Filling in the Questionnaire

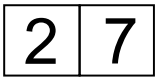
Please use a **black** pen. To answer questions simply put a **cross** (not a tick) in the circle/box which is most accurate in your opinion, like this:

If you make a mistake, shade the circle/box in like this:

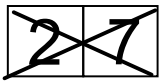
then cross the correct circle/box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes. If possible, please use CAPITAL LETTERS.

When writing numbers inside boxes, please don't touch the sides of the box.



If you make a mistake when writing numbers inside boxes, please cross through the box and write your answer next to the box.



Please read each question carefully. Some questions are very similar to others or refer to different time periods.

If you do not want to answer a question, or if it does not apply to you, leave it blank.

There is a blank space available at the back of the questionnaire if you need additional space. If you use this sheet, please clearly indicate the question number you are answering.

Contents

Please complete the questionnaire using a BLACK PEN

Section A: General Health

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

This section asks you about your health and any hospital stays or operations you might have had.

A1) Which of the following would you say best describes your health nowadays and during the pandemic (from March 2020 to March 2022)?

		Fit and well	Mostly fit and well	Often unwell	Hardly ever well
a.	Nowadays	1 ○	2 ○	3 ○	4 ○
b.	During the pandemic	1 ○	2 ○	3 ○	4 ○

A2) Have you been admitted to hospital **since the start of the pandemic** (March 2020)?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question A3 on the next page**

If <u>yes</u>:

a. How many times? ☐☐

b. Please list the reasons for each admission:

i) Admission 1:

ii) Admission 2:

iii) Admission 3:

iv) Other admission(s):

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A3) Have you had any of these operations and, if yes, how old were you at the time? *Please select all that apply.*
Please answer 'no' or give the age(s) at which you had the operation(s).

		No	Yes, under 25	Yes, 25 or older	Yes, age not known
a.	Hernia	0 ☐	1 ☐	2 ☐	4 ☐
b.	Appendix removed	0 ☐	1 ☐	2 ☐	4 ☐
c.	Tonsils and/or adenoids out	0 ☐	1 ☐	2 ☐	4 ☐
d.	Gall bladder removed	0 ☐	1 ☐	2 ☐	4 ☐
e.	Hysterectomy	0 ☐	1 ☐	2 ☐	4 ☐
f.	Plastic surgery *Please cross and describe*	0 ☐	1 ☐	2 ☐	4 ☐

		No	Yes, under 25	Yes, 25 or older	Yes, age not known
g.	Caesarean section	0 ☐	1 ☐	2 ☐	4 ☐
h.	Hip replacement	0 ☐	1 ☐	2 ☐	4 ☐
i.	Knee replacement	0 ☐	1 ☐	2 ☐	4 ☐
j.	Cataract removal	0 ☐	1 ☐	2 ☐	4 ☐
k.	Pacemaker inserted	0 ☐	1 ☐	2 ☐	4 ☐
l.	Colostomy operation	0 ☐	1 ☐	2 ☐	4 ☐
m.	Other operation(s) *Please cross and describe*	0 ☐	1 ☐	2 ☐	4 ☐

If you need more space, please use the box on page 41 and mark as question 'A3'.

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A4) How would you rate your hearing in each ear, without hearing aids?

		Always very good	Occasional problems (e.g. infections or glue ear)	There are some sounds I cannot hear	Never very good	I cannot hear much at all
a.	Left ear	1 ○	2 ○	3 ○	4 ○	5 ○
b.	Right ear	1 ○	2 ○	3 ○	4 ○	5 ○

c. Do you have a hearing aid?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question A5 below**

If <u>yes</u>:

d. How often do you use it?

Most of the time 3 ○ Sometimes 2 ○

Hardly ever 1 ○ Never 0 ○

A5) Do you get or have you had noises (such as ringing or buzzing) in your head, or in one or both ears, that lasts for more than five minutes at a time?

Yes, most of the time 3 ○ Yes, a lot of the time 2 ○

Yes, some of the time 1 ○ No, not at all 0 ○

A6) How would you rate your sight without glasses or contact lenses?
Please select all that apply

		Always very good	I can't see clearly at a distance	I can't see clearly close up	I cannot see much at all
a.	Left eye	1 ☐	2 ☐	3 ☐	4 ☐
b.	Right eye	1 ☐	2 ☐	3 ☐	4 ☐

A7) Do you wear glasses or contact lenses?

		Yes, always	Yes, sometimes	No, never
a.	Glasses	2 ○	1 ○	0 ○
b.	Contact lenses	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A8) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Back ache	2 ○	1 ○	0 ○
b.	Knee pain	2 ○	1 ○	0 ○
c.	Neck ache	2 ○	1 ○	0 ○
d.	Shoulder ache	2 ○	1 ○	0 ○
e.	Pain in other joints	2 ○	1 ○	0 ○
f.	Chest pain	2 ○	1 ○	0 ○
g.	Headaches	2 ○	1 ○	0 ○
h.	Stomach aches	2 ○	1 ○	0 ○
i.	Earache	2 ○	1 ○	0 ○

A9) Has a doctor ever told you that you have:

		Yes, had in past	Yes, have now	No, never
a.	Angina	2 ○	1 ○	0 ○
b.	Fibromyalgia	2 ○	1 ○	0 ○
c.	Rheumatoid arthritis	2 ○	1 ○	0 ○
d.	Rheumatism	2 ○	1 ○	0 ○
e.	Osteoarthritis	2 ○	1 ○	0 ○
f.	Other type of arthritis *Please cross and describe*	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A10) What types of pain killers do you use for any aches and pains?
Please cross one answer on each line

		Every day	Often	Sometimes	Never
a.	Paracetamol	3 ○	2 ○	1 ○	0 ○
b.	Ibuprofen	3 ○	2 ○	1 ○	0 ○
c.	Aspirin	3 ○	2 ○	1 ○	0 ○
d.	Codeine	3 ○	2 ○	1 ○	0 ○
e.	Naproxen	3 ○	2 ○	1 ○	0 ○
f.	Co-codamol	3 ○	2 ○	1 ○	0 ○
g.	Something else *Please cross and describe*	3 ○	2 ○	1 ○	0 ○

A11) Are there any problems for which you have regular treatment or medicine nowadays?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to section B on page 9**

If <u>yes</u>:

a. Please describe these problems and regular treatment or medicine:

	a) Problem	b) Treatment or medicine
1		
2		
3		
4		
5		

If you need more space, please use the box on page 41, stating clearly that you are answering question 'A11'.

