ACHA-NCHA II

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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Health, Health Education and Safety

1. How would you describe your general health?

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor ○ Don't know

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

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

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

(Please mark the appropriate column for each row)

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

5. Within the last 12 months:

(Please mark the appropriate column for each row)

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

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6. **Within the last 12 months, have you been in an intimate (coupled/partnered) relationship that was:**

(Please mark the appropriate column for each row)

	Yes	No
Emotionally abusive? (e.g., called derogatory names, yelled at, ridiculed)	○	○
Physically abusive? (e.g., kicked, slapped, punched)	○	○
Sexually abusive? (e.g., forced to have sex when you didn't want it, forced to perform or have an unwanted sexual act performed on you)	○	○

7. **How safe do you feel:**

(Please mark the appropriate column for each row)

	Very safe	Somewhat safe	Somewhat unsafe	Not safe at all
On this campus (daytime)?	○	○	○	○
On this campus (nighttime)?	○	○	○	○
In the community surrounding this school (daytime)?	○	○	○	○
In the community surrounding this school (nighttime)?	○	○	○	○

Alcohol, Tobacco, and Drugs

8. **Within the last 30 days, on how many days did you use:**

(Please mark the appropriate column for each row)

	Never used	Have used, but not in last 30 days	1-2 days	3-5 days	6-9 days	10-19 days	20-29 days	Used daily
Cigarettes	○	○	○	○	○	○	○	○
Tobacco from a water pipe (hookah)	○	○	○	○	○	○	○	○
Cigars, little cigars, clove cigarettes	○	○	○	○	○	○	○	○
Smokeless tobacco	○	○	○	○	○	○	○	○
Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○	○
Marijuana (pot, weed, hashish, hash oil)	○	○	○	○	○	○	○	○
Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○
Methamphetamine (crystal meth, ice, crank)	○	○	○	○	○	○	○	○
Other amphetamines (diet pills, bennies)	○	○	○	○	○	○	○	○
Sedatives (downers, ludes)	○	○	○	○	○	○	○	○
Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○
Anabolic steroids (Testosterone)	○	○	○	○	○	○	○	○
Opiates (heroin, smack)	○	○	○	○	○	○	○	○
Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○
MDMA (Ecstacy)	○	○	○	○	○	○	○	○
Other club drugs (GHB, Ketamine, Rohypnol)	○	○	○	○	○	○	○	○
Other illegal drugs	○	○	○	○	○	○	○	○

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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)

	Never used	Have used, but not in last 30 days	1-2 days	3-5 days	6-9 days	10-19 days	20-29 days	Used daily
Cigarettes	○	○	○	○	○	○	○	○
Tobacco from a water pipe (hookah)	○	○	○	○	○	○	○	○
Cigars, little cigars, clove cigarettes	○	○	○	○	○	○	○	○
Smokeless tobacco	○	○	○	○	○	○	○	○
Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○	○
Marijuana (pot, weed, hashish, hash oil)	○	○	○	○	○	○	○	○
Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○
Methamphetamine (crystal meth, ice, crank)	○	○	○	○	○	○	○	○
Other amphetamines (diet pills, bennies)	○	○	○	○	○	○	○	○
Sedatives (downers, ludes)	○	○	○	○	○	○	○	○
Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○
Anabolic steroids (Testosterone)	○	○	○	○	○	○	○	○
Opiates (heroin, smack)	○	○	○	○	○	○	○	○
Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○
MDMA (Ecstacy)	○	○	○	○	○	○	○	○
Other club drugs (GHB, Ketamine, Rohypnol)	○	○	○	○	○	○	○	○
Other illegal drugs	○	○	○	○	○	○	○	○

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.)**

DRINKS ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○

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.)**

HOURS ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○

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.)**

DRINKS ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○ ○○

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

- ○ N/A, don't drink
- ○ None
- ○ 1 time
- ○ 2 times
- ○ 3 times
- ○ 4 times
- ○ 5 times
- ○ 6 times
- ○ 7 times
- ○ 8 times
- ○ 9 times
- ○ 10 or more times

14. **Within the last 30 days, did you:**

(Please mark the appropriate column for each row)

