use of a computer or other electronic device to engage in bullying.

- Yes
- No
- Don't know
- Refused

If you answered "No/ No, never" to questions 140, 141, and 143, please proceed to question 145

144. Did you seek help in dealing with the aggression/cyber-bullying that you experienced?

- Yes, and I received all the help that I needed
- Yes, but I did not receive all the help that I needed
- No

- Don't know
- Refused

145. In the past 12 months, have you personally experienced any instances of racism?

- Yes
- No → If no, go to question 148.
- Don't know
- Refused

146. Where did the racism occur? *Mark all that apply.*

- At home
- At work/school
- In the community
- Outside the community
- Other (*Specify*)
- Don't know
- Refused

147. Has this racism negatively affected your self-esteem?

<input type="radio"/> No effect	<input type="radio"/> Very strong effect
<input type="radio"/> Little effect	<input type="radio"/> Don't know
<input type="radio"/> Some effect	<input type="radio"/> Refused
<input type="radio"/> Strong effect	

The following questions are about your mood over the past month.

148. In the past month, how often did you feel tired out for no good reason?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

149. In the past month, how often did you feel nervous?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

150. In the past month, how often did you feel so nervous that nothing could calm you down?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

151. In the past month, how often did you feel hopeless?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

152. In the past month, how often did you feel restless or fidgety?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

153. In the past month, how often did you feel so restless you could not sit still?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

154. In the past month, how often did you feel depressed?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

155. In the past month, how often did you feel that everything was an effort?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

156. In the past month, how often did you feel so sad that nothing could cheer you up?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

157. In the past month, how often did you feel worthless?

<input type="radio"/> All of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> Don't know
<input type="radio"/> Some of the time	<input type="radio"/> Refused
<input type="radio"/> A little of the time	

158. Thinking about the amount of stress in your life, are most days ...?

- Not at all stressful
- Not very stressful
- A bit stressful
- Quite a bit stressful
- Extremely stressful
- Don't know
- Refused

159. In the past 12 months, did you feel like you needed to see or talk on the telephone to anyone about your emotional or mental health?

- Yes
- No
- Don't know
- Refused

160. In the past 12 months, who have you seen or talked on the telephone to about your emotional or mental health?
Mark all that apply.

- Immediate family member
- Other family member
- Friend
- Traditional healer
- Family doctor
- Mental health professional (e.g., psychologist, psychiatrist, counselor, therapist, etc.)
- CHR (Community Health Representative)
- Nurse

- Social worker
- Crisis line worker
- Other (**Specify**) :
- No one
- Don't know
- Refused

161. 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?

Mark one response for each item.

	All of the time	Most of the time	Some of the time	Almost none of the time	None of the time	Don't know	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							

The following questions relate to the sensitive issue of suicide.

162. In the past 12 months, has a close friend or family member taken their own life?

- Yes
- No
- Don't know
- Refused

163. Have you ever seriously considered suicide?

- Yes
- No → If no, go to question 166.
- Don't know
- Refused

164. When did these suicidal thoughts occur?

Mark all that apply.

- In the past 12 months
- As an adult
- As an adolescent (aged 12-17)
- As a child (less than 12 years old)
- Don't know
- Refused

165. Did you see or talk to a health professional about these suicidal thoughts?

- Yes
- No
- Don't know
- Refused

166. Have you ever attempted suicide?

- Yes
- No → If no, go to Residential Schools section.
- Don't know

Refused

167. When did the suicide attempt(s) occur?
Mark all that apply.

- In the past 12 months
- As an adult
- As an adolescent (aged 12-17)
- As a child (less than 12 years old)
- Don't know
- Refused

168. Did you see or talk to a health professional following your suicide attempt(s)?

- Yes
- No
- Don't know
- Refused

Section: Residential Schools

The following questions are about Residential Schools.

Note: 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.