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If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP

Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

PAIN SUPPORT

Help and support for people in pain.

painuk.org/help-and-support

HEARING SUPPORT

Support, information and guidance about hearing loss.

hearinglink.org/services/helpdesk

Tel: 01844 348 111

Section B: Allergies and Breathing

This section asks about allergies and any problems you might have with your breathing.

B1) Would you say that you are allergic to anything?

Yes 1 ○ No 0 ○ → **If no, please go to question B2 on the next page**

If yes:

a. Is it to: *Please answer yes or no on each line*

		Yes	No
i)	Cat hair	1 ○	0 ○
ii)	Other animal hair	1 ○	0 ○
iii)	Pollen	1 ○	0 ○
iv)	Dust	1 ○	0 ○
v)	Insect bites or stings	1 ○	0 ○
vi)	Peanuts	1 ○	0 ○
vii)	Other types of nut	1 ○	0 ○
viii)	Other foods *Please cross and describe*	1 ○	0 ○
ix)	Medication (e.g. penicillin) *Please cross and describe*	1 ○	0 ○
x)	Something else *Please cross and describe*	1 ○	0 ○

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Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

B2) How often have you had the following **in the past year**?

		Often	Sometimes	Not at all
a.	Attacks of wheezing with whistling on the chest	2 ○	1 ○	0 ○
b.	A dry itchy rash	2 ○	1 ○	0 ○
c.	A blotchy blistery rash (hives)	2 ○	1 ○	0 ○
d.	Sneezing attacks	2 ○	1 ○	0 ○
e.	Runny nose	2 ○	1 ○	0 ○
f.	Watery eyes	2 ○	1 ○	0 ○
g.	Attacks of breathlessness	2 ○	1 ○	0 ○
h.	Feelings of anxiety or panic about your breathing	2 ○	1 ○	0 ○
i.	Light-headedness or dizziness with breathlessness	2 ○	1 ○	0 ○
j.	Sighing or yawning	2 ○	1 ○	0 ○
k.	Feelings of breathlessness after only minor exercise	2 ○	1 ○	0 ○
l.	Pins and needles in the hands or arms or around the mouth	2 ○	1 ○	0 ○
m.	Difficulty coordinating breathing and talking	2 ○	1 ○	0 ○
n.	Coughing often during the night	2 ○	1 ○	0 ○
o.	Coughing often when you wake in the morning	2 ○	1 ○	0 ○

B3) Have you ever assumed or been told that you have hay fever?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B4 below**

a. About how old were you when you were first aware of having hay fever? ☐☐ Cross this box if you don't know 1 ☐

b. Do you still get hay fever? Yes 1 ○ No 0 ○

c. Do you take medication for hay fever? Yes 1 ○ No 0 ○

If <u>yes</u>, what sort of medication?

B4) Have you ever been told by a doctor that you had eczema?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B5 below**

a. About how old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Do you still get eczema?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B5 below**

c. Do you use medications (e.g. creams, lotions, ointments) for eczema? Yes 1 ○ No 0 ○

If <u>yes</u>, what medications do you use for eczema?

B5) Have you ever been told by a doctor that you had asthma?

Yes 1 ○ No 0 ○ → **If no, please go to question B6 on the next page**

a. How old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Have you ever needed oral corticosteroids (e.g. prednisolone tablets for an asthma attack)?

Yes, recently (in the past year) 2 ○

Yes, in the past 1 ○

No 0 ○

c. Do you still have asthma?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B6 below**

d. Are you taking any other medication for asthma nowadays?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to e below**

If <u>yes</u>, what asthma medication are you taking?

e. Would you be interested in taking part in a follow-up interview about how you are coping with asthma?

Yes 1 ○ No 0 ○

B6) These questions are about your breathing. Please give the answer for each statement which best matches your breathing nowadays.

		Not at all	Mild	Mode-rate	Severe
a.	My breath does not go in all the way	0 ○	1 ○	2 ○	3 ○
b.	My breathing requires more work	0 ○	1 ○	2 ○	3 ○
c.	I feel short of breath	0 ○	1 ○	2 ○	3 ○
d.	I have difficulty catching my breath	0 ○	1 ○	2 ○	3 ○
e.	I cannot get enough air	0 ○	1 ○	2 ○	3 ○
f.	My breathing is uncomfortable	0 ○	1 ○	2 ○	3 ○
g.	My breathing is exhausting	0 ○	1 ○	2 ○	3 ○
h.	My breathing makes me feel depressed	0 ○	1 ○	2 ○	3 ○
i.	My breathing makes me feel miserable	0 ○	1 ○	2 ○	3 ○
j.	My breathing is distressing	0 ○	1 ○	2 ○	3 ○
k.	My breathing makes me agitated	0 ○	1 ○	2 ○	3 ○
l.	My breathing is irritating	0 ○	1 ○	2 ○	3 ○

B7) Have you ever been told by a doctor that you had a chronic lung condition?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B8 on the next page**

a. About how old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Did you have any of these diagnoses and are they still present?

