



American College Health Association **National College Health Assessment**

**Instructions:**

*The following questions ask about various aspects of your health.*

*To answer the questions, fill in the oval that corresponds to your response.*

*Select only one response unless instructed otherwise.*

*Use a No. 2 pencil or blue or black ink pen only. Do not use pens with ink that soaks through the paper.*

CORRECT: ● INCORRECT: ☑ ✕ ○ ●

*This survey is completely voluntary. You may choose not to participate or not to answer any specific question. You may skip any question you are not comfortable in answering.*

*Please make no marks of any kind on the survey which could identify you individually.*

*Composite data will then be shared with your campus for use in health promotion activities.*

***Thank you for taking the time and thought to complete this survey. We appreciate your participation!***



American College Health Association

**National College Health Assessment**

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**PAGE ONE**

PLEASE DO NOT WRITE IN THIS AREA



**SERIAL #**

3/8" spine  
perforation

# Health, Health Education and Safety

## 1. How would you describe your general health?

- Excellent   
  Very good   
  Good   
  Fair   
  Poor   
  Don't know

## 2. Have you received information on the following topics from your college or university?

## 3. Are you interested in receiving information on the following topics from your college or university?

(Please mark the appropriate column for each question to the right)

	No	Yes	No	Yes
Alcohol and other drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cold/Flu/Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grief and loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How to help others in distress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injury prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nutrition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem use of Internet/computer games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual assault/Relationship violence prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease/infection (STD/I) prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stress reduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicide prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violence prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 4. Within the last 12 months, how often did you:

(Please mark the appropriate column for each row)

	N/A, did not do this activity within the last 12 months	Never	Rarely	Sometimes	Most of the time	Always
Wear a seatbelt when you rode in a car?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you rode a bicycle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you rode a motorcycle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you were inline skating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 5. Within the last 12 months:

(Please mark the appropriate column for each row)

	No	Yes
Were you in a physical fight?	<input type="radio"/>	<input type="radio"/>
Were you physically assaulted (do not include sexual assault)?	<input type="radio"/>	<input type="radio"/>
Were you verbally threatened?	<input type="radio"/>	<input type="radio"/>
Were you sexually touched without your consent?	<input type="radio"/>	<input type="radio"/>
Was sexual penetration attempted (vaginal, anal, oral) without your consent?	<input type="radio"/>	<input type="radio"/>
Were you sexually penetrated (vaginal, anal, oral) without your consent?	<input type="radio"/>	<input type="radio"/>
Were you a victim of stalking (e.g., waiting for you outside your classroom, residence, or office; repeated emails/phone calls)?	<input type="radio"/>	<input type="radio"/>



9. Within the last 30 days, how often do you think the typical student at your school used:

(State your best estimate; Please mark the appropriate column for each row)

3-5 days 6-9 days  
1-2 days 10-19 days  
Have used, but not in last 30 days 20-29 days  
Never used Used daily

	Never used	1-2 days	3-5 days	6-9 days	10-19 days	20-29 days	Used daily
Cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco from a water pipe (hookah)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigars, little cigars, clove cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smokeless tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol (beer, wine, liquor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marijuana (pot, weed, hashish, hash oil)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine (crack, rock, freebase)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methamphetamine (crystal meth, ice, crank)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other amphetamines (diet pills, bennies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sedatives (downers, ludes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinogens (LSD, PCP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anabolic steroids (Testosterone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opiates (heroin, smack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhalants (glue, solvents, gas)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDMA (Ecstasy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other club drugs (GHB, Ketamine, Rohypnol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other illegal drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

One drink of alcohol is defined as a 12 oz. can or bottle of beer or wine cooler, a 4 oz. glass of wine, or a shot of liquor straight or in a mixed drink.

10. The last time you "partied"/socialized how many drinks of alcohol did you have? (If you did not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

D	<input type="text"/>	<input type="text"/>
R	<input type="text"/>	<input type="text"/>
I	<input type="text"/>	<input type="text"/>
N	<input type="text"/>	<input type="text"/>
K	<input type="text"/>	<input type="text"/>
S	<input type="text"/>	<input type="text"/>

11. The last time you "partied"/socialized over how many hours did you drink alcohol? (If you did not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

H	<input type="text"/>	<input type="text"/>
O	<input type="text"/>	<input type="text"/>
U	<input type="text"/>	<input type="text"/>
R	<input type="text"/>	<input type="text"/>
S	<input type="text"/>	<input type="text"/>

12. How many drinks of alcohol do you think the typical student at your school had the last time he/she "partied"/socialized? (If you think the typical student at your school does not drink alcohol, please enter 00. If less than 10, enter 01, 02, 03, etc.)