169. Did you attend a residential school?

- Yes
- No → If no, go to question 174.
- Don't know
- Refused

170. At what age did you start to attend residential school?

Age in years

MIN: 4 MAX: 18
DK, RF

171. At what age did you leave residential school?

Age in years

MIN: 4 MAX: 18
DK, RF

172. Do you believe that your overall health and well-being have been affected by your attendance at residential school?

- Yes, negatively impacted
- Yes, positively impacted → Go to question 174.
- No impact → Go to question 174.
- Don't know
- Refused

173. Of the following possibilities, which do you feel contributed to the negative impact on your health and well-being?
Mark all that apply

<input type="checkbox"/> Loss of language	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Loss of cultural identity	<input type="checkbox"/> Witnessing abuse
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Separation from community
<input type="checkbox"/> Loss of traditional religion/spirituality	<input type="checkbox"/> Harsh discipline
<input type="checkbox"/> Isolation from family	<input type="checkbox"/> Poor education

<input type="checkbox"/> Harsh living conditions (e.g., lack of heat)	<input type="checkbox"/> Lack of food
<input type="checkbox"/> Lack of proper clothing	<input type="checkbox"/> Bullying from other children
<input type="checkbox"/> Not able to talk about it	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Verbal or emotional abuse	

DK, RF

174. Were any of your family members ever a student at residential school?

	Yes	No	Don't know	Refused
Mother or female guardian				
Father or male guardian				
At least one grandparent				
Brother(s)/sister(s)				
Spouse/common-law partner				
Children				
Other family member/s				

Section: Community Wellness and Traditional Culture

This set of questions focuses on community wellness and traditional culture.

175. In general, how safe do you feel in your community?

- Very safe
- Reasonably safe
- Somewhat unsafe
- Very unsafe
- Don't know
- Refused

176. What are the main strengths of your community? *Mark all that apply.*

<input type="checkbox"/> Awareness of First Nations culture	<input type="checkbox"/> Low rates of crime
<input type="checkbox"/> Community health programs	<input type="checkbox"/> Low rates of suicide
<input type="checkbox"/> Control over decisions	<input type="checkbox"/> Natural environment/resources
<input type="checkbox"/> Education and training opportunities	<input type="checkbox"/> Policing
<input type="checkbox"/> Elders	<input type="checkbox"/> Social connections (community working together, sense of belonging)
<input type="checkbox"/> Family values/connections	<input type="checkbox"/> Spirituality
<input type="checkbox"/> Good employment opportunities	<input type="checkbox"/> Strong economy
<input type="checkbox"/> Good leisure/recreation facilities	<input type="checkbox"/> Strong leadership
<input type="checkbox"/> Health (physical or mental)	<input type="checkbox"/> Traditional gatherings/ceremonial activities (e.g., powwow)
<input type="checkbox"/> Housing	<input type="checkbox"/> Use of First Nation language
<input type="checkbox"/> Low rates of alcohol and drug abuse	<input type="checkbox"/> Other (Specify) :

DK, RF

177. What are the main challenges your community is currently facing?

Mark all that apply.

<input type="checkbox"/> Access to recreational facilities	<input type="checkbox"/> Housing
<input type="checkbox"/> Alcohol and drug abuse	<input type="checkbox"/> Natural environment/resources
<input type="checkbox"/> Control over decisions	<input type="checkbox"/> Policing
<input type="checkbox"/> Crime	<input type="checkbox"/> Politics
<input type="checkbox"/> Culture	<input type="checkbox"/> Racism
<input type="checkbox"/> Education and training opportunities	<input type="checkbox"/> Suicide
<input type="checkbox"/> Employment/number of jobs	<input type="checkbox"/> Violence
<input type="checkbox"/> Funding	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Gambling	<input type="checkbox"/> Don't know
<input type="checkbox"/> Gang activity	<input type="checkbox"/> Refused
<input type="checkbox"/> Health (physical or mental)	

178. Has there been any change in these areas in the past 12 months?

	Good progress/ change	Some progress/ change	No progress/ change	Worsening	Don't know	Refused
Access to recreational facilities						
Alcohol and drug abuse						
Control over decisions						
Crime						
Culture						
Education and training opportunities						
Employment/ number of jobs						
Funding						
Gambling						
Gang activity						
Health (physical or mental)						
Housing						
Natural environment/resources						
Policing						
Politics						
Racism						
Suicide						
Violence						
Other (Specify):						

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

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

Section: Education

These questions are about your education.

