

NATIONAL OUTCOME MEASURES

**Adopted and Modified by Indiana Prevention Resource Center from
Youth Community Survey Form -- Center for Substance Abuse Prevention**

Survey Form

This survey is voluntary. If you choose to take it, you may skip any question you don't want to answer.

This survey asks about your experience and opinion on a number of things related to alcohol, tobacco, and drug use. Your answers to these questions will be confidential. That means no one will connect your answers with your name or any other information about you that can identify who you are. To help us keep your answers anonymous, please do not write your name on this survey form.

The information in this survey will be used to learn more about the effectiveness of programs in preventing substance abuse and protecting youth.

This is not a test, so there are no right or wrong answers. Some questions may ask you to select all of the answers that are relevant, and others ask you to select a single answer. If the question asks for a single answer and you don't find an answer that exactly fits, choose one that comes closest.

Thank you for agreeing to participate in this survey.

RECORD MANAGEMENT: Your survey administrator will tell you what to fill in for these administrative questions. You may leave all but **Date Completed** blank if you are not given any instructions.

Participant ID

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Contract/Grant ID

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date Completed

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



Survey Type (Check one)

- Baseline Exit First follow-up after exit Second follow-up

Study Design Group (Check one)

- Intervention Comparison

Program Name

Cohort Number

These questions ask for general information about you. Please mark the response that best describes you.

1. What is your gender? (Check one)

- Male Female

2. Are you Hispanic or Latino? (Check one)

- Yes No

3. What is your race? (Select one or more)

- White
 Black or African American
 American Indian
 Native Hawaiian or Other Pacific Islander
 Asian
 Alaska Native

4. What is your date of birth?

/ /
Month Day Year

The next few questions ask about your use of and attitudes toward tobacco, alcohol, and other substances.

5. Think back over the past 30 days and report how many days, if any, you used the following substances:

			Fill in number of days (0 –30)	Check if don't know or can't say
Cigarettes: Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	5a.	During the past 30 days, on how many days did you smoke part or all of a cigarette?	_____	<input type="checkbox"/>
Other tobacco products: Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	5b.	During the past 30 days, on how many days did you use other tobacco products?	_____	<input type="checkbox"/>
Alcoholic beverages: Include beer, wine, wine coolers, malt beverages, and liquor	5c.	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	_____	<input type="checkbox"/>
Marijuana or hashish: Also known as grass, pot, hash, or hash oil	5d.	During the past 30 days, on how many days did you use marijuana or hashish?	_____	<input type="checkbox"/>
Methamphetamine : It is a highly addictive stimulant, also known as meth, crystal, ice or speed, .	5e.	During the past 30 days, on how many days did you use methamphetamine?	_____	<input type="checkbox"/>
Cocaine or crack cocaine, a highly addictive stimulant, also known as coke, snow or smack (usually a white powder)	5f	During the past 30 days, on how many days did you use crack or crack cocaine?	_____	<input type="checkbox"/>
Heroin, a highly addictive drug that relieves pain. (usually injected)	5g	During the past 30 days, on how many days did you use heroin?	_____	<input type="checkbox"/>
Hallucinogens (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), Ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)	5h	During the past 30 days, on how many days did you use any hallucinogens?	_____	<input type="checkbox"/>
Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish	5i.	During the past 30 days, on how many days did you use inhalants?	_____	<input type="checkbox"/>
Prescription drugs without a doctor's orders, just to get high	5j.	During the past 30 days, on how many days did you use prescription drugs without a prescription??	_____	<input type="checkbox"/>

6. Think back over your entire lifetime and try to remember whether you have EVER used any of the following substances. If so, what was your age the FIRST TIME you used the substance:

			Check if NEVER	Fill in your age when you first used (in years)	Check if don't know or can't say
Cigarettes: Include menthol and regular cigarettes and loose tobacco rolled into cigarettes	6a.	Ever smoked part or all of a cigarette?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other tobacco products: Include any tobacco product other than cigarettes such as snuff, chewing tobacco, and smoking tobacco from a pipe	6b.	Ever used any other tobacco product?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Alcoholic beverages: Include beer, wine, wine coolers, malt beverages, and liquor	6c.	Ever had a drink of an alcoholic beverage? Do NOT include any time when you only had a sip or two from a drink.	<input type="checkbox"/>	_____	<input type="checkbox"/>
Marijuana or hashish: Also known as grass, pot, hash, or hash oil	6d.	Ever used marijuana or hashish?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Methamphetamine : a highly addictive stimulant, also known as meth, crystal, ice or speed, .	6e.	Ever used methamphetamine?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Cocaine or crack cocaine, a highly addictive stimulant, also known as coke, snow or smack (usually a white powder)	6f.	Ever used cocaine?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Heroin, a highly addictive drug that relieves pain. (usually injected)	6g.	Ever used heroin?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Hallucinogens (drugs that cause people to see or experience things that are not real) such as LSD (sometimes called acid), ecstasy (sometimes called MDMA), PCP or peyote (sometimes called angel dust)	6h.	Ever used hallucinogens, like LSD, ecstasy, PCP, or peyote?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid, or shoe polish to get high	6i	Ever used inhalants or sniffed substances?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Prescription drugs without a doctor's orders, just to get high	6j	Ever used prescription drugs without a doctor's orders?	<input type="checkbox"/>	_____	<input type="checkbox"/>

7. For each of the following nine questions check the box that shows how YOU think or feel.

		Strongly Disapprove	Somewhat Disapprove	Neither Approve nor Disapprove	Somewhat Approve	Strongly Approve	Don't Know or Can't Say
7a	How do <i>you</i> feel about someone your age smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b	How do you think <i>your close friends</i> would feel about YOU smoking one or more packs of cigarettes a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c	How do <i>you</i> feel about someone your age trying marijuana or hashish once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7d	How do <i>you</i> feel about someone your age using marijuana or hashish once a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7e	How do <i>you</i> feel about someone your age trying methamphetamine once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7f	How do <i>you</i> feel about someone your age using methamphetamine once a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7g	How do <i>you</i> feel about someone your age trying cocaine once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7h	How do <i>you</i> feel about someone your age using cocaine once a month or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7i	How do <i>you</i> feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. For each of the five questions below check one box that shows HOW MUCH you think people RISK HARMING themselves physically or in other ways when they do the following things:.

		No Risk	Slight Risk	Moderate Risk	Great Risk	Don't Know or Can't Say
8a.	When they smoke one or more packs of CIGARETTES per day?	<input type="checkbox"/>				
8b.	When they smoke MARIJUANA once or twice a week?	<input type="checkbox"/>				
8c.	When they use COCAINE once or twice a week?	<input type="checkbox"/>				
8d.	When they use METHAMPHETAMINE once or twice a week?	<input type="checkbox"/>				
8e.	When they have five or more drinks of an ALCOHOLIC BEVERAGE once or twice a week?	<input type="checkbox"/>				

This section asks just a few additional questions about your attitudes and experiences.

9. Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you? (Check one)

- More Likely
 Less Likely
 Would Make No Difference
 Don't Know or Can't Say

10. DURING THE PAST 12 MONTHS, have you driven a vehicle while you were under the influence of alcohol?

- Yes
 No
 Don't Know or Can't Say

11. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By PARENTS, we mean your biological parents, adoptive parents, stepparents, or adult guardians—whether or not they live with you.

- Yes
 No
 Don't know or can't say

12. During the past 12 months, do you recall hearing, reading, or watching an advertisement about prevention of substance abuse?

- Yes
 No
 Don't Know or Can't Say