

FIRST NATIONS REGIONAL HEALTH SURVEY



OUR VOICE, OUR SURVEY, OUR REALITY

Youth Questionnaire

TABLE OF CONTENTS

PERSONAL INFORMATION	1
LANGUAGE AND CULTURE	1
GENERAL HEALTH	4
HEALTH CONDITIONS	6
INJURY	9
HEALTH CARE UTILIZATION	12
DENTAL CARE	12
FOOD AND NUTRITION	13
PHYSICAL ACTIVITY	15
SMOKING	17
ALCOHOL AND DRUG USE	19
SEXUAL ACTIVITIES	21
PERSONAL WELLNESS	24
EDUCATION	31
HOUSEHOLD AND LIVING ENVIRONMENT	33
RESIDENTIAL SCHOOLS	35
COMMUNITY WELLNESS	35
ENDING	37

Youth 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

DK, RF

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

☐ Yes
☐ No

3. Are you male or female?

☐ Male ☐ Female

4. 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

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

Section: Language and Culture

Now a few questions about languages and culture.

6. 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, etc.

☐ English → if English used most, go to question 8.

- ☐ French → if French language used most, go to question 8.
- ☐ First Nations language → if First Nations language used, go to question 9.
- ☐ More than one of the above
- ☐ Other (Specify): → if other language used most, go to question 8.
- ☐ Don't know
- ☐ Refused

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

- ☐ English and French
- ☐ English and First Nations language → Go to question 9
- ☐ French and First Nations language → Go to question 9
- ☐ French, English and First Nations language → Go to question 9
- ☐ Don't know
- ☐ Refused

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

- ☐ Yes
- ☐ No → if no, go to question 11.
- ☐ Don't know
- ☐ Refused

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

DK, RF

10.

How well can you understand [pipe in language from question 9]?

- 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 9]?

- 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 9]?

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 9]?

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

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

Please check a response for each phrase.

11. Speaking my First Nations language is important to me.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

DK, RF

12. Traditional cultural events are important in my life.

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

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

DK, RF

13. How often do you take part in your local community's cultural events?

- ☐ Always/almost always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

DK, RF

14. Who helps you in understanding your culture?

Mark all that apply.

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

Section: General Health

The following questions ask about your general health status.

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

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

16. 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

17. 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	

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

- ☐ Excellent

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

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

- ☐ Feet/inches
- ☐ Centimetres → if centimetres, go to question 21.
- DK, RF

20. How tall are you without your shoes on?

Feet Inches

(MIN: 2) (MAX: 7) (MIN: 0) (MAX: 11)

Warning if < 3'4"

DK, RF

If feet/inches for question 19, go to question 22.

21. How tall are you without your shoes on?

Centimetres

(MIN: 60) (MAX: 241)

Warning if < 100 cm

DK, RF

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

- ☐ Pounds
- ☐ Kilograms → if Kilograms, go to question 24.
- DK, RF

23. How much do you weigh?

Pounds

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

DK, RF

If pounds for question 22, go to question 25.

24. How much do you weigh?

Kilograms

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

DK, RF

25. How satisfied are you with your weight?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

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.

26. 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**.

27. If yes, what age were you diagnosed?

28. 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	26. Told that you have:				If Yes: →	27. Age when diagnosed	28. If yes, are you undergoing treatment?			
	Yes	No	DK	R			Yes	No	DK	R
Allergies	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? <input type="radio"/> Yes <input type="radio"/> No				DK		R				

