

RANDS3 Questionnaire

[START OF SURVEY]

CREATE DATA-ONLY VARIABLE: QUAL

1=Qualified Complete

2=Not Qualified

3=In progress

AT START OF SURVEY COMPUTE QUAL=3 "IN PROGRESS"

CREATE MODE_START

1=CATI

2=CAWI

[DISPLAY – WINTRO_1]

Thank you for agreeing to participate in our new AmeriSpeak survey! To thank you for sharing your opinions, we will give you a reward of [\[INCENTWCOMMA\]](#) AmeriPoints after completing the survey. As always, your answers are confidential.

Please use the "Continue" and "Previous" buttons to navigate between the questions within the questionnaire. Do not use your browser buttons.

[DISPLAY]

OMBNOTICE.

Thank you again for agreeing to participate. Your survey will continue on the next screen.

[SPACE]

[REDUCE TEXT SIZE SLIGHTLY; TEXT BELOW BORED BY THIN BLACK BOX/OUTLINE]

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[SHOW IF P_GROUP=1]

[SP; PROMPT TWICE IF REFUSED]

A_PHSTAT.

Would you say your health in general is excellent, very good, good, fair, or poor?

RESPONSE OPTIONS:

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

[SHOW IF P_GROUP=2]

[SP; PROMPT TWICE IF REFUSED]

B_PHSTAT.

Would you say your health in general is very good, good, fair, bad, or very bad?

RESPONSE OPTIONS:

1. Very good
2. Good
3. Fair
4. Bad
5. Very bad

[MP]

PROBE1.

When you answered the previous question about your health, what did you think of?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

- A. Your diet and nutrition
- B. Your exercise habits
- C. Your smoking or drinking habits
- D. Your health problems or conditions
- E. Your *lack of* health problems or conditions
- F. The amount of pain that you have
- G. Your ability to do daily activities without assistance
- H. The amount of sleep you get
- I. Your mental or emotional health

[GRID, SP; 5,4]

PROBE2.

Please rate your agreement with the following statements:

GRID ITEMS:

- A. I have a healthy diet
- B. I get enough exercise
- C. I drink more alcohol than I should
- D. I smoke more than I should
- E. I'm satisfied with my sleep
- F. I don't have any major health problems or medical conditions
- G. I frequently experience pain
- H. I'm able to perform my daily activities independently
- I. My thoughts or emotions sometimes cause me problems

RESPONSE OPTIONS:

- 1. Strongly Agree
 - 2. Somewhat Agree
 - 3. Somewhat Disagree
 - 4. Strongly Disagree
-

[SP]

RX12M_A.

At any time in the <u>PAST 12 MONTHS</u>, did you take prescription medication?

RESPONSE OPTIONS:

- 1. Yes
 - 2. No
-

[DISPLAY]

INTRO_MED.

The next series of questions will ask you about certain medical conditions.

[SP]

HYPEV.

Have you <u>ever</u> been told by a doctor or other health professional that you had hypertension, also called high blood pressure?

RESPONSE OPTIONS:

- 1. Yes
 - 2. No
-

[SP]

PROBE9.

How did you define hypertension?

RESPONSE OPTIONS:

1. A feeling when you are stressed or overwhelmed
 2. A medical condition when a medical professional tells you that you have chronic high blood pressure
 3. A medical condition when a medical professional tells you that you have had one or two high blood pressure readings
-

[SHOW IF HYPEV=1]

[SP]

HYPDIF_A.

Were you told on two or more different visits that you had hypertension, also called high blood pressure?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF HYPDIF_A =1]

[SP]

HYPYR.

During the past 12 months, have you had hypertension, also called high blood pressure?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF HYPEV=1]

[SP]

HYPMED2.

Are you now taking any medicine prescribed by a doctor for your high blood pressure?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SP]

CHLEV.

Have you ever been told by a doctor or other health professional that you had high cholesterol?

RESPONSE OPTIONS:

1. Yes

2. No
-

[SHOW IF CHLEV=1]

[SP]

CHLYR.

During the past 12 months, have you had high cholesterol?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF CHLEV=1]

[SP]

CHLMDNW2.

Are you now taking any medication prescribed by a doctor to help lower your cholesterol?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SP]

AASMEV.

Have you ever been told by a doctor or other health professional that you had asthma?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF AASMEV=1]

[SP]

AASSTILL.

Do you still have asthma?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF AASMEV=1]

[SP]

AASSMYR.

During the past 12 months have you had an episode of asthma, or an asthma attack?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF AASMEV=1]

[SP]

AASSMERYR.

<u>During the past 12 months</u> have you had to visit an emergency room or urgent care center because of asthma?

RESPONSE OPTIONS:

1. Yes
2. No

[SP]

PREDIB_A.

Has a doctor or other health professional <u>ever</u> told you that you had prediabetes or borderline diabetes?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF S_GENDER=2]

[SP]

GESDIB_A.

Has a doctor or other health professional <u>ever</u> told you that you had <i>gestational diabetes</i>, a type of diabetes that occurs <u>only</u> during pregnancy?

<i>Gestational diabetes</i> is diabetes that you did not have prior to being pregnant and goes away after you are pregnant. Pregnant women are usually screened for gestational diabetes during the 24th to 28th week of pregnancy.

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF S_GENDER=1 OR 2]

[SP]

DIBEV_A.

[SHOW IF S_GENDER=2) AND (PREDIB_A = 1) AND (GESDIB_A = 1)] Not including prediabetes or gestational diabetes, has a doctor or other health professional <u>ever</u> told you that you had diabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 1) AND (GESDIB_A = 2, 98)] Not including prediabetes, has a doctor or other health professional <u>ever</u> told you that you had diabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 2, 98) AND (GESDIB_A = 1)] Not including gestational diabetes, has a doctor or other health professional <u>ever</u> told you that you had diabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 2, 98) AND (GESDIB_A = 2, 98)] Has a doctor or other health professional <u>ever</u> told you that you had diabetes?

[SHOW IF (S_GENDER=1) AND (PREDIB_A = 1)] Not including prediabetes, has a doctor or other health professional <u>ever</u> told you that you had diabetes?