180. Did you complete a high school diploma?

NOTE: Please include completion through an upgrading or high school equivalency program such as General Educational Development (GED) or Adult Basic Education (ABE).

For Québec: This includes only the Secondary School Diploma (SSD) and equivalencies such as the General Development Test (GDT), Attestation of Equivalence of Secondary V Studies (AESS), or General Educational Development Testing Service (GEDTS). Please exclude any secondary vocational studies.

- Yes → If yes, go to question 184
- No → If no, go to question 182
- Don't know
- Refused

The following question is for Québec residents only. Please proceed to question 182 if you are not a Québec resident.

181. Did you complete a secondary school vocational diploma or attestation of vocational studies?

NOTE: Please include the Secondary School Vocational Diploma (SSVD), Attestation of Vocational Specialization (AVS), or Attestation of Vocational Education (AVE)

- Yes → If yes, go to question 185
- No
- Don't know
- Refused

Please proceed to question 183 if you are a Québec resident.

182. What is the highest grade that you have completed for **elementary and secondary school** (junior high, high school)?

<input type="radio"/> No schooling	<input type="radio"/> Grade 5	<input type="radio"/> Grade 11
<input type="radio"/> Preschool/Kindergarten	<input type="radio"/> Grade 6	<input type="radio"/> Grade 12
<input type="radio"/> Grade 1	<input type="radio"/> Grade 7	<input type="radio"/> Grade 13 (Ontario)
<input type="radio"/> Grade 2	<input type="radio"/> Grade 8	<input type="radio"/> Other (<i>Specify</i>):
<input type="radio"/> Grade 3	<input type="radio"/> Grade 9	<input type="radio"/> Don't know
<input type="radio"/> Grade 4	<input type="radio"/> Grade 10	<input type="radio"/> Refused

The following question is for Québec residents only. Please proceed to question 184 if you are not a Québec resident.

183. What is the highest grade that you have completed for **elementary and secondary school** (for Québec residents)?

<input type="radio"/> No schooling	<input type="radio"/> Grade 5	<input type="radio"/> Secondary V (or Grade 11)
<input type="radio"/> Preschool/Kindergarten	<input type="radio"/> Grade 6	<input type="radio"/> Grade 12
<input type="radio"/> Grade 1	<input type="radio"/> Secondary I (or Grade 7)	<input type="radio"/> Some secondary vocational studies
<input type="radio"/> Grade 2	<input type="radio"/> Secondary II (or Grade 8)	<input type="radio"/> Other (<i>Specify</i>):
<input type="radio"/> Grade 3	<input type="radio"/> Secondary III (or Grade 9)	<input type="radio"/> Don't know
<input type="radio"/> Grade 4	<input type="radio"/> Secondary IV (or Grade 10)	<input type="radio"/> Refused

Please proceed to question 185 if you are a Québec resident.

184. Other than elementary and secondary grades (junior high/high school), what other education have you **completed**? Mark all that apply.

<input type="radio"/> None	<input type="radio"/> Diploma or certificate from trade, technical or vocational school	<input type="radio"/> Master's degree
<input type="radio"/> Some trade, technical, or vocational school	<input type="radio"/> Diploma or certificate from community college, CEGEP, or university	<input type="radio"/> Earned doctorate (PhD)
<input type="radio"/> Some community college or CEGEP	<input type="radio"/> University/undergraduate degree	<input type="radio"/> Other (<i>Specify</i>):
<input type="radio"/> Some university	<input type="radio"/> Professional (e.g., medical, law, teaching, pharmacy, accounting, etc.) degree	

DK, RF

The following question is for Québec residents only. Please proceed to question 186 if you are not a Québec resident.