		No	Yes, still present	Yes, in past
i)	COPD (Chronic Obstructive Pulmonary Disease)	0 ○	1 ○	2 ○
ii)	Chronic bronchitis	0 ○	1 ○	2 ○
iii)	Emphysema	0 ○	1 ○	2 ○
iv)	Pulmonary fibrosis	0 ○	1 ○	2 ○
v)	Bronchiectasis	0 ○	1 ○	2 ○
vi)	Other	0 ○	1 ○	2 ○

Please cross and describe

c. What treatment were you recommended to have?

i) Medication Yes 1 ○ No 0 ○

If <u>yes</u>, what medication?

ii) Exercises Yes 1 ○ No 0 ○

If <u>yes</u>, are you doing them nowadays? Yes 1 ○ No 0 ○

iii) Other treatment Yes 1 ○ No 0 ○

If <u>yes</u>, what other treatment?

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

B8) Have you ever had any of the following?

		Yes, in the past	Yes, in the last 2 years	Not at all
a.	Frequent chest infections (at least 2 per year)	2 ○	1 ○	0 ○
b.	Admission to hospital due to a lung condition	2 ○	1 ○	0 ○
c.	Time off work due to a lung condition	2 ○	1 ○	0 ○
d.	Other lung condition *Please cross and describe*	2 ○	1 ○	0 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP

Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

Section C: More About Your Health

This section asks about any other health problems or illnesses that you might have.

C1) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Indigestion	2 ○	1 ○	0 ○
b.	Nausea	2 ○	1 ○	0 ○
c.	Vomiting	2 ○	1 ○	0 ○
d.	Diarrhoea (the runs)	2 ○	1 ○	0 ○
e.	Piles (haemorrhoids)	2 ○	1 ○	0 ○
f.	Constipation	2 ○	1 ○	0 ○
g.	IBS (irritable bowel syndrome)	2 ○	1 ○	0 ○
h.	Crohn's disease	2 ○	1 ○	0 ○
i.	Ulcerative colitis	2 ○	1 ○	0 ○
j.	Other gut problems *Please cross and describe*	2 ○	1 ○	0 ○

C2) Have you ever been told by a doctor that you had diabetes?

Yes 1 ○ No 0 ○ → **If no, please go to question C3 on the next page**

a. How old were you when you were first told? ☐☐

b. Which type of diabetes?

Type 1 1 ○ Type 2 2 ○ Not sure 9 ○

c. What treatment do/did you use to control it? *Please select all that apply*

None 0 ☐ Insulin 1 ☐

Diet 2 ☐ Other medication 3 ☐

continued on the next page

continued:

d. If you have been pregnant, have you only had it when pregnant? (gestational diabetes)

Yes 1 ○ No 0 ○ Not applicable 9 ○

If <u>yes</u>, please go to question C3 below

e. Would you be interested in taking part in a follow-up interview about how you are coping (or have coped) with diabetes?

Yes 1 ○ No 0 ○

C3) Have you ever been told by a doctor that you had hypertension or high blood pressure?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question C4 below**

a. How old were you when you were first told? ☐☐

b. Have you only had it when pregnant?

Yes 1 ○ No 0 ○ Not applicable 9 ○

c. Do you still have high blood pressure?

Yes 1 ○ No 0 ○

d. What was the latest reading? *Enter like 120/80* ☐☐☐ / ☐☐☐

Cross this box if you don't know 1 ☐

C4) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Psoriasis	2 ○	1 ○	0 ○
b.	Urinary infection or cystitis	2 ○	1 ○	0 ○
c.	Varicose veins	2 ○	1 ○	0 ○
d.	Headache or migraine	2 ○	1 ○	0 ○
e.	Fatigue or tiredness	2 ○	1 ○	0 ○

C5) Has a doctor ever told you that you have or have had any of the following:

		Yes, had it recently	Yes, in past	No, not at all
a.	Kidney disease	2 ○	1 ○	0 ○
b.	Liver disease	2 ○	1 ○	0 ○
c.	Epilepsy	2 ○	1 ○	0 ○
d.	Multiple sclerosis	2 ○	1 ○	0 ○
e.	ME or chronic fatigue syndrome	2 ○	1 ○	0 ○
f.	Long Covid	2 ○	1 ○	0 ○
g.	Stomach ulcer	2 ○	1 ○	0 ○
h.	Cancer *Please cross and describe type*	2 ○	1 ○	0 ○
i.	Pelvic inflammatory disease	2 ○	1 ○	0 ○
j.	Heart attack	2 ○	1 ○	0 ○
k.	A Stroke	2 ○	1 ○	0 ○
l.	Depression	2 ○	1 ○	0 ○
m.	PTSD (Post-traumatic stress disorder)	2 ○	1 ○	0 ○
n.	Anorexia	2 ○	1 ○	0 ○
o.	Bulimia	2 ○	1 ○	0 ○
p.	Binge eating disorder	2 ○	1 ○	0 ○
q.	Anxiety	2 ○	1 ○	0 ○
r.	Alcoholism	2 ○	1 ○	0 ○
s.	Drug addiction	2 ○	1 ○	0 ○
t.	Other type of addiction *Please cross and describe*	2 ○	1 ○	0 ○

C6) How tall are you?
Please either enter the number of whole feet in one box (e.g. 5) and the inches in the next box (e.g.7), or, alternatively, enter the number of whole centimetres in the third box.

a. Feet [ ] AND b. Inches [ ][ ] OR c. Centimetres [ ][ ][ ]

C7) Please tell us your current weight:
Please either enter the number of whole stones in one box (e.g. 10) and the pounds in the next box (e.g.7), or, alternatively, enter the number of kilograms in the third box to one decimal place (e.g. 70.5).

a. Stones [ ][ ] AND b. Pounds [ ][ ] OR c. Kilograms [ ][ ][ ]

If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP
Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

PAIN SUPPORT
Help and support for people in pain.

painuk.org/help-and-support

ANXIETY UK
User-led organisation, supporting people with anxiety disorders, including PTSD.

www.anxietyuk.org.uk

Tel: 03444 775 774
(9:30am-5:30pm Mon-Fri)

Section D: Eating, Weight and Exercise

We would like to collect information about your eating, weight and exercise. We realise that you may find some of these questions upsetting. If you prefer not to answer these questions, please leave them blank and go to the next section. Remember there are no right or wrong answers, we just want to know what you think.