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
Chronic back pain, excluding arthritis	Y	N	DK	R			Y	N	DK	R
Chronic ear infections	Y	N	DK	R			Y	N	DK	R
Dermatitis/atopic eczema	Y	N	DK	R			Y	N	DK	R
Developmental disorder such as Cerebral Palsy, Down Syndrome, Spina Bifida										
Diabetes	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
Fetal Alcohol Spectrum Disorder (FASD)	Y	N	DK	R			Y	N	DK	R
Hearing impairment	Y	N	DK	R			Y	N	DK	R
Heart Condition	Y	N	DK	R			Y	N	DK	R
Hepatitis	Y	N	DK	R			Y	N	DK	R
→ If yes, what type of hepatitis do you have? O Type A O Type B O Type C			DK	R						
High Blood Pressure	Y	N	DK	R			Y	N	DK	R
→ If yes, was the high blood pressure related to pregnancy? O Yes O No O Don't know O Refused										
Kidney Problem	Y	N	DK	R			Y	N	DK	R
Learning Disorder	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
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
→ If yes, is your tuberculosis active or inactive? O Active O Inactive			DK	R						
Other (Specify):	Y	N	DK	R			Y	N	DK	R

If no diabetes, please proceed to question 34.

If respondent is male, please proceed to question 31.

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

31. 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

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

Ask about treatment type. Mark all that apply.

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

DK, RF

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

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

34. 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, school, 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.

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

- ☐ Yes, once
- ☐ Yes, more than once
- ☐ No → if no, go to Health Care Utilization section.
- ☐ Don't know
- ☐ Refused

If "Yes, more than once" for question 35, then please note: For the following injury questions, please think about your most serious injury only.

36. 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"/> Electrocution	<input type="radio"/> Other (Specify):
<input type="radio"/> Concussion or other brain injury	

DK, RF

37. What month did it happen?

- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August

- ☐ September
- ☐ October
- ☐ November
- ☐ December
- ☐ Don't know
- ☐ Refused

38. 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	

39. Where did the injury occur?

<input type="radio"/> Home or in someone else's home	<input type="radio"/> Community buildings (community centre, band office)
<input type="radio"/> School (non-sport related)	<input type="radio"/> Industrial or construction area
<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):

DK, RF

40. What were you doing when the injury 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"/> Riding a bicycle
<input type="radio"/> Sleeping, eating, personal care	<input type="radio"/> Driver or passenger in/on road motor vehicle (including motorcycles, trucks)
<input type="radio"/> Driver or passenger in/on off-road motor vehicle (including boat, ATV, snowmobile)	<input type="radio"/> Walking
<input type="radio"/> Working at a job or business	<input type="radio"/> Other (Specify):

DK, RF

41. What caused the injury?

<input type="radio"/> Motor vehicle accident	<input type="radio"/> Contact with a machine, tool, etc.
→ Were you wearing a seat belt?	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Refused	
<input type="radio"/> ATV accident	<input type="radio"/> Smoke, fire, flames

→ Were you wearing a helmet? O Yes O No O Don't know O Refused	
O Snowmobile accident	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 (e.g., flood)
O Boating accident	O Falling through 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 → go to question 42	O Suicide attempt or other self-inflicted injury
O Domestic/family violence	O Bicycle accident
	→ Were you wearing a helmet? O Yes O No O Don't know O Refused
O Accidentally struck or crushed by object(s)	O Other (Specify):
O Other physical assault	

DK, RF

If injury was not the result of a fall, please proceed to question 43.

42. How did you fall?

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

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

Mark all that apply.

O Doctor's office	O At school
O Physiotherapist or massage therapist's office	O At work
O Chiropractor's office	O At home
O Hospital emergency room	O By Internet/telephone/e-health
O Walk-in clinic	O Traditional healer
O Community Health Centre/Nursing station	O Other (Specify):
O Dental practitioner	O Didn't receive any medical treatment

DK, RF

44. 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: Health Care Utilization

The following questions are about your health care use.

45. 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)						

46. In the past 12 months, have you had any of the following tests or examinations?

Please check a response for each.

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

47. Have you received an HPV vaccine?

Note: The HPV vaccine is available for the prevention of the human papillomavirus and HPV-related cancers.

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Section: Dental Care

The next section asks questions about your dental health.

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

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

49. 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

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

Mark all that apply.

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

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Section: Food and Nutrition

The following questions ask about the foods you eat and drink.