[SHOW IF (S_GENDER=1) AND (PREDIB_A = 2, 98)] Has a doctor or other health professional <u>ever</u> told you that you had diabetes?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF DIBEV_A=1]

[NUMBOX, RANGE 1-120, 998]

DIBAGE_A.

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 1) AND (GESDIB_A = 1)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes, not including prediabetes or gestational diabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 1) AND (GESDIB_A = 2, 98)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes, not including prediabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 2, 98) AND (GESDIB_A = 1)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes, not including gestational diabetes?

[SHOW IF (S_GENDER=2) AND (PREDIB_A = 2, 98) AND (GESDIB_A = 2, 98)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes?

[SHOW IF (S_GENDER=1) AND (PREDIB_A = 1)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes, not including prediabetes?

[SHOW IF (S_GENDER=1) AND (PREDIB_A = 2, 98)] How old were you when a doctor or other health professional <u>first</u> told you that you had diabetes?

[SPACE]

<i>Enter 1 if age was 1 or younger.</i>

[NUMBER BOX, RANGE 1-120] Age at which diagnosed

[SHOW IF (DIBEV_A=1) OR (PREDIB_A=1)]

[SP]

DIBPILL_A.

Are you now taking diabetic pills to lower your blood sugar? These are sometimes called oral agents or oral hypoglycemic agents.

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF (DIBEV_A=1) OR (PREDIB_A=1)]

[SP]

DIBINS_A.

Insulin can be taken by shot or pump. Are you now taking insulin?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF (DIBEV_A=1)]

[SP]

DIBTYPE_A.

According to your doctor or other health professional, what type of diabetes do you have? Is it type 1, type 2, or some other type? If you don't remember or weren't told, that's OK.

RESPONSE OPTIONS:

1. Type 1
2. Type 2
3. Other type of diabetes
77. Don't know

[SP]

NEWLUNG.

Have you ever been told by a doctor or other health professional that you have Chronic Obstructive Pulmonary Disease, COPD, emphysema, or chronic bronchitis?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF NEWLUNG=1]

[MP]

PROBE13.

Which condition were you told you had?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

1. COPD
 2. Emphysema
 3. Chronic Bronchitis
 4. Bronchitis
 5. Something else, please specify: [TEXTBOX]
-

[SHOW IF NEWLUNG=1]

[SP]

PROBE14.

Thinking about the most recent time you had symptoms of Chronic Obstructive Pulmonary Disease, COPD, emphysema, or chronic bronchitis, how long did the symptoms last?

RESPONSE OPTIONS:

1. Less than one week
 2. One week to less than one month
 3. One month to less than three months
 4. Three or more months
-

[P_OPIOIDEXP=1]

[DISPLAY]

OPIOID1_INTRO.

These next questions are about the use of prescription pain relievers called opioids. When answering these questions, please do not include over-the-counter pain relievers such as aspirin, Tylenol, Advil, or Aleve.

[RECORD AND COMPUTE TIME ON SCREEN]

[SP]

OPIOID1.

During the past 12 months, have you taken any opioid pain relievers prescribed by a doctor, dentist, or other health professional? Examples include hydrocodone, Vicodin, Norco, Lortab, oxycodone, OxyContin, Percocet and Percodan.

RESPONSE OPTIONS:

1. Yes
 2. No
-

[P_OPIOIDEXP=1 AND P_IMAGEEXP=1]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP; DISPLAY 9 ITEMS IN 3 X 3 GRID ACROSS 4 SCREENS; AT THE END OF EACH SCREEN ADD A SP “NONE OF THESE” AT THE END OF THE PAGE]

[DISPLAY IMAGES FROM PDF; PLEASE SHRINK IMAGES BY 30%; HAVE THE IMAGE BE CLICKABLE FOR INDICATING RESPONSE]

[PLEASE HIDE ITEM TEXT – ONLY IMAGE SHOULD APPEAR]

OPIOID2.

Please look at the names and pictures of the pain relievers shown below. Please note that some forms of these pain relievers may look different from the pictures, but you should include any form that you have used.

[SPACE]

In the <u>past 12 months</u>, which, if any, of these pain relievers have you used?

RESPONSES:

1. Vicodin
2. Lortab
3. Norco
4. Zohydro ER
5. Hydrocodone (generic)
6. OxyContin
7. Percocet
8. Percodan
9. Roxicodone
10. Oxycodone (generic)
11. Ultram
12. Ultram ER
13. Ultracet
14. Tramadol (generic)
15. Extended-release tramadol (generic)
16. Tylenol with codeine 3 or 4 (NOT over-the-counter Tylenol)
17. Codeine pills (generic)
18. Avinza
19. Kadian
20. MS Contin
21. Morphine (generic)
22. Extended-release morphine (generic)
23. Duragesic
24. Fentora
25. Fentanyl (generic)
26. Suboxone
27. Buprenorphine (generic)
28. Buprenorphine plus naloxone (generic)
29. Opana
30. Opana ER
31. Oxymorphone (generic)
32. Extended-release oxymorphone (generic)
33. Demerol

34. Dilaudid or hydromorphone
35. Exalgo or extended-release hydromorphone
36. Methadone

[P_OPIOIDEXP=1 AND P_IMAGEEXP=2]

[MP; DISPLAY 9 ITEMS ACROSS 4 SCREENS; AT THE END OF EACH SCREEN ADD A SP "NONE OF THESE" AT THE END OF THE PAGE]

[RECORD AND COMPUTE TIME ON SCREEN]

OPIOID2_MOD.

In the <u>past 12 months</u>, which, if any, of these pain relievers have you used?

RESPONSES:

1. Vicodin
2. Lortab
3. Norco
4. Zohydro ER
5. Hydrocodone (generic)
6. OxyContin
7. Percocet
8. Percodan
9. Roxycodone
10. Oxycodone (generic)
11. Ultram
12. Ultram ER
13. Ultracet
14. Tramadol (generic)
15. Extended-release tramadol (generic)
16. Tylenol with codeine 3 or 4 (NOT over-the-counter Tylenol)
17. Codeine pills (generic)
18. Avinza
19. Kadian
20. MS Contin
21. Morphine (generic)
22. Extended-release morphine (generic)
23. Duragesic
24. Fentora
25. Fentanyl (generic)
26. Suboxone
27. Buprenorphine (generic)
28. Buprenorphine plus naloxone (generic)
29. Opana
30. Opana ER
31. Oxymorphone (generic)
32. Extended-release oxymorphone (generic)
33. Demerol
34. Dilaudid or hydromorphone
35. Exalgo or extended-release hydromorphone

36. Methadone

[P_OPIOIDEXP=2]

[DISPLAY]

OPIOID2_INTRO.