D1) Which of the following are you trying to do about your weight?

I am not trying to do anything about my weight	Stay the same	Gain weight	Lose weight
1 ○	2 ○	3 ○	4 ○

D2) During the **past year**, did you exercise to lose weight or avoid gaining weight?

Never 0 ○ → **If never, please go to question D3 below**

Less than once a month	1-3 times a month	1-4 times a week	5 or more times a week
1 ○	2 ○	3 ○	4 ○

	No	Yes, some-times	Yes, freq-uently
a. Did you exercise to lose weight or avoid gaining weight even when you were sick or injured?	0 ○	1 ○	2 ○
b. Was it difficult for you to do your work because of the amount of time that you were exercising to lose weight or avoid gaining weight?	0 ○	1 ○	2 ○

D3) During the **past year**, did you:

	Never	Less than once a month	1-3 times a month	Once a week or more
a. Fast (not eat for a least a day) to lose weight or avoid gaining weight?	0 ○	1 ○	2 ○	3 ○
b. Make yourself throw up to lose weight or avoid gaining weight?	0 ○	1 ○	2 ○	3 ○
c. Take laxatives to lose weight or avoid gaining weight?	0 ○	1 ○	2 ○	3 ○
d. Take **other** tablets,medications or substances to lose weight or avoid gaining weight? *Please cross and describe*	0 ○	1 ○	2 ○	3 ○

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If you answered <u>never</u> to all of D3a, b, c and d, on the previous page, please go straight to question D4 below.

e. Was there a period of **at least 3 months** during the **past year** when you fasted, made yourself throw up, took laxatives or other tablets to lose weight or avoid gaining weight?

Yes 1 ○ No 0 ○

D4) Sometimes people will eat an amount of food that most people, like their friends or family, would consider to be very large, in a short period of time (overeating). During the **past year**, how often did this happen?

Never 0 ○ → **If <u>never</u>, please go to question D5 below**

Less than once a month 1 ○

1-3 times a month 2 ○

Once a week or more 3 ○

a. During these episodes (overeating) did you feel out of control, like you couldn't stop eating even if you wanted to?

Yes, always 2 ○ Yes, sometimes 1 ○ No 0 ○

b. Was there a period of **at least 3 months** during the **past year** when you had episodes of overeating **and** felt out of control?

No 0 ○ Yes, monthly 1 ○ Yes, weekly 2 ○

D5) In the **past year:**

a. Have you felt fat?

No 0 ○ Slightly 1 ○ Somewhat 2 ○

Very 3 ○ Extremely 4 ○

b. How **afraid** were you that you might gain weight or become fat?

Not at all	Slightly	Somewhat	Very	Extremely
0 ○	1 ○	2 ○	3 ○	4 ○

c. How **happy** have you been with the way your body looks or your weight?

Not at all	A little	Reasonably	Very	Completely
0 ○	1 ○	2 ○	3 ○	4 ○

In the **past year:**

d. How dependent has your self-worth been on your body shape or weight?

Not at all dependent	1	2	3	4	5	6	7	Completely dependent
	○	○	○	○	○	○	○	

e. In the **past year**, have you weighed much **less** than other people thought you ought to weigh?

Yes 1 ○

No 0 ○ → **If no, or don't know, please go to question D6 below**

Don't know 9 ○ →

f. Did you think your low weight had negative consequences for your health?

Not at all 0 ○ Somewhat 1 ○ Very much 2 ○ Don't know 9 ○

g. During the time when you were at this low weight, did you ever experience your body or parts of your body to be larger than they actually were or than other people thought they were?

Not at all 0 ○ Somewhat 1 ○ Very much 2 ○ Don't know 9 ○

D6) Has anyone **ever** told you that they thought you had an eating disorder? *Please cross all that apply.*

		No	Yes, a friend	Yes, a family member	Yes, a doctor, nurse, or other healthcare professional
a.	Anorexia nervosa	0 ☐	1 ☐	2 ☐	3 ☐
b.	Bulimia nervosa	0 ☐	1 ☐	2 ☐	3 ☐
c.	Binge eating disorder	0 ☐	1 ☐	2 ☐	3 ☐
d.	Eating disorder not otherwise specified/Other specified feeding or eating disorder	0 ☐	1 ☐	2 ☐	3 ☐
e.	Avoidant and restrictive food intake disorder	0 ☐	1 ☐	2 ☐	3 ☐

If you answered no to every question a to e, above, please go straight to question D7 on the next page.

f. Did you receive treatment for your eating disorder?

Yes 1 ○ No 0 ○

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D7) Do you think you have a problem with eating, involving avoidance or restriction of foods?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to section E on page 26**

D8) Have your eating habits (avoidance or restriction of certain foods) **ever** led to difficulty maintaining a sufficient weight, or to you losing weight?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question D9 below**

a. Have others (for example, doctors, family members) **ever** been concerned about your weight loss, or about you having difficulty maintaining your weight due to your eating habits?

Yes 1 ○ No 0 ○

D9) Have you **ever** been told by **any health professional** that due to your eating habits you were not growing as expected, or that your height was less than it should be?