	N/A, don't drive	N/A, don't drink	No	Yes
Drive after drinking any alcohol at all	○	○	○	○
Drive after drinking five or more drinks of alcohol	○	○	○	○

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15. During the last 12 months, when you "partied"/socialized, how often did you:

(Please mark the appropriate column for each row)

	N/A, don't drink	Never	Rarely	Sometimes	Most of the time	Always
Alternate non-alcoholic with alcoholic beverages	○	○	○	○	○	○
Avoid drinking games	○	○	○	○	○	○
Choose not to drink alcohol	○	○	○	○	○	○
Determine, in advance, not to exceed a set number of drinks	○	○	○	○	○	○
Eat before and/or during drinking	○	○	○	○	○	○
Have a friend let you know when you have had enough	○	○	○	○	○	○
Keep track of how many drinks you were having	○	○	○	○	○	○
Pace your drinks to 1 or fewer per hour	○	○	○	○	○	○
Stay with the same group of friends the entire time you were drinking	○	○	○	○	○	○
Stick with only one kind of alcohol when drinking	○	○	○	○	○	○
Use a designated driver	○	○	○	○	○	○

16. Within the last 12 months, have you experienced any of the following as a consequence of your drinking?

(Please mark the appropriate column for each row)

	N/A, don't drink	No	Yes
Did something you later regretted	○	○	○
Forgot where you were or what you did	○	○	○
Got in trouble with the police	○	○	○
Had sex with someone without giving your consent	○	○	○
Had sex with someone without getting their consent	○	○	○
Had unprotected sex	○	○	○
Physically injured yourself	○	○	○
Physically injured another person	○	○	○
Seriously considered suicide	○	○	○

17. Within the last 30 days, what percent of students at your school used:
State your best estimate. (If less than 10, please enter 00, 01, 02, etc.)

Cigarettes % Used	Alcohol % Used	Marijuana % Used
00	00	00
01	01	01
02	02	02
03	03	03
04	04	04
05	05	05
06	06	06
07	07	07
08	08	08
09	09	09

18. Within the last 12 months, have you taken any of the following prescription drugs that were not prescribed to you?

(Please mark the appropriate column for each row)

	No	Yes
Antidepressants (e.g., Celexa, Lexapro, Prozac, Wellbutrin, Zoloft)	○	○
Erectile dysfunction drugs (e.g., Viagra, Cialis, Levitra)	○	○
Pain killers (e.g., OxyContin, Vicodin, Codeine)	○	○
Sedatives (e.g., Xanax, Valium)	○	○
Stimulants (e.g., Ritalin, Adderall)	○	○

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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.) →

PARTNERS

0	0
1	1
2	2
3	3
4	4
5	5
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)

	Yes	No
Female	○	○
Male	○	○
Transgender	○	○

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

(Please mark the appropriate column for each row)

	Yes	No, have done this sexual activity in the past but not in the last 30 days	No, have never done this sexual activity
Oral sex?	○	○	○
Vaginal intercourse?	○	○	○
Anal intercourse?	○	○	○

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)

	Have not done this sexual activity during the last 30 days	N/A, never did this sexual activity	CONDOM/ BARRIER USE: Never	Rarely	Sometimes	Most of the time	Always
Oral sex?	○	○	○	○	○	○	○
Vaginal intercourse?	○	○	○	○	○	○	○
Anal intercourse?	○	○	○	○	○	○	○

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)

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

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)

	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?	○	○	○	○	○	○	○	○
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?	○	○	○	○	○	○	○	○

Mental Health

30. Have you ever:

(Please mark the appropriate column for each row)

	Yes, in the last 12 months	Yes, in the last 30 days	Yes, in the last 2 weeks	No, not in last 12 months	No, never
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	○	○	○	○	○

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31. Within the last 12 months, have you been diagnosed or treated by a professional for any of the following?