185. Other than elementary and secondary grades, what other education have you **completed** (for Québec residents)? Mark all that apply.

<input type="radio"/> None	<input type="radio"/> Some university / Undergraduate university certificate	<input type="radio"/> Doctorate degree
<input type="radio"/> Some technical college/CEGEP	<input type="radio"/> Bachelor's degree	<input type="radio"/> Other (<i>Specify</i>):
<input type="radio"/> Some general college/CEGEP	<input type="radio"/> Graduate Certificate	<input type="radio"/> Don't know
<input type="radio"/> Technical college/CEGEP diploma	<input type="radio"/> Professional (e.g., medical, law, teaching, pharmacy, accounting, etc.) degree	<input type="radio"/> Refused
<input type="radio"/> General college/CEGEP diploma	<input type="radio"/> Master's Degree	

186. Was your training in a health field?

Note: Health field includes nursing, medicine, lab technician, dentist, epidemiology, etc.

- Yes
- No
- Don't know
- Refused

Section: Employment and Income

The following questions ask about your employment situation and income. This information will be kept confidential and your answers cannot be tracked back to you.

187. Are you currently working at a job or business for pay (wages, salary, self-employed)?

- Yes → If yes, go to question 190
- No
- Don't know
- Refused

188. Are you currently looking for work?

- Yes → If yes, go to question 192
- No
- Don't know
- Refused

189. If no, which of the following best describes your situation?

<input type="radio"/> Poor health or disabled	<input type="radio"/> Caring for other relative	<input type="radio"/> There is no work in my community
<input type="radio"/> Seasonal worker	<input type="radio"/> Stay-at-home parent	<input type="radio"/> Other (Specify):
<input type="radio"/> Retired	<input type="radio"/> Student	<input type="radio"/> Don't know
<input type="radio"/> On maternity/parental leave	<input type="radio"/> No longer looking for work, gave up	<input type="radio"/> Refused

If not working, please proceed to question 192.

190. Where is your main job located?

- In own First Nation community
- In another First Nation community
- In a non-First Nation community
- Other (Specify):
- Don't know
- Refused

191. On average, how many paid hours do you usually work per week at your main job? (Please exclude overtime).

Hours

DK, RF (MIN: 1.0, MAX: 168.0 – warning at 48.0 hours)

192. For the [previous year (ending December 31, 2014)], please think of your **total personal income** from all sources, before deductions. We are asking for the total sum of all the money you made in the past year. Please include income from social assistance, child tax benefits, disability benefits, workers' compensation, etc.

Reminder: Your answers will remain confidential.

Which income range does it fall into?

<input type="radio"/> No income	<input type="radio"/> \$15,000-\$19,999	<input type="radio"/> \$40,000-\$49,999	<input type="radio"/> \$80,000 and over
<input type="radio"/> \$1-\$4,999	<input type="radio"/> \$20,000-\$24,999	<input type="radio"/> \$50,000-\$59,999	<input type="radio"/> Don't know
<input type="radio"/> \$5,000-\$9,999	<input type="radio"/> \$25,000-\$29,999	<input type="radio"/> \$60,000-\$69,999	<input type="radio"/> Refused
<input type="radio"/> \$10,000-\$14,999	<input type="radio"/> \$30,000-\$39,999	<input type="radio"/> \$70,000-\$79,999	

193. This question concerns basic expenses for your household.

In the past 12 months, did you ever struggle to meet the following basic living requirements?
(i.e., have to borrow money, miss bill payments to satisfy your basic living needs)

Basic Needs	No	A few times a year	Monthly	More than once a month	Not applicable	Don't know	Refused
Food							
Shelter							
Utilities (heat, electricity)							
Clothing							
Transportation							
Childcare							

Section: Housing

This section pertains to your living arrangements.