D	<input type="text"/>	<input type="text"/>
R	<input type="text"/>	<input type="text"/>
I	<input type="text"/>	<input type="text"/>
N	<input type="text"/>	<input type="text"/>
K	<input type="text"/>	<input type="text"/>
S	<input type="text"/>	<input type="text"/>

13. Over the last two weeks, how many times have you had five or more drinks of alcohol at a sitting?

- |  |                               |                               |  |
|--|-------------------------------|-------------------------------|--|
| <input type="radio"/> N/A, don't drink | <input type="radio"/> 2 times | <input type="radio"/> 5 times | <input type="radio"/> 8 times          |
| <input type="radio"/> None             | <input type="radio"/> 3 times | <input type="radio"/> 6 times | <input type="radio"/> 9 times          |
| <input type="radio"/> 1 time           | <input type="radio"/> 4 times | <input type="radio"/> 7 times | <input type="radio"/> 10 or more times |

14. Within the last 30 days, did you:

(Please mark the appropriate column for each row)

Yes  
No  
N/A, don't drink  
N/A, don't drive

Drive after drinking any alcohol at all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive after drinking five or more drinks of alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Sex Behavior and Contraception

19. Within the last 12 months, with how many partners have you had oral sex, vaginal intercourse, or anal intercourse? (If you did not have a sex partner within the last 12 months, please enter 00. If less than 10, enter 01, 02, 03, etc.) →

P		
A	①	①
R	①	①
T	②	②
N	③	③
E	④	④
R	⑤	⑤
S	⑥	⑥
	⑦	⑦
	⑧	⑧
	⑨	⑨

20. Within last 12 months, did you have sexual partner(s) who were:

(Please mark the appropriate column for each row)

	No	Yes
Female	<input type="radio"/>	<input type="radio"/>
Male	<input type="radio"/>	<input type="radio"/>
Transgender	<input type="radio"/>	<input type="radio"/>

21. Within the last 30 days, did you have:

(Please mark the appropriate column for each row)

- Oral sex?
- Vaginal intercourse?
- Anal intercourse?

	No, have never done this sexual activity	No, have done this sexual activity in the past but not in the last 30 days	Yes
Oral sex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Within the last 30 days, how often did you or your partner(s) use a condom or other protective barrier (e.g., male condom, female condom, dam, glove) during:

(Please mark the appropriate column for each row)

- Oral sex?
- Vaginal intercourse?
- Anal intercourse?

	N/A, never did this sexual activity	Have not done this sexual activity during the last 30 days	Never	Rarely	Sometimes	Most of the time	Always	CONDOM/ BARRIER USE
Oral sex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23A. Did you or your partner use a method of birth control to prevent pregnancy the last time you had vaginal intercourse?

- Yes (continue to item 23B)
- N/A, have not had vaginal intercourse (skip to item 24)
- No, have not had vaginal intercourse that could result in a pregnancy (skip to item 24)
- No, did not want to prevent pregnancy (skip to item 24)
- No, did not use any birth control method (skip to item 24)
- Don't know (skip to item 24)

23B. Please indicate whether or not you or your partner used each of the following methods of birth control to prevent pregnancy the last time you had vaginal intercourse. (Please mark the appropriate column for each row)

	No	Yes		No	Yes
Birth control pills (monthly or extended cycle)	<input type="radio"/>	<input type="radio"/>	Diaphragm or cervical cap	<input type="radio"/>	<input type="radio"/>
Birth control shots	<input type="radio"/>	<input type="radio"/>	Contraceptive sponge	<input type="radio"/>	<input type="radio"/>
Birth control implants	<input type="radio"/>	<input type="radio"/>	Spermicide (e.g., foam, jelly, cream)	<input type="radio"/>	<input type="radio"/>
Birth control patch	<input type="radio"/>	<input type="radio"/>	Fertility awareness (e.g., calendar, mucous, basal body temperature)	<input type="radio"/>	<input type="radio"/>
Vaginal ring	<input type="radio"/>	<input type="radio"/>	Withdrawal	<input type="radio"/>	<input type="radio"/>
Intrauterine device (IUD)	<input type="radio"/>	<input type="radio"/>	Sterilization (e.g., hysterectomy, tubes tied, or vasectomy)	<input type="radio"/>	<input type="radio"/>
Male condom	<input type="radio"/>	<input type="radio"/>	Other method	<input type="radio"/>	<input type="radio"/>
Female condom	<input type="radio"/>	<input type="radio"/>			