52. 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

53. 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 (Specify):				

DK, RF

54. 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

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

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

56. In the past 12 months, how often did you eat breakfast?

- ☐ Always
- ☐ Almost always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Don't know
- ☐ Refused

Section: Physical Activity

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

57. 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 → If none, go to question 60.
<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	

58. 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 <i>(insert all checked above)</i>	Number of times participated

DK, RF

MIN: 1 MAX: 300

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

Note: Some examples of time estimates:

$\frac{1}{2}$ hour = 30 minutes 1 hour = 60 minutes 1 $\frac{1}{2}$ hours = 90 minutes 2 hours = 120 minutes

Activity <i>(insert all checked above)</i>	Average length of time participated

DK, RF

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

60. 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 $\frac{1}{2}$ hours = 90 minutes 2 hours = 120 minutes 2 $\frac{1}{2}$ 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

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

____ hours
____ minutes

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

Section: Smoking

We are now going to ask you about your personal habits.

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

- ☐ Yes, daily → Go to question 64.
- ☐ Yes, occasionally → Go to question 65.
- ☐ No
- ☐ Don't know
- ☐ Refused

63. Have you ever smoked cigarettes?

(Current non-smokers only)

- ☐ Yes, daily → Go to question 67.
- ☐ Yes, occasionally → Go to question 67.
- ☐ No → If no, go to question 72.
- ☐ Don't know
- ☐ Refused

64. On average, how many cigarettes do you currently smoke each day?

(Current daily smokers) **Approximate if necessary**

Number of cigarettes

MIN: 1 MAX: 99

DK, RF

65. At what age did you begin smoking cigarettes?

(Current smokers)

Age in years

MIN: 5 MAX: 121

DK, RF

66. 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 72.

67. 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

68. At what age did you begin smoking cigarettes?

(ex-smokers only)

Age in years

MIN: 5 MAX: 121

DK, RF

69. At what age did you quit smoking cigarettes?

(ex-smokers only)

Age in years

MIN: 5 MAX: 121

DK, RF

70. What were your reasons for quitting smoking?

Mark all that apply.

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

71. What method(s) did you use to quit smoking?

Mark all that apply.

<input type="radio"/> Cold turkey/will power alone	<input type="radio"/> 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"/> Hypnosis	<input type="radio"/> Electronic cigarette
<input type="radio"/> Nicotine replacement patch	<input type="radio"/> Other (Specify):
<input type="radio"/> Nicotine replacement gum	<input type="radio"/> Don't know
<input type="radio"/> Zyban (bupropion)	<input type="radio"/> Refused

72. 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

73. 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

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

- ☐ Yes
- ☐ No → If no, please proceed to question 78.
- ☐ Don't know
- ☐ Refused

75. 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

76. 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

77. 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

78. 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.

	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)							

79. 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 83.

80. 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 82

81. 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

82. 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

83. 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.

If you are 14 years of age or younger, please proceed to question 86.

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

85. Do you identify as being ...?

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

86. Have you ever had sexual intercourse?

- ☐ Yes
- ☐ No → if no, go to question 96.
- ☐ Don't know
- ☐ Refused

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

- ☐ Yes
- ☐ No → if no, go to question 93.
- ☐ Don't know
- ☐ Refused

88. 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

89. 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="checkbox"/> Withdrawal	<input type="checkbox"/> Surgery (hysterectomy, vasectomy, tubes tied)
<input type="checkbox"/> Patch	<input type="checkbox"/> Intrauterine Device (IUD)
<input type="checkbox"/> Condoms (male or female)	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Birth control pills	<input type="checkbox"/> None → Go to question 92.
<input type="checkbox"/> Depo Provera (injection)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Rhythm (natural family planning)	<input type="checkbox"/> Refused

90. 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

91. How often do you use condoms during intercourse?

- ☐ Always → if always, go to question 93.
- ☐ Most of the time
- ☐ Occasionally
- ☐ Never
- ☐ Don't know
- ☐ Refused

92. 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

DK, RF

93. Have you ever been pregnant or gotten someone pregnant?

- ☐ Yes
- ☐ No → If you answered no, go to question 96.
- ☐ Don't know
- ☐ Refused

94. How many children have you **[given birth to/fathered]**?

If none, please enter '0' and please proceed to question 96.