Yes 1 ○ No 0 ○

D10) Has **any healthcare professional ever**:

	Yes	No
a. Said that you have a **nutritional deficiency due to your eating habits** (for example, low iron, low vitamin B12, low vitamin C)?	1 ○	0 ○
b. **Prescribed** special supplements (for example, pills or drinks containing vitamins, minerals or nutrients) **specifically to help with your nutrition?**	1 ○	0 ○
c. **Prescribed** special supplements (for example, high-calorie drinks or 'shots', or dessert-style high-calorie supplements) **specifically to help you maintain or gain weight?**	1 ○	0 ○

D11) Has your eating caused you difficulties:
Please cross all that apply, i.e. if now and in the past, please cross both.

		Yes, now	Yes, in the past	No
a.	In daily functioning? This might be at work or when you are at home.	1 ☐	2 ☐	0 ☐
b.	In interactions with other people (for example, arguments with parents, siblings, significant others, co-workers), or in making or sustaining friendships or other close relationships?	1 ☐	2 ☐	0 ☐
c.	In social situations, for example, going out with friends, eating at work, or staying away from home?	1 ☐	2 ☐	0 ☐

D12) Have you **ever** been particularly sensitive to the **texture or consistency** of food, putting you off eating any foods or trying new foods (for example, only eating foods of a certain texture only or having difficulty eating foods with different textures mixed together, such as pasta with sauce, or sandwiches)? *Please cross all that apply.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D13 below**

a. How much sensitivity to **texture or consistency** has affected your eating?

No negative effect or no particular sensitivity	0	1	2	3	4	5	6	Extremely negative effects: only eating a limited number of preferred foods
	○	○	○	○	○	○	○	

D13) Have you **ever** been particularly sensitive to the **appearance** of food, putting you off eating any foods or trying new foods (for example, if food does not look 'right', such as burnt ends of fries, broken biscuits, or if food is the 'wrong' colour)? *Please cross all that apply.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D14 on the next page**

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a. How much has sensitivity to the **appearance** of food affected your eating?

No negative effect or no particular	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	Extremely negative effects, not eating many foods, only eating a limited number of preferred foods

D14) Have you ever **forgotten** to eat or found it **difficult to make time** to eat? *Please cross all that apply, i.e. if now and in the past, please cross both.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D15 below**

a. How often have you **forgotten** to eat or found it **difficult to make time** to eat?

Never	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	Always

D15) Have you ever **lacked enjoyment** in food or eating (even if only certain foods)? *Please cross all that apply.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D16 below**

a. How often have you **lacked enjoyment** in food or eating?

Never	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	Always

D16) Have you ever **felt full** before your meal is finished, or **stopped eating sooner** than others because you had enough? *Please cross all that apply.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D17 on the next page**

a. How often have you **felt full** or **stopped eating** early?

Never	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	Always

D17) Have you ever **avoided or restricted the amount or type** of food you ate, because you were **afraid that something bad might happen**, like being sick, choking, having an allergic reaction, or being in pain?
Please cross all that apply, i.e. if now and in the past, please cross both.

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to question D18 below**

a. How often has being **afraid something bad might happen** affected your eating?

Never 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ Always

D18) Have you ever **avoided eating situations** because you were **worried something bad might happen**, like being sick, choking, having an allergic reaction, or being in pain while eating? *Please cross all that apply.*

Yes, now 1 ☐ Yes, in the past 2 ☐

No 0 ☐ → **If <u>no</u>, please go to section E on the next page**

a. How often have you **avoided eating situations** due to such worries?

Never 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ Always

If you are affected by any of the issues raised in this section, you may wish to seek support from:

BEAT

The UK's eating disorder charity

www.b-eat.co.uk

Tel: 0345 634 1414

Alternatively, there are a number of organisations listed at the back of the questionnaire.

Section E: Your Feelings

Please cross through circles like this in BLACK PEN: ⊗

The questions in this section ask you about your feelings and the way you behave. There are some questions about suicide and self-harm.

We realise that you may find some of these questions upsetting. If you prefer not to answer these questions, please leave them blank.

You can find information for support organisations on our helplines page.

You may have answered these questions in previous questionnaires, but you might be feeling differently now and it's important that we understand changes over time.

E1) Please indicate the way you have felt in the **past week**:

a. I have been able to laugh and see the funny side of things

As much as I always could	3 ○	Not quite so much now	2 ○
Definitely not so much now	1 ○	Not at all	0 ○

b. I have looked forward with enjoyment to things

As much as I ever did	3 ○	Rather less than I used to	2 ○
Definitely less than I used to	1 ○	Hardly at all	0 ○

c. I have blamed myself unnecessarily when things went wrong

Yes, most of the time	3 ○	Yes, some of the time	2 ○
Not very often	1 ○	No, never	0 ○

d. I have been anxious or worried for no good reason

No, not at all	0 ○	Hardly ever	1 ○
Yes, sometimes	2 ○	Yes, often	3 ○

e. I have felt scared or panicky for no very good reason

Yes, quite a lot	3 ○	Yes, sometimes	2 ○
No, not much	1 ○	No, not at all	0 ○

continued on the next page...