24. Within the last 12 months, have you or your partner(s) used emergency contraception (“morning after pill”)?

- N/A, have not had vaginal intercourse in the last 12 months
- No
- Yes
- Don't know

25. Within the last 12 months, have you or your partner(s) become pregnant?

- N/A, have not had vaginal intercourse in the last 12 months
- No
- Yes, unintentionally
- Yes, intentionally
- Don't know

## Weight, Nutrition, and Exercise

26. How do you describe your weight?

- Very underweight
- Slightly underweight
- About the right weight
- Slightly overweight
- Very overweight

27. Are you trying to do any of the following about your weight?

- I am not trying to do anything about my weight
- Stay the same weight
- Lose weight
- Gain weight

28. How many servings of fruits and vegetables do you usually have per day?

(1 serving = 1 medium piece of fruit; 1/2 cup fresh, frozen, or canned fruits/vegetables; 3/4 cup fruit/vegetable juice; 1 cup salad greens; or 1/4 cup dried fruit)

- 0 servings per day
- 1–2 servings per day
- 3–4 servings per day
- 5 or more servings per day

29. On how many of the past 7 days did you:

(Please mark the appropriate column for each row)

- Do moderate-intensity cardio or aerobic exercise (caused a noticeable increase in heart rate, such as a brisk walk) for at least 30 minutes?
- Do vigorous-intensity cardio or aerobic exercise (caused large increases in breathing or heart rate, such as jogging) for at least 20 minutes?
- Do 8-10 strength training exercises (such as resistance weight machines) for 8-12 repetitions each?

	0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Do moderate-intensity cardio or aerobic exercise (caused a noticeable increase in heart rate, such as a brisk walk) for at least 30 minutes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do vigorous-intensity cardio or aerobic exercise (caused large increases in breathing or heart rate, such as jogging) for at least 20 minutes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do 8-10 strength training exercises (such as resistance weight machines) for 8-12 repetitions each?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Mental Health

30. Have you ever:

(Please mark the appropriate column for each row)

- Felt things were hopeless
- Felt overwhelmed by all you had to do
- Felt exhausted (not from physical activity)
- Felt very lonely
- Felt very sad
- Felt so depressed that it was difficult to function
- Felt overwhelming anxiety
- Felt overwhelming anger
- Intentionally cut, burned, bruised, or otherwise injured yourself
- Seriously considered suicide
- Attempted suicide

	No, not in last 12 months	Yes, in the last 2 weeks	Yes, in the last 30 days	Yes, in the last 12 months
Felt things were hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelmed by all you had to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt exhausted (not from physical activity)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt very lonely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt very sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt so depressed that it was difficult to function	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelming anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelming anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intentionally cut, burned, bruised, or otherwise injured yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriously considered suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attempted suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





35. Have you ever received psychological or mental health services from your current college/university's Counseling or Health Service?

- No  Yes

36. If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional?

- No  Yes

37. Within the last 12 months, how would you rate the overall level of stress you have experienced?

- No stress  
 Less than average stress  
 Average stress  
 More than average stress  
 Tremendous stress

## Physical Health

38. Within the last 30 days, did you do any of the following?

(Please mark the appropriate column for each row)

Exercise to lose weight

Diet to lose weight

Vomit or take laxatives to lose weight

Take diet pills to lose weight

	No	Yes
Exercise to lose weight	<input type="radio"/>	<input type="radio"/>
Diet to lose weight	<input type="radio"/>	<input type="radio"/>
Vomit or take laxatives to lose weight	<input type="radio"/>	<input type="radio"/>
Take diet pills to lose weight	<input type="radio"/>	<input type="radio"/>

39. Have you:

(Please mark the appropriate column for each row)

Had a dental exam and cleaning in the last 12 months?

(Males) Performed testicular self exam in the last 30 days?

(Females) Performed breast self exam in the last 30 days?

(Females) Had a routine gynecological exam in the last 12 months?

Used sunscreen regularly with sun exposure?

Ever been tested for Human Immunodeficiency Virus (HIV) infection?

	No	Yes	Don't know
Had a dental exam and cleaning in the last 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Males) Performed testicular self exam in the last 30 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Females) Performed breast self exam in the last 30 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Females) Had a routine gynecological exam in the last 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used sunscreen regularly with sun exposure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ever been tested for Human Immunodeficiency Virus (HIV) infection?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. Have you received the following vaccinations (shots)?