(Please mark the appropriate column for each row)

	No	Yes, diagnosed but not treated	Yes, treated with medication	Yes, treated with psychotherapy	Yes, treated with medication and psychotherapy	Yes, other treatment
Anorexia	⬭	⬭	⬭	⬭	⬭	⬭
Anxiety	⬭	⬭	⬭	⬭	⬭	⬭
Attention Deficit and Hyperactivity Disorder (ADHD)	⬭	⬭	⬭	⬭	⬭	⬭
Bipolar Disorder	⬭	⬭	⬭	⬭	⬭	⬭
Bulimia	⬭	⬭	⬭	⬭	⬭	⬭
Depression	⬭	⬭	⬭	⬭	⬭	⬭
Insomnia	⬭	⬭	⬭	⬭	⬭	⬭
Other sleep disorder	⬭	⬭	⬭	⬭	⬭	⬭
Obsessive Compulsive Disorder (OCD)	⬭	⬭	⬭	⬭	⬭	⬭
Panic attacks	⬭	⬭	⬭	⬭	⬭	⬭
Phobia	⬭	⬭	⬭	⬭	⬭	⬭
Schizophrenia	⬭	⬭	⬭	⬭	⬭	⬭
Substance abuse or addiction (alcohol or other drugs)	⬭	⬭	⬭	⬭	⬭	⬭
Other addiction (e.g., gambling, internet, sexual)	⬭	⬭	⬭	⬭	⬭	⬭
Other mental health condition	⬭	⬭	⬭	⬭	⬭	⬭

32. Have you ever been diagnosed with depression? ⬭ No ⬭ Yes

33. Within the last 12 months, have any of the following been traumatic or very difficult for you to handle?

(Please mark the appropriate column for each row)

	No	Yes
Academics	⬭	⬭
Career-related issue	⬭	⬭
Death of a family member or friend	⬭	⬭
Family problems	⬭	⬭
Intimate relationships	⬭	⬭
Other social relationships	⬭	⬭
Finances	⬭	⬭
Health problem of a family member or partner	⬭	⬭
Personal appearance	⬭	⬭
Personal health issue	⬭	⬭
Sleep difficulties	⬭	⬭
Other	⬭	⬭

34. Have you ever received psychological or mental health services from any of the following?

(Please mark the appropriate column for each row)

	No	Yes
Counselor/Therapist/Psychologist	⬭	⬭
Psychiatrist	⬭	⬭
Other medical provider (e.g., physician, nurse practitioner)	⬭	⬭
Minister/Priest/Rabbi/Other clergy	⬭	⬭

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)

	Yes	No
Exercise to lose weight	○	○
Diet to lose weight	○	○
Vomit or take laxatives to lose weight	○	○
Take diet pills to lose weight	○	○

39. Have you:

(Please mark the appropriate column for each row)

	Don't know	Yes	No
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?	○	○	○

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

(Please mark the appropriate column for each row)

	Don't know	Yes	No
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)	○	○	○

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41. Within the last 12 months, have you been diagnosed or treated by a professional for any of the following?

(Please mark the appropriate column for each row)

	Yes	No
Allergies	○	○
Asthma	○	○
Back pain	○	○
Broken bone/Fracture/Sprain	○	○
Bronchitis	○	○
Chlamydia	○	○
Diabetes	○	○
Ear infection	○	○
Endometriosis	○	○
Genital herpes	○	○
Genital warts/Human Papillomavirus (HPV)	○	○
Gonorrhea	○	○
Hepatitis B or C	○	○
High blood pressure	○	○
High cholesterol	○	○
Human Immunodeficiency Virus (HIV)	○	○
Irritable Bowel Syndrome (IBS)	○	○
Migraine headache	○	○
Mononucleosis	○	○
Pelvic Inflammatory Disease (PID)	○	○
Repetitive stress injury (e.g., carpal tunnel syndrome)	○	○
Sinus infection	○	○
Strep throat	○	○
Tuberculosis	○	○
Urinary tract infection	○	○

42. On how many of the past 7 days did you get enough sleep so that you felt rested when you woke up in the morning?

○ 0 days ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

43. People sometimes feel sleepy during the daytime. In the past 7 days, how much of a problem have you had with sleepiness (feeling sleepy, struggling to stay awake) during your daytime activities?