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f. Things have been getting on top of me

Yes, most of the time 3 ○ Yes, sometimes 2 ○

No, hardly ever 1 ○ No, not at all 0 ○

g. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time 3 ○ Yes, sometimes 2 ○

Not very often 1 ○ No, not at all 0 ○

h. I have felt sad or miserable

Yes, most of the time 3 ○ Yes, sometimes 2 ○

Not very often 1 ○ No, not at all 0 ○

i. I have been so unhappy that I have been crying

Yes, most of the time 3 ○ Yes, quite often 2 ○

Only occasionally 1 ○ No, never 0 ○

j. The thought of harming myself has occurred to me

Yes, quite often 3 ○ Sometimes 2 ○

Hardly ever 1 ○ Never 0 ○

E2) Please indicate the way you feel nowadays:

		Very often	Often	Not very often	Never
a.	Do you feel upset for no obvious reason?	3 ○	2 ○	1 ○	0 ○
b.	Have you felt as though you might faint?	3 ○	2 ○	1 ○	0 ○
c.	Do you feel uneasy and restless?	3 ○	2 ○	1 ○	0 ○
d.	Do you sometimes feel panicky?	3 ○	2 ○	1 ○	0 ○
e.	Do you worry a lot?	3 ○	2 ○	1 ○	0 ○
f.	Do you feel strung-up inside?	3 ○	2 ○	1 ○	0 ○
g.	Do you ever have the feeling you are going to pieces?	3 ○	2 ○	1 ○	0 ○
h.	Do you have bad dreams which upset you when you wake up?	3 ○	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

E3) Over the **past two weeks** how often have you been bothered by the following problems?

		Not at all	Less than half the days	More than half the days	Nearly every day
a.	Feeling nervous, anxious or on edge	0 ○	1 ○	2 ○	3 ○
b.	Not being able to stop or control worrying	0 ○	1 ○	2 ○	3 ○
c.	Worrying too much about different things	0 ○	1 ○	2 ○	3 ○
d.	Trouble relaxing	0 ○	1 ○	2 ○	3 ○
e.	Being so restless that it is hard to sit still	0 ○	1 ○	2 ○	3 ○
f.	Becoming easily annoyed or irritable	0 ○	1 ○	2 ○	3 ○
g.	Feeling afraid as though something awful might happen	0 ○	1 ○	2 ○	3 ○

E4) For the next four statements please tell us how much you feel they are like you:

		Not at all like me	A little bit like me	Moder-ately like me	Quite a bit like me	Extre-mely like me
a.	I often have the feeling that I would just like to run away	0 ○	1 ○	2 ○	3 ○	4 ○
b.	I feel powerless to change things	0 ○	1 ○	2 ○	3 ○	4 ○
c.	I feel trapped inside myself	0 ○	1 ○	2 ○	3 ○	4 ○
d.	I feel I'm in a deep hole I can't get out of	0 ○	1 ○	2 ○	3 ○	4 ○

The following questions are about thoughts of suicide and hurting yourself on purpose, also sometimes referred to as self-harm. We know this is a sensitive subject, but it is important to ask about it now, as it is not uncommon. By finding out about self-harm we can find ways of helping people.

We realise that you may find some of these questions upsetting. If you prefer not to answer these questions, please leave them blank.

You can find information for support organisations on our helplines page.

If you do not want to answer questions on this topic please go to section F on page 33.

E5) Has anyone in your family died by suicide / taken their own life?

Yes 1 ○ No 0 ○ → **If no, please go to question E6 below**

a. Who in your family has done this? *Please select all that apply.*

Parent 1 ☐ Brother or sister 2 ☐ Your child 4 ☐

Your partner 5 ☐ Someone else 6 ☐ *Please cross and describe*

b. How old were you when you experienced your **first** loss of a family member to suicide? ☐☐ years old

E6) Have any of your close friends died by suicide / taken their own life?

Yes 1 ○ No 0 ○ → **If no, please go to question E7 on the next page**

a. How old were you when you experienced your **first** loss of a friend to suicide? ☐☐ years old

E7) Has anyone in your family (not including yourself) ever hurt themselves on purpose (e.g. by taking an overdose of pills, or by cutting themselves)?
Please do not include a family member who has died by suicide.

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E8 below**

a. Who in your family has done this? *Please select all that apply.*

Parent 1 ☐ Brother or sister 2 ☐ Your child 4 ☐

Your partner 5 ☐ Someone else 6 ☐ *Please cross and describe*

b. How old were you when this first happened? ☐☐ years old

E8) Have any of your close friends **ever** hurt themselves on purpose (e.g. by taking an overdose of pills, or by cutting themselves)?
Please do not include a friend who has died by suicide.

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E9 below**

a. How old were you when this **first** happened? ☐☐ years old

E9) Have you **ever** hurt yourself on purpose in any way (e.g. by taking an overdose of pills, or by cutting yourself)?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E10 on page 32**

a. How many times have you done this **in the last year**?

Not in the past year 0 ○ Once 1 ○

2-5 times 2 ○ 6-10 times 3 ○

More than 10 times 4 ○

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b. Have you ever hurt yourself on purpose (e.g. by taking an overdose of pills, or by cutting yourself), without intending to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to c below**

(i) When was the last time you hurt yourself on purpose, without intending to kill yourself?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

c. On any of the occasions you have hurt yourself on purpose, have you ever seriously wanted to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to d below**

(i) When was the last time you hurt yourself on purpose and you seriously wanted to kill yourself?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

<u>Please note these questions are for research only and we will not contact you about your answers. Please use our helplines page if you feel suicidal.</u>

d. **In your lifetime**, do any of the following reasons help to explain why you have hurt yourself on purpose? *Please select all that apply.*

I wanted to show how desperate I was feeling	1 ☐
I wanted to die	2 ☐
I wanted to punish myself	3 ☐
I wanted to frighten someone	4 ☐
I wanted to get relief from a terrible state of mind	5 ☐
Some other reason *Please cross and describe*	6 ☐

e. How old were you when this **first** happened? ☐☐ years old

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E10) Have you **ever** thought of killing yourself, even if you would not really do it?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to section F on the next page.**

a. When was the **last time** you felt like this?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

b. Have you **ever** made plans to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to d below**

c. When was the **last time** you felt like this?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

d. Did your religious beliefs, or lack of them, play a role in:

	Yes, my belief did	Yes, my lack of belief did	No	Don't know	Prefer not to answer
(i) Making a plan to do it?	1 ○	2 ○	0 ○	9 ○	8 ○
(ii) Preventing you from following through with it?	1 ○	2 ○	0 ○	9 ○	8 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

SHOUT
Support around self-harm
Text: 85258
giveusashout.org/get-help/issues/help-self-harm/

SAMARITANS
Emotional support for everyone
samaritans.org
Tel: 116 123 (24 hours)

Section F: Unusual Experiences

Different people experience life in different ways. We are interested in finding out more about experiences that you may have had.