(Please mark the appropriate column for each row)

Hepatitis B

Human Papillomavirus/HPV (cervical cancer vaccine)

Influenza (the flu) in the last 12 months (shot or nasal mist)

Measles, Mumps, Rubella

Meningococcal disease (meningococcal meningitis)

Varicella (chicken pox)

	No	Yes	Don't know
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Human Papillomavirus/HPV (cervical cancer vaccine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influenza (the flu) in the last 12 months (shot or nasal mist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Measles, Mumps, Rubella	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meningococcal disease (meningococcal meningitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Varicella (chicken pox)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



# Impediments to Academic Performance

(Please select the most serious outcome for each item below)

Significant disruption in thesis, dissertation, research, or practicum work

Received an incomplete or dropped the course

Received a lower grade in the course

Received a lower grade on an exam or important project

I have experienced this issue but my academics have not been affected

This did not happen to me/not applicable

45. Within the last 12 months, have any of the following affected your academic performance?

Alcohol use	○ ○ ○ ○ ○ ○
Allergies	○ ○ ○ ○ ○ ○
Anxiety	○ ○ ○ ○ ○ ○
Assault (physical)	○ ○ ○ ○ ○ ○
Assault (sexual)	○ ○ ○ ○ ○ ○
Attention Deficit and Hyperactivity Disorder (ADHD)	○ ○ ○ ○ ○ ○
Cold/Flu/Sore throat	○ ○ ○ ○ ○ ○
Concern for a troubled friend or family member	○ ○ ○ ○ ○ ○
Chronic health problem or serious illness (e.g., diabetes, asthma, cancer)	○ ○ ○ ○ ○ ○
Chronic pain	○ ○ ○ ○ ○ ○
Death of a friend or family member	○ ○ ○ ○ ○ ○
Depression	○ ○ ○ ○ ○ ○
Discrimination (e.g., homophobia, racism, sexism)	○ ○ ○ ○ ○ ○
Drug use	○ ○ ○ ○ ○ ○
Eating disorder/problem	○ ○ ○ ○ ○ ○
Finances	○ ○ ○ ○ ○ ○
Gambling	○ ○ ○ ○ ○ ○
Homesickness	○ ○ ○ ○ ○ ○
Injury (fracture, sprain, strain, cut)	○ ○ ○ ○ ○ ○
Internet use/computer games	○ ○ ○ ○ ○ ○
Learning disability	○ ○ ○ ○ ○ ○
Participation in extracurricular activities (e.g., campus clubs, organizations, athletics)	○ ○ ○ ○ ○ ○
Pregnancy (yours or your partner's)	○ ○ ○ ○ ○ ○
Relationship difficulties	○ ○ ○ ○ ○ ○
Roommate difficulties	○ ○ ○ ○ ○ ○
Sexually transmitted disease/infection (STD/I)	○ ○ ○ ○ ○ ○
Sinus infection/Ear infection/Bronchitis/Strep throat	○ ○ ○ ○ ○ ○
Sleep difficulties	○ ○ ○ ○ ○ ○
Stress	○ ○ ○ ○ ○ ○
Work	○ ○ ○ ○ ○ ○
Other (please specify _____)	○ ○ ○ ○ ○ ○

## Demographic Characteristics

46. How old are you? → 

Years	

47. What is your gender?

Female 

0	0
---	---

Male 

1	1
---	---

Transgender 

2	2
---	---

Transgender 

3	3
---	---

Transgender 

4	4
---	---

48. What is your sexual orientation?

Heterosexual 

5	5
---	---

Gay/Lesbian 

6	6
---	---

Bisexual 

7	7
---	---

Unsure 

8	8
---	---

Unsure 

9	9
---	---

49. What is your height in feet and inches? →

Ft.	Inch
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

50. What is your weight in pounds? →

W	E	I	G	H	T	Pounds
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

3/8" spine part



#### ADDITIONAL UCLA QUESTIONS 2014

1) Please indicate your level of agreement with the following statements:

Scale: strongly disagree, disagree, agree, strongly agree

- I know the definition of consent
- If a friend or I were to be sexually assaulted, I know what confidential support options are available to me at UCLA.
- If a friend or I were to be sexually assaulted, I know what reporting options are available to me at UCLA.

2) If you were to be sexually assaulted, how comfortable would you be in reporting the incident to UCLA authorities?

Scale: comfortable, somewhat comfortable, neither comfortable or uncomfortable, somewhat uncomfortable, uncomfortable

3) If you were to be sexually assaulted, how comfortable would you be in seeking support from UCLA resources?

Scale: comfortable, somewhat comfortable, neither comfortable or uncomfortable, somewhat uncomfortable, uncomfortable