194. Is your primary residence (home)...?

- Rented by you or another member of this household
- Owned by you or another member of this household → Please proceed to question 196
- Other (Specify):
- Don't know
- Refused

195. Do you live in band (community) owned housing?

- Yes
- No
- Don't know
- Refused

196. Does your home have...?

Home Amenities	Yes	No	Don't know	Refused
A working smoke detector				
A carbon monoxide detector				
A fire extinguisher				
A telephone with service				
A computer				
An Internet connection				
A refrigerator				
A stove for cooking and/or heating				
Electricity				
Cold running water				
Hot running water				
A flush toilet				
Either a septic tank or sewage service (any kind)				
Garbage collection service				

197. Is your dwelling in need of repairs?

Major repairs include defective plumbing or electrical wiring, structural repairs to walls, floors, ceiling, etc.
Minor repairs include missing or loose floor tiles, bricks, shingles, defective steps, railings, siding, etc.

- Yes, major repairs
- Yes, minor repairs
- No, only regular maintenance is required (painting, furnace cleaning)
- Don't know
- Refused

198. In the past 12 months, has there been mold or mildew in your home?

Water damage from broken pipes, leaks or flood, and moisture in the air can cause mold and mildew to form.

- Yes
- No
- Don't know
- Refused

199. What is the main water supply for your household?

Refers to the main water supply where most of the household's water comes from for showers, toilets, etc. Not necessarily the same source as drinking water.

<input type="radio"/> Piped in (local or community water supply)	<input type="radio"/> Collect it yourself from river, lake, pond	<input type="radio"/> Other (Specify):
<input type="radio"/> Trucked in	<input type="radio"/> Collect it yourself from water plant	<input type="radio"/> Don't know
<input type="radio"/> Well (individual or shared)	<input type="radio"/> From a neighbour's house	<input type="radio"/> Refused

200. Do you consider the main water supply in your home safe for drinking year round?

- Yes
- No
- Don't know
- Refused

201. Do you use any other sources of drinking water?

Mark all that apply.

<input type="radio"/> No other sources	<input type="radio"/> Boiled tap water
<input type="radio"/> Bottled water	<input type="radio"/> River, lake or stream
<input type="radio"/> Filtered tap water	<input type="radio"/> Distilled water
<input type="radio"/> Water from another house	<input type="radio"/> Other (Specify):

DK, RF

Section: Migration

The next set of questions concerns your individual migration patterns (whether or not you have lived away from the community, returned to the community, etc.)

202. Have you lived outside of your First Nation community?

- Yes
- No → If no, go to Ending section.
- Don't know
- Refused

203. What were the reasons you moved away from your community?

Mark all that apply.

<input type="radio"/> Employment	<input type="radio"/> Employment of spouse/partner
<input type="radio"/> Family responsibilities	<input type="radio"/> Marital/domestic problems
<input type="radio"/> Education	<input type="radio"/> Support for disability
<input type="radio"/> Relationship	<input type="radio"/> Other medical needs
<input type="radio"/> Housing	<input type="radio"/> Other (Specify):

DK, RF

204. Why did you return to your community?

Mark all that apply.

<input type="radio"/> Family	<input type="radio"/> Job opportunities
<input type="radio"/> Connection to community/home	<input type="radio"/> Familiar culture
<input type="radio"/> Exposure of children to culture	<input type="radio"/> Other (Specify):
<input type="radio"/> Housing became available	

DK, RF

Section: Ending

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

- Yes
- No
- Don't know
- Refused

Are there any issues that affect the well-being of adults in your community that we missed? What should we include in the next cycle? Are there any questions that should not be asked??

That completes the questionnaire. Thank you for participating in the RHS!

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