These next questions are about any use of prescription pain relievers. Please do not include “over-the-counter” pain relievers such as aspirin, Tylenol, Advil, or Aleve.

[P_OPIOIDEXP=2 AND P_IMAGEEXP=1]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP; DISPLAY 9 ITEMS IN 3 X 3 GRID ACROSS 4 SCREENS; AT THE END OF EACH SCREEN ADD A SP “NONE OF THESE” AT THE END OF THE PAGE]

[DISPLAY IMAGES FROM PDF; PLEASE SHRINK IMAGES BY 30%; HAVE THE IMAGE BE CLICKABLE FOR INDICATING RESPONSE]

[PLEASE HIDE ITEM TEXT – ONLY IMAGE SHOULD APPEAR]

OPIOID2_2.

Please look at the names and pictures of the pain relievers shown below. Please note that some forms of these pain relievers may look different from the pictures, but you should include any form that you have used.

[SPACE]

In the past 12 months, which, if any, of these pain relievers have you used?

RESPONSES:

1. Vicodin
2. Lortab
3. Norco
4. Zohydro ER
5. Hydrocodone (generic)
6. OxyContin
7. Percocet
8. Percodan
9. Roxicodone
10. Oxycodone (generic)
11. Ultram
12. Ultram ER
13. Ultracet
14. Tramadol (generic)
15. Extended-release tramadol (generic)
16. Tylenol with codeine 3 or 4 (NOT over-the-counter Tylenol)
17. Codeine pills (generic)
18. Avinza
19. Kadian
20. MS Contin
21. Morphine (generic)
22. Extended-release morphine (generic)
23. Duragesic

24. Fentora
25. Fentanyl (generic)
26. Suboxone
27. Buprenorphine (generic)
28. Buprenorphine plus naloxone (generic)
29. Opana
30. Opana ER
31. Oxymorphone (generic)
32. Extended-release oxymorphone (generic)
33. Demerol
34. Dilaudid or hydromorphone
35. Exalgo or extended-release hydromorphone
36. Methadone

[P_OPIOIDEXP=2 AND P_IMAGEEXP=2]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP; DISPLAY 9 ITEMS ACROSS 4 SCREENS; AT THE END OF EACH SCREEN ADD A SP "NONE OF THESE" AT THE END OF THE PAGE]

OPIOID2_MOD_2.

In the <u>past 12 months</u>, which, if any, of these pain relievers have you used?

RESPONSES:

1. Vicodin
2. Lortab
3. Norco
4. Zohydro ER
5. Hydrocodone (generic)
6. OxyContin
7. Percocet
8. Percodan
9. Roxicodone
10. Oxycodone (generic)
11. Ultram
12. Ultram ER
13. Ultracet
14. Tramadol (generic)
15. Extended-release tramadol (generic)
16. Tylenol with codeine 3 or 4 (NOT over-the-counter Tylenol)
17. Codeine pills (generic)
18. Avinza
19. Kadian
20. MS Contin
21. Morphine (generic)
22. Extended-release morphine (generic)
23. Duragesic
24. Fentora
25. Fentanyl (generic)

26. Suboxone
27. Buprenorphine (generic)
28. Buprenorphine plus naloxone (generic)
29. Opana
30. Opana ER
31. Oxymorphone (generic)
32. Extended-release oxymorphone (generic)
33. Demerol
34. Dilaudid or hydromorphone
35. Exalgo or extended-release hydromorphone
36. Methadone

[P_OPIOIDEXP=2]

[RECORD AND COMPUTE TIME ON SCREEN]

[SP]

OPIOID1_2.

<u>During the past 12 months</u>, have you taken any opioid pain relievers prescribed by a doctor, dentist, or other health professional? Examples include hydrocodone, Vicodin, Norco, Lortab, oxycodone, OxyContin, Percocet and Percodan.

RESPONSE OPTIONS:

1. Yes
2. No

PROGRAMMING: CREATE DOV_OPIOID

IF **ONLY ONE ITEM SELECTED** IN (OPIOID2A=1-OPIOIDJJ=1) OR (OPIOID2_MODA=1- OPIOID2_MODJJ=1) OR (OPIOID2_2A=1- OPIOID2_2JJ=1) OR (OPIOID2_MOD_2A=1- OPIOID2_MOD_2JJ=1) **DOV_OPIOID=1**
 “One Item selected in NSDUH series”

Only One medication selected in OPIOID2, OPIOID2_MOD, OPIOID2_2, OPIOID2_MOD_2 questions, assign DOV_OPIOID=1 value

IF **MULTIPLE ITEMS SELECTED** IN (OPIOID2A=1-OPIOIDJJ=1) OR (OPIOID2_MODA=1- OPIOID2_MODJJ=1) OR (OPIOID2_2A=1- OPIOID2_2JJ=1) OR (OPIOID2_MOD_2A=1- OPIOID2_MOD_2JJ=1) **DOV_OPIOID=2**
 “Multiple Items selected in NSDUH series”

More than one medication selected in OPIOID2, OPIOID2_MOD, OPIOID2_2, OPIOID2_MOD_2 questions, assign DOV_OPIOID=2 value

IF **NONE SELECTED** IN ((OPIOID2A=2-OPIOIDJJ=2) OR (OPIOID2_MODA=2- OPIOID2_MODJJ=2) OR (OPIOID2_2A=2- OPIOID2_2JJ=2) OR (OPIOID2_MOD_2A=1- OPIOID2_MOD_2JJ=1)) AND (OPIOID1=1 OR OPIOID1_2=1) **DOV_OPIOID=3** “NO medications selected in NSDUH question, but said YES to HIS question”

NO medications selected in OPIOID2, OPIOID2_MOD, OPIOID2_2, OPIOID2_MOD_2 questions, BUT Respondent says YES in OPIOID1 OR OPIOID1_2, assign DOV_OPIOID=3 value

IF MISSING DOV_OPIOID, DOV_OPIOID=4 “NO Opioids reported being used in the past 12 months”

If none of the first 3 conditions are met, assign DOV_OPIOID=4 value and skip OPIOID3 through OPIOID6.