Some, or even all of these questions might not apply to you, but it is important that we ask everyone the same questions. We realise that you may find some of these questions distressing. If you prefer not to answer these questions, please leave them blank.

F1) Have you **ever** heard voices that other people couldn't hear?

Yes, definitely	Yes, maybe	No, never	
2 ○	1 ○	0 ○	→ **If <u>no</u>, please go to question F2 below**

a. How often have you heard voices that other people couldn't hear in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F2) Have you **ever** seen something or someone that other people couldn't see?

Yes, definitely	Yes, maybe	No, never	
2 ○	1 ○	0 ○	→ **If <u>no</u>, please go to F3 on the next page**

a. How often have you seen things that other people couldn't see in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F3) Have you **ever** thought you were being followed or spied on?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If no, please go to question F4 below**

a. How often have you thought you were being followed or spied on in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

F4) Have you **ever** believed that people were following you or spying on you as part of a plot to harm you in some way, and which your family or friends did not believe existed?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If no, please go to question F5 below**

a. How often have you believed that people were following you or spying on you as part of a plot, in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

F5) Some people believe that other people can read their thoughts. Have other people **ever** read your thoughts?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If no, please go to question F6 below**

a. How often have you believed that other people can read your thoughts in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

b. Do you think people have sometimes used special powers to read your thoughts?

Yes definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○

F6) Have you **ever** believed that you were being sent special messages through the television or the radio, or that a programme had been arranged just for you alone?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If no, please go to F7 on the next page**

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a. How often have you been sent special messages in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F7) Have you **ever** felt that you were under the control of some special power?

Yes, definitely	Yes, maybe	No, never	
2 ○	1 ○	0 ○	→ **If <u>no</u>, please go to question F8 below**

a. How often have you thought you were under the control of a special power in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

b. Who did you think was controlling you (at any time in the past)?

God or other religious figure	1 ○	A computer or machine	2 ○
Someone or something else	3 ○	Don't know	9 ○

c. Did it control what you were doing or thinking, such that you had no will of your own?

Yes definitely	Yes, maybe	No, never
2 ○	1 ○	0 ○

F8) Have you **ever** felt that you are somebody really very special, or that you have special powers like reading people's minds, or that you have been chosen to perform great and special tasks?
This doesn't mean that you are just clever or that you come from an important family.

Yes, definitely	Yes, maybe	No, never	
2 ○	1 ○	0 ○	→ **If <u>no</u>, please go to Section G on the next page**

a. How often have you thought you are somebody really very special, or that you have special powers in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

MIND - Advice and support for anyone with a mental health problem **mind.org.uk**
Tel: 0300 123 3393 **Text: 86463**

Section G: Being a Parent

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

G1) Are you a parent? *Include biological, step, foster and adopted children.*

Yes 1 ○ No 0 ○ → **If no, please go to question G4 on the next page**

G2) How many children do you have? *Please include all children you feel you have parental responsibility for, including biological, step, foster and adopted children.* ☐☐

G3) What is/are your child/childrens' date(s) of birth, sex, and your relationship to them?

We have provided space for up to 4 children. If you have had more than 4 children, please use the space on page 41 and clearly indicate you are answering question K3.

a. Your **first** child:

i) Date of birth: DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

ii) Sex: Male 1 ○ Female 2 ○

iii) Are you a biological parent of your first child? Yes 1 ○ No 0 ○

b. Your **second** child:

i) Date of birth: DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

ii) Sex: Male 1 ○ Female 2 ○

iii) Are you a biological parent of your second child? Yes 1 ○ No 0 ○

c. Your **third** child:

i) Date of birth: DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

ii) Sex: Male 1 ○ Female 2 ○

iii) Are you the biological parent of your third child? Yes 1 ○ No 0 ○

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d. Your **fourth** child:

i) Date of birth: DD / MM / YYYY

ii) Sex: Male 1 ○ Female 2 ○

iii) Are you the biological parent of your fourth child? Yes 1 ○ No 0 ○

G4) Are you/your partner currently pregnant?

Yes, I am pregnant 1 ○ Yes, my partner is pregnant 2 ○

No 0 ○ → **If no, please go to question G7 below**

G5) What is the expected due date of your baby? DD / MM / YYYY

G6) Where do you expect your baby to be born?

Southmead Hospital 1 ○ St Michael's Hospital 2 ○

Weston General Hospital 3 ○ RUH Bath 4 ○

Other (please specify) 5 ○

G7) Are you or your partner trying for a baby at the moment?

No, not trying for a baby 0 ○

Yes, been trying for 0-6 months 1 ○

Yes, been trying for 6-12 months 2 ○

Yes, been trying for more than 12 months 3 ○

G8) **If you are a parent** or **are expecting a child**, would you be happy to receive further details about COCO90s (Children of the Children of the 90s)?

Yes 1 ○ Already in COCO90s 2 ○

No 0 ○ Not applicable 9 ○

If you would like to know more about COCO90s please go to:

www.childrenofthe90s.ac.uk/coco90s

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Section H: More About Your Feelings

This section asks about how you feel about certain things.

H1) Please respond to the following questions on a scale from 0 to 10:

a. My relationships are as satisfying as I would want them to be.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

b. How often do you worry about being able to meet normal monthly living expenses?