MIN: 0 MAX: 70 (warning after 15)

DK, RF

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

MIN: 5 MAX: 70, Warning if < 10

DK, RF

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

96. 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

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Section: Personal Wellness

The following questions are about your personal wellness.

98. 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

99. Have you ever attended an Aboriginal Head Start program?

- ☐ Yes
- ☐ No → If you answered no, go to question 101.
- ☐ Don't know
- ☐ Refused

100. How long did you attend Aboriginal Head Start?

Years Months

(MIN: 0 MAX: 6) (MIN: 0 MAX: 11)

DK, RF

101. 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	Don't know	Refused
Take part in sport teams or lessons						
Take part in art or music groups or lessons						
Take part in traditional activities (e.g., singing, drumming, or dancing groups or lessons)						
Have a job such as baby-sitting, working at a store, tutoring						

102. 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
Physically					
Emotionally					
Mentally					
Spiritually					

DK, RF

103. 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					

DK, RF

104. Have you been bullied in the past 12 months?

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

Bullying happens in four basic ways: physical (hitting, kicking, stealing, etc.); verbal (teasing, name-calling, etc.); indirect (spreading rumours, excluding people, mean gestures, etc.); and cyber-bullying (covered in next question).

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

105. 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 answered "No" to bullying questions (104 & 105), please proceed to question 107

106. Did you seek help in dealing with the 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

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

107. 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	

108. 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	

109. 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	

110. 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	

111. 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	

112. 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	

113. 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	

114. 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	

115. 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	

116. 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	

117. 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

118. 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					

DK, RF

119. 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
I feel loved							
I feel lonely							
I feel stressed							

DK, RF

120. 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

121. 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.

- ☐ Parents
- ☐ 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

122. People sometimes look to others for companionship, assistance, guidance or other types of support. Please indicate 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							

123. 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	Medical Doctor or nurse	Principal, teacher or counselor	Other (Specify)	No one	Don't Know	Refused
Family problems											
Relationships (boyfriend/girlfriend)											
Financial problems											
Drugs/Alcohol											
Anger/feeling out of control											
Depression											

Suicidal thoughts											
Problems with friends											
Sexual assault											
Physical assault											
Sexually transmitted infections											
Birth Control											
Pregnancy											
Bullying											

The following questions relate to the sensitive issue of suicide.

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

125. Have you ever seriously considered suicide?

- ☐ Yes
- ☐ No → if no, go to question 128.
- ☐ Don't know
- ☐ Refused

126. When did these suicidal thoughts occur?
Mark all that apply.

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

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

128. Have you ever attempted suicide?

- ☐ Yes
- ☐ No → if no, go to Education section.
- ☐ Don't know
- ☐ Refused

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

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

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Section: Education

The following group of questions is about education.

131. Are you currently attending school?

- ☐ Yes
- ☐ No → if no, go to question 133.
- ☐ Don't know
- ☐ Refused

Please proceed to question 132a if you are a Québec resident.

132. What grade are you currently in?

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

The following question is for Québec residents only. Please proceed to question 133 if you are not a Québec resident.

132a. What grade are you currently in?

<input type="radio"/> Grade 4	<input type="radio"/> Secondary V (Grade 11)
<input type="radio"/> Grade 5	<input type="radio"/> Grade 12
<input type="radio"/> Grade 6	<input type="radio"/> Secondary vocational school
<input type="radio"/> Secondary I (Grade 7)	<input type="radio"/> CEGEP
<input type="radio"/> Secondary II (Grade 8)	<input type="radio"/> Other (Specify):
<input type="radio"/> Secondary III (Grade 9)	<input type="radio"/> Don't know
<input type="radio"/> Secondary IV (Grade 10)	<input type="radio"/> Refused

133. 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 |

Please proceed to question 134a if you are a Québec resident.