[SHOW IF (OPIOID1=1 OR OPIOID1_2=1) OR ((OPIOID2A=1 THROUGH OPIOID2JJ=1) OR (OPIOID2_MODA=1 THROUGH OPIOID2_MODJJ=1) OR (OPIOID2_2A=1 THROUGH OPIOID2_2JJ=1) OR (OPIOID2_MOD_2A=1 THROUGH OPIOID2_MOD_2JJ))]

[RECORD AND COMPUTE TIME ON SCREEN]

[SP]

OPIOID3.

[IF DOV_OPIOID=1] You said you took [INSERT THE ONE ITEM SELECTED IN OPIOID2, OPIOID2_MOD, OPIOID2_2, OR OPIOID2_MOD_2] in the past 12 months.

[SPACE]

[IF DOV_OPIOID=1] Are you currently taking this medication?

[IF DOV_OPIOID=2] You said you took the following medications in the past 12 months:

[SPACE]

[INSERT, IN BULLET LIST, THE ITEMS SELECTED IN OPIOID2, OPIOID2_MOD, OPIOID2_2, OR OPIOID2_MOD_2; SEE A_PHQImp FOR EXAMPLE OF BULLET LIST OF INSERTED TEXT]

[SPACE]

[IF DOV_OPIOID=2] Are you currently taking any of these medications?

[IF DOV_OPIOID=3] You said you took an opioid pain reliever in the past 12 months.

[SPACE]

[IF DOV_OPIOID=3] Are you currently taking any opioid pain relievers?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF OPIOID3=1]

[RECORD AND COMPUTE TIME ON SCREEN]

[SP]

OPIOID4.

[IF DOV_OPIOID=1] About how long have you been taking this medication?

[IF DOV_OPIOID=2] About how long have you been taking these medications?

[IF DOV_OPIOID=3] About how long have you been taking opioid pain relievers?

RESPONSE OPTIONS:

1. Less than a week
2. 1 to 4 weeks
3. 1 to 6 months
4. 6 months to a year
5. 1 to 5 years
6. 5 years or more

[SHOW IF OPIOID3=2, 98]

[RECORD AND COMPUTE TIME ON SCREEN]

[SP]

OPIOID5.

[IF DOV_OPIOID=1] About how long were you taking this medication?

[IF DOV_OPIOID=2] About how long were you taking these medications?

[IF DOV_OPIOID=3] About how long were you taking opioid pain relievers?

RESPONSE OPTIONS:

1. Less than a week
2. 1 to 4 weeks
3. 1 to 6 months
4. 6 months to a year
5. 1 to 5 years
6. 5 years or more

[SHOW IF (OPIOID1=1 OR OPIOID1_2=1) OR ((OPIOID2A=1 THROUGH OPIOID2JJ=1) OR (OPIOID2_MODA=1 THROUGH OPIOID2_MODJJ=1) OR (OPIOID2_2A=1 THROUGH OPIOID2_2JJ=1) OR (OPIOID2_MOD_2A=1 THROUGH OPIOID2_MOD_2JJ))]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP]

OPIOID6.

[IF DOV_OPIOID=1] What were the reasons you took this medication the last time?

[IF DOV_OPIOID=2] What were the reasons you took these medications the last time?

[IF DOV_OPIOID=3] What were the reasons you took opioid pain relievers the last time?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. To relieve physical pain
2. To relax or relieve tension
3. To increase or decrease the effect(s) of some other drug
4. To feel good or get high
5. To help with my sleep
6. To help me with my feelings or emotions
7. Because I am "hooked" or I have to have them
8. For a suicide attempt or suicidal thoughts
9. Because of peer pressure, friends, or trying to feel cool

[RECORD AND COMPUTE TIME ON SCREEN]

[MP]

PROBE18.

Please select the statements, if any, that apply to you:

RESPONSE OPTIONS, RANDOMIZE:

- A. I'm not sure what an opioid is
 - B. I have never taken an opioid pain killer in my life
 - C. I don't like to take pills; I'm not a pill person
 - D. I have pain that requires me to take opioid pain killers
 - E. I use opioid pain relievers responsibly
 - F. I'm addicted, or used to be addicted to opioids
 - G. I understand the harm opioids can cause
 - H. I have heard about the opioid crisis in the news
 - I. I know someone who has been hurt by opioid pain killers
 - J. I have only taken opioid pills briefly to help recover from an injury or medical procedure
-

[SP]

ANX_1.

How often do you feel worried, nervous, or anxious?

RESPONSE OPTIONS:

- 1. Daily
 - 2. Weekly
 - 3. Monthly
 - 4. A few times a year
 - 5. Never
-

[SP]

ANX_2.

Do you take prescription medication for these feelings?

RESPONSE OPTIONS:

- 1. Yes
 - 2. No
-

[SHOW IF (ANX_1=1,2,3,4) OR ((ANX_1=5) AND (ANX_2=1))]

[SP]

ANX_3.

Thinking about the last time you felt worried, nervous, or anxious, how would you describe the level of these feelings?

RESPONSE OPTIONS:

- 1. A little

2. A lot
 3. Somewhere in between a little and a lot
-

[SP]

DEP_1.

How often do you feel depressed?

RESPONSE OPTIONS:

1. Daily
 2. Weekly
 3. Monthly
 4. A few times a year
 5. Never
-

[SP]

DEP_2.

Do you take prescription medication for depression?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF (DEP_1=1,2,3,4) OR ((DEP_1=5) AND (DEP_2=1))]

[SP]

DEP_3.

Thinking about the last time you felt depressed, how depressed did you feel?