	0	1	2	3	4	5	6	7	8	9	10	
Worry all of the time	○	○	○	○	○	○	○	○	○	○	○	Do not ever worry

c. How often do you worry about safety, food, or housing?

	0	1	2	3	4	5	6	7	8	9	10	
Worry all of the time	○	○	○	○	○	○	○	○	○	○	○	Do not ever worry

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

H2) Please consider each of the following statements. How often have you been feeling like this in the **past two weeks**?

		None of the time	Rarely	Some-times	Often	All the time
a.	I've been feeling optimistic about the future	0 ○	1 ○	2 ○	3 ○	4 ○
b.	I've been feeling useful	0 ○	1 ○	2 ○	3 ○	4 ○
c.	I've been feeling relaxed	0 ○	1 ○	2 ○	3 ○	4 ○
d.	I've been feeling interested in other people	0 ○	1 ○	2 ○	3 ○	4 ○
e.	I've had energy to spare	0 ○	1 ○	2 ○	3 ○	4 ○
f.	I've been dealing with problems well	0 ○	1 ○	2 ○	3 ○	4 ○
g.	I've been thinking clearly	0 ○	1 ○	2 ○	3 ○	4 ○
h.	I've been feeling good about myself	0 ○	1 ○	2 ○	3 ○	4 ○
i.	I've been feeling close to other people	0 ○	1 ○	2 ○	3 ○	4 ○
j.	I've been feeling confident	0 ○	1 ○	2 ○	3 ○	4 ○
k.	I've been able to make up my own mind about things	0 ○	1 ○	2 ○	3 ○	4 ○
l.	I've been feeling loved	0 ○	1 ○	2 ○	3 ○	4 ○
m.	I've been interested in new things	0 ○	1 ○	2 ○	3 ○	4 ○
n.	I've been feeling cheerful	0 ○	1 ○	2 ○	3 ○	4 ○

H3) Please respond to the following questions on a scale from 0 to 10:

a. Overall, how satisfied are you with life as a whole these days?

	0	1	2	3	4	5	6	7	8	9	10	
Not satisfied at all	○	○	○	○	○	○	○	○	○	○	○	Completely satisfied

b. In general, how happy or unhappy do you usually feel?

	0	1	2	3	4	5	6	7	8	9	10	
Extremely unhappy	○	○	○	○	○	○	○	○	○	○	○	Extremely happy

c. In general, how would you rate your physical health?

	0	1	2	3	4	5	6	7	8	9	10	
Poor	○	○	○	○	○	○	○	○	○	○	○	Excellent

d. How would you rate your overall mental health?

	0	1	2	3	4	5	6	7	8	9	10	
Poor	○	○	○	○	○	○	○	○	○	○	○	Excellent

e. Overall, to what extent do you feel the things you do in your life are worthwhile?

	0	1	2	3	4	5	6	7	8	9	10	
Not at all worthwhile	○	○	○	○	○	○	○	○	○	○	○	Completely worthwhile

f. I understand my purpose in life.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

g. I always act to promote good in all circumstances, even in difficult and challenging situations.

	0	1	2	3	4	5	6	7	8	9	10	
Not true of me	○	○	○	○	○	○	○	○	○	○	○	Completely true of me

h. I am always able to give up some happiness now for greater happiness later.

	0	1	2	3	4	5	6	7	8	9	10	
Not true of me	○	○	○	○	○	○	○	○	○	○	○	Completely true of me

i. I am content with my friendships and relationships.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

If you are affected by any of the issues raised in this section, you may wish to seek support from:

MIND - Advice and support for anyone with a mental health problem
mind.org.uk **Tel: 0300 123 3393** **Text: 86463**

Completing the Questionnaire

I1) What is your **date of birth**? DD / MM / YYYY 1 9

I2) What is **today's date**? DD / MM / YYYY 2 0

Attend your @30 clinic visit and receive a £40 voucher!
Parents are now invited to attend our @30 clinic. Please update your details at:
childrenofthe90s.ac.uk/update-your-details
so that we can send you an invite. We offer a range of days & times, and you can attend with your family/partner too.

We are also always trying to find ways to reduce our paper use. To ensure that we send you your questionnaires via your preferred method, can you please let us know how you would like to complete your questionnaires? If you choose 'online' we will no longer send out paper questionnaires as part of our reminder process.

Online 1 ○ Paper 2 ○

Extra space for answering questions
Please clearly indicate the question number(s) your answer applies to.

Thank you!

Many thanks for completing your questionnaire. The information you provide is really important to our ongoing research.

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Life @ 31 + Questionnaire

STRICTLY CONFIDENTIAL (when completed)

Version 1 30/03/2023

Questionnaire Number

If you'd like to add a comment, please do so in the box below.

When completed, please send this back in the freepost envelope provided, or post to this address. If you do not wish to complete this questionnaire, please leave it blank and return it to us. We will then know not to send you any more reminders.

Freepost (RRXX-UUZG-HTLK)
Children of the 90s
Oakfield House
15-23 Oakfield Grove
Bristol
BS8 2BN

If you **would like to receive** a thank you voucher for completing your questionnaire, please **cross this box**: ☐
Children of the 90s will send your voucher to the email/postal address we have listed on our records. Vouchers will be sent within 4 weeks of receiving your questionnaire using the details we hold for you.
If you want to update the details that we have for you please visit:
childrenofthe90s.ac.uk/update-your-details

To be entered into the prize draw we must have received your questionnaire by midnight on Monday 4th September 2023. If you win, we will contact you within two weeks using the contact details on our database. You will receive your prize up to six weeks after the draw has been held.

If you **wish to be entered** into the prize draw, please **cross this box**.

Enter Prize Draw ☐

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