134. Up to now, what is the highest grade that 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"/> Other (Specify):
<input type="radio"/> Grade 7	<input type="radio"/> Don't know
<input type="radio"/> Grade 8	<input type="radio"/> Refused
<input type="radio"/> Grade 9	

The following question is for Québec residents only. Please proceed to question 135 if you are not a Québec resident.

134a. Up to now, what is the highest grade that 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"/> Secondary IV (Grade 10)
<input type="radio"/> Grade 4	<input type="radio"/> Secondary V (Grade 11)
<input type="radio"/> Grade 5	<input type="radio"/> Grade 12
<input type="radio"/> Grade 6	<input type="radio"/> Some secondary vocational studies
<input type="radio"/> Secondary I (Grade 7)	<input type="radio"/> Other (Specify):
<input type="radio"/> Secondary II (Grade 8)	<input type="radio"/> Don't know
<input type="radio"/> Secondary III (Grade 9)	<input type="radio"/> Refused

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

136. Have you ever repeated a grade?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

137. Have you had any problems learning in school?

- ☐ Yes
- ☐ No → if no, go to Household and Living Environment section.
- ☐ Don't know
- ☐ Refused

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

Mark all that apply.

<input type="checkbox"/> Reading	<input type="checkbox"/> Too many distractions
<input type="checkbox"/> Writing	<input type="checkbox"/> Difficulty with the teacher
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Difficulties with subject(s) (e.g., math, science, social studies etc.)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Social problems (e.g., bullying, shy)	<input type="checkbox"/> Refused
<input type="checkbox"/> Short attention span	

Section: Household and Living Environment

Now some questions about your household and living environment.

139. **Including yourself**, how many children and youth currently live in your household the majority of the time?

Include all children under 18 years old who reside in the household.

If none, please enter "0".

0-5 years old	
6-11 years old	
12-17 years old	

MIN: 0 MAX: 25

DK, RF

140. How many adults 18 years and over currently live in your household the majority of the time?

If none, please enter '0.

MIN: 0 MAX: 25

DK, RF

141. 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 mother that adopted me
<input type="checkbox"/> Biological father	<input type="checkbox"/> The father that adopted me
<input type="checkbox"/> Brother(s)/sister(s)	<input type="checkbox"/> My boyfriend/girlfriend/spouse
<input type="checkbox"/> Other relatives (e.g., aunt, uncle, cousin, niece, nephew)	<input type="checkbox"/> My child(ren)
<input type="checkbox"/> Grandparent(s) (e.g., grandmother/grandfather)	<input type="checkbox"/> Unrelated person(s) (e.g., friends, foster family)
<input type="checkbox"/> My stepmother	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> My stepfather	<input type="checkbox"/> Don't know
<input type="checkbox"/> Step-brother(s)/step-sister(s)	<input type="checkbox"/> Refused

142. 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 |

143. What is the highest level of formal schooling that your parents or guardians have completed?

Please choose one answer from the list.

Parent's Education	Mother (or female guardian)	Father (or male guardian)
No formal education		
Some elementary school		
Elementary school		
Some high school		
High school diploma or high school equivalency certificate (Québec: general secondary school diploma only, not secondary vocational diploma)		
Some postsecondary education		
Diploma/certificate from trade or vocational school (Québec: include secondary vocational diploma)		
Diploma/certificate from community college, CEGEP		
University Degree		
Graduate Certificate (Québec)		
Professional (e.g., medical, law, teaching, pharmacy, accounting, etc.) degree		
Master's Degree		
Earned Doctorate (PhD)		

Other (Specify) :		
Not applicable (parent unknown)		
Don't know		
Refused		

Section: Residential Schools

The following question is 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.

144. 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)				
Other family member/s				

Section: Community Wellness

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

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

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

If you are 14 years of age or younger, please proceed to the Ending section

146. In your opinion, 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

147. In your opinion, 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)	

148. In your opinion, was 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 (<i>Specify</i>):						

Section: Ending

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

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Is there anything else about your health or the health of young people in your community that you think we should have asked about? Are there any questions that should not be asked?

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