RESPONSE OPTIONS:

1. A little
 2. A lot
 3. Somewhere in between a little and a lot
-

[SHOW IF P_GROUP=1]

[GRID, SP; 4,4]

A_PHQ.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

GRID ITEMS:

- A. Little interest or pleasure in doing things
- B. Feeling down, depressed, or hopeless
- C. Trouble falling or staying asleep, or sleeping too much
- D. Feeling tired or having little energy
- E. Poor appetite or overeating
- F. Feeling bad about yourself — or that you are a failure or have let yourself or your family down

- G. Trouble concentrating on things, such as reading the newspaper or watching television
- H. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

RESPONSE OPTIONS:

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

[SHOW IF A_PHQA=2,3,4 OR A_PHQB=2,3,4 OR A_PHQC=2,3,4 OR A_PHQD=2,3,4 OR A_PHQE=2,3,4 OR A_PHQF=2,3,4 OR A_PHQG=2,3,4 OR A_PHQH=2,3,4]

[SP]

A_PHQImp.

Over the past 2 weeks, you've been bothered by:

- [SHOW IF A_PHQ_A=2,3,4] Little interest or pleasure in doing things
- [SHOW IF A_PHQ_B=2,3,4] Feeling down, depressed, or hopeless
- [SHOW IF A_PHQ_C=2,3,4] Trouble falling or staying asleep, or sleeping too much
- [SHOW IF A_PHQ_D=2,3,4] Feeling tired or having little energy
- [SHOW IF A_PHQ_E=2,3,4] Poor appetite or overeating
- [SHOW IF A_PHQ_F=2,3,4] Feeling bad about yourself — or that you are a failure or have let yourself or your family down
- [SHOW IF A_PHQ_G=2,3,4] Trouble concentrating on things, such as reading the newspaper or watching television
- [SHOW IF A_PHQ_H=2,3,4] Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

[SPACE]

Altogether, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

RESPONSE OPTIONS:

1. Not at all difficult
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

[SHOW IF A_PHQA=2,3,4 OR A_PHQB=2,3,4 OR A_PHQC=2,3,4 OR A_PHQD=2,3,4 OR A_PHQE=2,3,4 OR A_PHQF=2,3,4 OR A_PHQG=2,3,4 OR A_PHQH=2,3,4]

[MP]

A_PROBE33.

Which of the following statements, if any, describe your feelings of being sad or depressed?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. Sometimes the feelings can be so intense that I cannot get out of bed.
 2. The feelings sometimes interfere with my life, and I wish that I did not have them.
 3. I get over the feelings quickly.
 4. Feeling that way is normal, and everyone feels that way sometimes.
 5. I have been told by a medical professional that I have depression.
-

[SHOW IF P_GROUP=B]

[GRID, SP; 4,3]

B_GAD.

Over the last 2 weeks, how often have you been bothered by the following problems?

GRID ITEMS:

- A. Feeling nervous, anxious or on edge
- B. Not being able to stop or control worrying
- C. Worrying too much about different things
- D. Trouble relaxing
- E. Being so restless that it is hard to sit still
- F. Becoming easily annoyed or irritable
- G. Feeling afraid as if something awful might happen

RESPONSE OPTIONS:

1. Not at all
 2. Several days
 3. More than half the days
 4. Nearly every day
-

[SHOW IF B_GADA=2,3,4 OR B_GADB=2,3,4 OR B_GADC=2,3,4 OR B_GADD=2,3,4 OR B_GADE=2,3,4 OR B_GADF=2,3,4 OR B_GADG=2,3,4]

[SP]

B_GADImp.

Over the past 2 weeks, you've been bothered by:

- [SHOW IF B_GAD_A=2,3,4]Feeling nervous, anxious or on edge
- [SHOW IF B_GAD_B=2,3,4]Not being able to stop or control worrying
- [SHOW IF B_GAD_C=2,3,4]Worrying too much about different things
- [SHOW IF B_GAD_D=2,3,4]Trouble relaxing
- [SHOW IF B_GAD_E=2,3,4]Being so restless that it is hard to sit still
- [SHOW IF B_GAD_F=2,3,4]Becoming easily annoyed or irritable
- [SHOW IF B_GAD_G=2,3,4]Feeling afraid as if something awful might happen

[SPACE]

Altogether, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

RESPONSE OPTIONS:

1. Not at all difficult

2. Somewhat difficult
 3. Very difficult
 4. Extremely difficult
-

[SHOW IF B_GADA=2,3,4 OR B_GADB=2,3,4 OR B_GADC=2,3,4 OR B_GADD=2,3,4 OR B_GADE=2,3,4 OR B_GADF=2,3,4 OR B_GADG=2,3,4]

[MP]

B_PROBE34.

Which of the following statements, if any, describe your feelings of being nervous or anxious?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. Sometimes the feelings can be so intense that my chest hurts and I have trouble breathing.
 2. These are positive feelings that help me to accomplish goals and be productive.
 3. The feelings sometimes interfere with my life, and I wish that I did not have them.
 4. Feeling that way is normal, and everyone feels that way sometimes
 5. I have been told by a medical professional that I have anxiety.
-

[SHOW IF P_GROUP=1]

[SP]

A_CHPAIN6M.

In the PAST 6 MONTHS, how often did you have pain?

RESPONSE OPTIONS:

1. Never
 2. Some days
 3. Most days
 4. Every day
-

[SHOW IF A_CHPAIN6M =2,3,4]

[SP]

A_PAINLMT6.

Over the PAST 6 MONTHS, how often did pain limit your life or work activities?

RESPONSE OPTIONS:

1. Never
 2. Some days
 3. Most days
 4. Every day
-

[SHOW IF P_GROUP=2]

[SP]

B_PAIN_2.

In the PAST 3 MONTHS, how often did you have pain?

RESPONSE OPTIONS:

1. Never
 2. Some days
 3. Most days
 4. Every day
-

[SHOW IF B_PAIN_2=2,3,4]

[SP]

B_PAINLMT3.

Over the PAST 3 MONTHS, how often did pain limit your life or work activities?

RESPONSE OPTIONS:

1. Never
 2. Some days
 3. Most days
 4. Every day
-

[SHOW IF (A_CHPAIN6M =2,3,4) OR (B_PAIN_2=2,3,4)]

[SP]

PAIN_4.