- ○ No problem at all
- ○ A little problem
- ○ More than a little problem
- ○ A big problem
- ○ A very big problem

44. In the past 7 days, how often have you:

(Please mark the appropriate column for each row)

	0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Awakened too early in the morning and couldn't get back to sleep?	○	○	○	○	○	○	○	○
Felt tired, dragged out, or sleepy during the day?	○	○	○	○	○	○	○	○
Gone to bed because you just could not stay awake any longer?	○	○	○	○	○	○	○	○
Had an extremely hard time falling asleep?	○	○	○	○	○	○	○	○

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SERIAL #

Impediments to Academic Performance

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

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

	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
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

	0	0
	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

47. What is your gender?

- ○ Female
- ○ Male
- ○ Transgender

48. What is your sexual orientation?

- ○ Heterosexual
- ○ Gay/Lesbian
- ○ Bisexual
- ○ Unsure

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

HEIGHT

Ft.		Inch	
	0	0	0
	1	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? →

WEIGHT

Pounds		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

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51. What is your year in school?

- ○ 1st year undergraduate
- ○ 2nd year undergraduate
- ○ 3rd year undergraduate
- ○ 4th year undergraduate
- ○ 5th year or more undergraduate
- ○ Graduate or professional
- ○ Not seeking a degree
- ○ Other

52. What is your enrollment status?

○ Full-time ○ Part-time ○ Other

53. Have you transferred to this college or university within the last 12 months?

○ No ○ Yes

54. How do you usually describe yourself?
(Mark all that apply)

- ○ White, non Hispanic (includes Middle Eastern)
- ○ Black, non Hispanic
- ○ Hispanic or Latino/a
- ○ Asian or Pacific Islander
- ○ American Indian, Alaskan Native, or Native Hawaiian
- ○ Biracial or Multiracial
- ○ Other

55. Are you an international student?

○ No ○ Yes

56. What is your relationship status?

- ○ Not in a relationship
- ○ In a relationship but not living together
- ○ In a relationship and living together

57. What is your marital status?

- ○ Single
- ○ Married/Partnered
- ○ Separated
- ○ Divorced
- ○ Other

58. Where do you currently live?

- ○ Campus residence hall
- ○ Fraternity or sorority house
- ○ Other college/university housing
- ○ Parent/guardian's home
- ○ Other off-campus housing
- ○ Other

59. Are you a member of a social fraternity or sorority? (e.g., National Interfraternity Conference, National Panhellenic Conference, National Pan-Hellenic Council, National Association of Latino Fraternal Organizations)

○ No ○ Yes

60. How many hours a week do you work for pay?

- ○ 0 hours
- ○ 1–9 hours
- ○ 10–19 hours
- ○ 20–29 hours
- ○ 30–39 hours
- ○ 40 hours
- ○ More than 40 hours

61. How many hours a week do you volunteer?

- ○ 0 hours
- ○ 1–9 hours
- ○ 10–19 hours
- ○ 20–29 hours
- ○ 30–39 hours
- ○ 40 hours
- ○ More than 40 hours

62. What is your primary source of health insurance?

- ○ My college/university sponsored plan
- ○ My parents' plan
- ○ Another plan
- ○ I don't have health insurance
- ○ I am not sure if I have health insurance

63. What is your approximate cumulative grade average?

○ A ○ B ○ C ○ D/F ○ N/A

64. Within the last 12 months, have you participated in organized college athletics at any of the following levels?

(Please mark the appropriate column for each row)	Yes	No
Varsity	○	○
Club sports	○	○
Intramurals	○	○

65. Do you have any of the following disabilities or medical conditions?

(Please mark the appropriate column for each row)	Yes	No
Attention Deficit and Hyperactivity Disorder (ADHD)	○	○
Chronic illness (e.g., cancer, diabetes, auto-immune disorders)	○	○
Deaf/Hard of hearing	○	○
Learning disability	○	○
Mobility/Dexterity disability	○	○
Partially sighted/Blind	○	○
Psychiatric condition	○	○
Speech or language disorder	○	○
Other disability	○	○

THANK YOU FOR COMPLETING THIS SURVEY

PLEASE DO NOT WRITE IN THIS AREA

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