Thinking about the last time you had pain, how much pain did you have?

RESPONSE OPTIONS:

1. A little
 2. A lot
 3. Somewhere in between a little and a lot
-

[SHOW IF (A_CHPAIN6M =2,3,4) OR (B_PAIN_2=2,3,4)]

[MP]

PROBE17.

Which of the following statements, if any, describe your pain in the PAST [IF P_GROUP=1, INSERT 6; IF P_GROUP=2, INSERT 3] MONTHS?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. It is constantly present
2. Sometimes I'm in a lot of pain and sometimes it's not so bad

3. Sometimes it's unbearable and excruciating
 4. When I get my mind on other things, I'm not aware of the pain
 5. It is occasional and does not last
 6. Medication can take my pain away completely
 7. My pain is because of my current or past work
 8. My pain is because of exercise
 9. My pain was caused by a recent injury or infection
 10. My pain is minor and infrequent
-

[DISPLAY]
SMK_INTRO.

These next questions are about cigarette smoking.

[SP]
SMKEV.

Have you smoked at least 100 cigarettes in your entire life?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF SMKEV=1]

[SP]
SMKNOW.

Do you now smoke cigarettes every day, some days, or not at all?

RESPONSE OPTIONS:

1. Every day
 2. Some days
 3. Not at all
-

[SHOW IF P_GROUP=1]

[SP]
A_ECIGEV_A.

The next question is about electronic cigarettes or e-cigarettes. E-cigarettes and other electronic vaping products include electronic hookahs (e-hookahs), vape pens, e-cigars, and others. These products are battery-powered and usually contain nicotine and flavors such as fruit, mint, or candy.

[SPACE]

Have you ever used an e-cigarette or other electronic vaping product, even one time in your entire life?

RESPONSE OPTIONS:

1. Yes

2. No

[SHOW IF P_GROUP=2]

[SP]

B_ECIGEV_A.

Have you ever used an e-cigarette or other electronic vaping product, even one time, in your entire life ?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[MP]

PROBE19.

What counts as an e-cigarette?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

1. A vape with cannabis, THC, or CBD oil
 2. A vape with nicotine or other flavored oil
 3. A hookah-pen or e-hookah
 4. An e-vaporizer
 5. A tobacco cigarette or cigar
 6. A marijuana cigarette
-

[DISPLAY]

ACTV_INTRO.

The next questions are about physical activities (exercise, sports, physically active hobbies...) that you may do in your leisure time. The first questions ask about light or moderate physical activities, then there will be questions about vigorous physical activities.

[NUMBOX, DROPDOWN, FOR DROPDOWN HAVE "Per week" AS DEFAULT DISPLAYED]

[PROMPT IF NUMBERBOX HAS VALUE BUT DROPDOWN LIST IS EMPTY]

MODNO.

How often do you do light or moderate leisure time physical activities for at least 10 minutes that cause only light sweating or a slight to moderate increase in breathing or heart rate?

per day/week/month

[NUMBER BOX, RANGE 0-995, 998] Number of times [DROPDOWN LIST]

DROPDOWN LIST RESPONSE OPTIONS:

1. Never
2. Per day
3. Per week
4. Per month
5. Per year
6. Unable to do this type of activity

[SHOW IF MODNO_DROPDOWN=2,3,4,5 AND (MODNO_NUMBOX>0 AND MODNO_NUMBOX NE '998')]
 [NUMBOX, DROPDOWN, FOR DROPDOWN HAVE "Minutes" AS DEFAULT DISPLAYED]
 [PROMPT IF NUMBERBOX HAS VALUE BUT DROPDOWN LIST IS EMPTY]
 MODLNGNO.

About how long do you do these light or moderate leisure-time physical activities each time?

Minutes/Hours

[NUMBER BOX, RANGE 1-90, 998] Number of [DROPDOWN LIST]

DROPDOWN LIST RESPONSE OPTIONS:

1. Minutes
2. Hours

[SHOW IF MODNO_DROPDOWN=2,3,4,5 AND (MODNO_NUMBOX>0 AND MODNO_NUMBOX NE '998')
 AND P_PROBEEXP=1]
 [RECORD AND COMPUTE TIME ON SCREEN]
 [MP]
 PROBE20_1.

Which of the following types of physical activity, if any, did you include when you answered the previous question?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

- A. Running or jogging
- B. Hiking
- C. Walking as part of your job
- D. Walking outside of work
- E. Yardwork or cleaning your home
- F. Working out with exercise equipment
- G. Lifting weights
- H. Cycling, swimming, or other aerobic exercises
- I. Yoga or stretching
- J. Playing a sport, please specify which sport: [TEXTBOX]
- K. Other, please specify: [TEXTBOX]

[SHOW IF MODNO_DROPDOWN=2,3,4,5 AND (MODNO_NUMBOX>0 AND MODNO_NUMBOX NE '998') AND P_PROBEEXP=2]

[RECORD AND COMPUTE TIME ON SCREEN]

[GRID, SP]

PROBE20_2.

Which of the following types of physical activity, if any, did you include when you answered the previous question?

GRID ITEMS:

- A. Running or jogging
- B. Hiking
- C. Walking as part of your job
- D. Walking outside of work
- E. Yardwork or cleaning your home
- F. Working out with exercise equipment
- G. Lifting weights
- H. Cycling, swimming, or other aerobic exercises
- I. Yoga or stretching
- J. Playing a sport, please specify which sport: [TEXTBOX]
- K. Other, please specify: [TEXTBOX]

RESPONSE OPTIONS:

- 1. Yes
- 2. No

[NUMBOX, DROPDOWN, FOR DROPDOWN HAVE "Per week" AS DEFAULT DISPLAYED]

[PROMPT IF NUMBERBOX HAS VALUE BUT DROPDOWN LIST IS EMPTY]

VIGNO.

How often do you do <u>vigorous</u> leisure-time physical activities for <u>at least 10 minutes</u> that cause <u>heavy</u> sweating or <u>large</u> increases in breathing or heart rate?

<u>per day/week/month</u>

[NUMBER BOX, RANGE 0-99, 998] Number of times [DROPDOWN LIST]

DROPDOWN LIST RESPONSE OPTIONS:

- 1. Never
- 2. Per day
- 3. Per week
- 4. Per month
- 5. Per year
- 6. Unable to do this type of activity

[SHOW IF VIGNO_DROPDOWN=2,3,4,5 AND (VIGNO_NUMBOX>0 AND VIGNO_NUMBOX NE '998')]

[NUMBOX, DROPDOWN, FOR DROPDOWN HAVE "Minutes" AS DEFAULT DISPLAYED]

[PROMPT IF NUMBERBOX HAS VALUE BUT DROPDOWN LIST IS EMPTY]

VIGLNGNO.

About how long do you do these vigorous leisure-time physical activities each time?

<u>Minutes/Hours</u>

[NUMBER BOX, RANGE 1-90, 998] Number of [DROPDOWN LIST]

DROPDOWN LIST RESPONSE OPTIONS:

1. Minutes
2. Hours

[SHOW IF VIGNO_DROPDOWN=2,3,4,5 AND (VIGNO_NUMBOX>0 AND VIGNO_NUMBOX NE '998') AND P_PROBEEXP=1]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP]

PROBE21_1.

Which of the following types of physical activity, if any, did you include when you answered the previous question?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. Running or jogging
2. Hiking
3. Walking as part of your job
4. Walking outside of work
5. Yardwork or cleaning your home
6. Working out with exercise equipment
7. Lifting weights
8. Cycling, swimming, or other aerobic exercises
9. Yoga or stretching
10. Playing a sport, please specify which sport: [TEXTBOX]
11. Other, please specify: [TEXTBOX]

[SHOW IF VIGNO_DROPDOWN=2,3,4,5 AND (VIGNO_NUMBOX>0 AND VIGNO_NUMBOX NE '998') AND P_PROBEEXP=2]

[RECORD AND COMPUTE TIME ON SCREEN]

[GRID, SP]

PROBE21_2.

Which of the following types of physical activity, if any, did you include when you answered the previous question?

GRID ITEMS:

- A. Running or jogging
- B. Hiking
- C. Walking as part of your job
- D. Walking outside of work
- E. Yardwork or cleaning your home

- F. Working out with exercise equipment
- G. Lifting weights
- H. Cycling, swimming, or other aerobic exercises
- I. Yoga or stretching
- J. Playing a sport, please specify which sport: [TEXTBOX]
- K. Other, please specify: [TEXTBOX]

RESPONSE OPTIONS:

1. Yes
2. No

[NUMBOX, DROPDOWN, FOR DROPDOWN HAVE "Per week" AS DEFAULT DISPLAYED]

[PROMPT IF NUMBERBOX HAS VALUE BUT DROPDOWN LIST IS EMPTY]

STRNGNO.

How often do you do leisure time physical activities specifically designed to strengthen your muscles such as lifting weights or doing calisthenics?

[SPACE]

<i>Include all such activities even if you have mentioned them before</i>.

per day/week/month

[NUMBER BOX, RANGE 0-995, 998] Number of times [DROPDOWN LIST]

DROPDOWN LIST RESPONSE OPTIONS:

1. Never
2. Per day
3. Per week
4. Per month
5. Per year
6. Unable to do this type of activity

[P_PROBEEXP=1]

[RECORD AND COMPUTE TIME ON SCREEN]

[MP]

PROBE22_1.

In the last week, did you do any of the following things for 20 or more minutes at once?

[SPACE]

<i>Please select all that apply.</i>

RESPONSE OPTIONS:

1. Running or jogging
2. Hiking
3. Walking as part of your job
4. Walking outside of work
5. Yardwork or cleaning your home
6. Working out with exercise equipment
7. Lifting weights

8. Cycling, swimming, or other aerobic exercises
 9. Yoga or stretching
 10. Playing a sport, please specify which sport: [TEXTBOX]
 11. Other, please specify: [TEXTBOX]
-

[P_PROBEEXP=2]

[RECORD AND COMPUTE TIME ON SCREEN]

[GRID, SP]

PROBE22_2.

In the last week, did you do any of the following things for 20 or more minutes at once?

GRID ITEMS:

- A. Running or jogging
- B. Hiking
- C. Walking as part of your job
- D. Walking outside of work
- E. Yardwork or cleaning your home
- F. Working out with exercise equipment
- G. Lifting weights
- H. Cycling, swimming, or other aerobic exercises
- I. Yoga or stretching
- J. Playing a sport, please specify which sport: [TEXTBOX]
- K. Other, please specify: [TEXTBOX]

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SP]

ACISAD.

During the <u>past 30 days</u>, how often did you feel so sad that nothing could cheer you up?

RESPONSE OPTIONS:

1. All of the time
 2. Most of the time
 3. Some of the time
 4. A little of the time
 5. None of the time
-

[SHOW IF ACISAD=1,2,3,4]

[MP]

PROBE29.

Which of the following statements, if any, describe your feelings of being sad or depressed?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

1. Sometimes the feelings can be so intense that I cannot get out of bed
 2. The feelings sometimes interfere with my life, and I wish that I did not have them
 3. I get over the feelings quickly
 4. Feeling that way is normal, and everyone feels that way sometimes
 5. I have been told by a medical professional that I have depression
-

[SP]

ACINERV.

During the past 30 days, how often did you feel nervous?

RESPONSE OPTIONS:

1. All of the time
 2. Most of the time
 3. Some of the time
 4. A little of the time
 5. None of the time
-

[SHOW IF ACINERV=1,2,3,4]

[MP]

PROBE30.

Which of the following statements, if any, describe your feelings of being nervous or anxious?

[SPACE]

Please select all that apply.

RESPONSE OPTIONS:

1. Sometimes the feelings can be so intense that my chest hurts and I have trouble breathing.
 2. These are positive feelings that help me to accomplish goals and be productive.
 3. The feelings sometimes interfere with my life, and I wish that I did not have them.
 4. Feeling that way is normal, and everyone feels that way sometimes.
 5. I have been told by a medical professional that I have anxiety.
-

[GRID, SP]

ACIRSTLS.

During the past 30 days, how often did you feel...

GRID ITEMS:

- A. Restless or fidgety
- B. Hopeless
- C. That everything was an effort

RESPONSE OPTIONS:

1. All of the time
 2. Most of the time
 3. Some of the time
 4. A little of the time
 5. None of the time
-

[SP]

PROBE31.

Would you consider everything being an effort a good thing or a bad thing?

RESPONSE OPTIONS:

1. Good thing
 2. Bad thing
 3. Neither good nor bad
-

[SHOW IF ACIRSTLS_C = 1,2,3,4]

[SP]

PROBE32.

How concerned are you about feeling as if everything is an effort?

RESPONSE OPTIONS:

1. Very concerned
 2. Somewhat concerned
 3. A little concerned
 4. Not at all concerned
-

[SP]

ACIWTHLS.

During the past 30 days, how often did you feel worthless?

RESPONSE OPTIONS:

1. All of the time
 2. Most of the time
 3. Some of the time
 4. A little of the time
 5. None of the time
-

[DISPLAY]

INJ_INTRO.

The next set of questions asks about injuries. People can be injured accidentally, or on purpose. They may hurt themselves or others may cause them to be hurt.

[SP]

INJURY1.

The first question is about repetitive strain injuries. By this, we mean injuries caused by repeating the same movement over an extended period. Examples include carpal tunnel syndrome, tennis elbow, or tendonitis. DURING THE PAST 3 MONTHS, did you have any injuries due to repetitive strain?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SP]

INJURY2.

[IF INJURY1=1, INSERT <i>Not including any of the repetitive strain injuries you just mentioned,</i>]

DURING THE PAST 3 MONTHS, did you have an accident or an injury where any part of your body was hurt?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF INJURY2=1]

[SP]

INJURY3.

Were any of these injuries serious enough to limit your usual activities for at least 24 hours after the injury occurred?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF INJURY2=1]

[SP]

INJURY4.

Were any of these injuries serious enough that you missed at least one day of work or school?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF INJURY3=1 OR INJURY4=1]

[DISPLAY]

NUMTIMES_INTRO.

[IF INJURY1=1, INSERT <i>Not counting repetitive strain injuries,</i> please; IF INJURY1=2,98, INSERT Please] think about all of the accidents or events that caused an injury IN THE PAST 3 MONTHS, and that caused you to miss at least one day of work or school, or that made it difficult for you to do things that you usually do for one day or more.

[SHOW IF INJURY3=1 OR INJURY4=1]

[NUMBOX]

INJURY5.

DURING THE PAST 3 MONTHS, how many times did these accidents or injury events occur?

<u>Number of times: </u>

[NUMBER BOX, RANGE 0-995, 998]

[SHOW IF INJURY3=1 OR INJURY4=1]

[GRID, SP; 3,3]

INJURY6.

DURING THE PAST 3 MONTHS, did [IF INJURY5=1,998 INSERT this injury; IF INJURY5=2-995, INSERT any of these injuries] occur while you were:

GRID ITEMS:

- A. working at a job or business?
- B. at school, taking classes, or doing schoolwork?
- C. playing sports or exercising, including walking, biking, or running for exercise? (Please also include recreational sports such as skating, skiing, tennis, golf, bowling, or fishing).
- D. doing household activities, such as housework, cooking, home maintenance, or yardwork?
- E. doing leisure activities, such as hobbies, volunteer work, socializing, watching TV, or relaxing?
- F. walking to get some place outside your home?

RESPONSE OPTIONS:

1. Yes
 2. No
-

[SHOW IF INJURY3=1 OR INJURY4=1]

[DISPLAY]

CAUSE_INTRO.

The next questions are about two ways that you might have been injured. Remember that we are just talking about [IF INJURY5=1, 998 INSERT the injury; IF INJURY5=2-995, INSERT any of the injuries] that caused you to miss at least one day of work or school, or that made it difficult for you to do things that you usually do for one day or more.

[SHOW IF INJURY3=1 OR INJURY4=1]

[SP]

INJURY12.

DURING THE PAST 3 MONTHS, [IF INJURY5=1, 998 INSERT was this injury; IF INJURY5=2-995, INSERT were any of these injuries] a result of a fall or falling?

RESPONSE OPTIONS:

1. Yes
2. No

[SHOW IF INJURY3=1 OR INJURY4=1]

[SP]

INJURY13.

DURING THE PAST 3 MONTHS, [IF INJURY5=1, 998 INSERT was this injury; IF INJURY5=2-995, INSERT were any of these injuries] a result of a collision involving a motor vehicle?

RESPONSE OPTIONS:

1. Yes
2. No

RE-COMPUTE QUAL=1 "COMPLETE"

SET CO_DATE, CO_TIME, CO_TIMER VALUES HERE

CREATE MODE_END

1=CATI

2=CAWI

SCRIPTING NOTES: PUT QFINAL1, QFINAL2, QFINAL3 in the same screen.

[SINGLE CHOICE]

QFINAL1.

Thank you for your time today. To help us improve the experience of AmeriSpeak members like yourself, please give us feedback on this survey.

[RED TEXT – CAWI ONLY] If you do not have any feedback for us today, please click "Continue" through to the end of the survey so we can make sure your opinions are counted and for you to receive your AmeriPoints reward.

Please rate this survey overall from 1 to 7 where 1 is Poor and 7 is Excellent.

Poor						Excellent
1	2	3	4	5	6	7

[SINGLE CHOICE – CAWI ONLY]

QFINAL2.

Did you experience any technical issues in completing this survey?

1. Yes – please tell us more in the next question
2. No

[TEXT BOX]

QFINAL3.

Do you have any general comments or feedback on this survey you would like to share? If you would like a response from us, please email support@AmeriSpeak.org or call (888) 326-9424.

[DISPLAY]

END.

[CAWI version]

Those are all the questions we have. You have earned a reward of [INCENTWCOMMA] AmeriPoints for completing the survey. If you have any questions at all for us, you can email us at support@AmeriSpeak.org or call us toll-free at **888-326-9424**. Thank you for participating in our new AmeriSpeak survey!

You can close your browser window now if you wish or click Continue below to be redirected to the AmeriSpeak member website.