

PROFILE OF ADAPTATION TO LIFE

(B) PERSONAL EXPERIENCES

(_____)
Subj. #

(A) MOOD SCALE

DURING LAST WEEK, INCLUDING TODAY, HOW OFTEN HAVE YOU FELT . . .

Please mark the answer for each question that best describes how you felt this past week. Mark your answer choices, like this:

DURING THE PAST WEEK, HAVE YOU FELT . . .	Answer choices				
	1 Rarely	2 Some-times	3 Often	4 Almost Always	
Vigorous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Alert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
Happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
Calm and relaxed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
Content?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
Secure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
Confidence in yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
Inner calm and peace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9

DURING THE PAST WEEK, HAVE YOU FELT . . .	Answer choices				
	1 Never	2 Rarely	3 Some-times	4 Often	
Discouraged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
Uneasy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
On edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Gloomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Like crying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Worried?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Bored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Annoyed, irritated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20

DURING THE PAST MONTH, I'VE
(Please answer each statement below)

	Answer choices				
	1 Rarely	2 Some-times	3 Often	4 Almost Always	
Enjoyed talking with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Felt trusting of people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Found work useful and interesting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Enjoyed people I live with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24
Found people accept me as I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Been involved, interested in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Felt needed and useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Controlled my negative thinking and increased my positive thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Found things I've needed coming to me by "coincidence" or "chance"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29

DURING THE PAST MONTH, I'VE FELT . . .

	Answer choices				
	1 Never	2 Rarely	3 Some-times	4 Often	
A lack of order around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Dissatisfied with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Critical of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Annoyed, irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
An impulse to hurt someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Left out of things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
That people treated me unfairly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
Bothered by sloppiness around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Disappointed in people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Worried about debts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Uncertain about who I really am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Unhappy about the work I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
My family finds fault with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
No one seemed interested in how I really feel inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43

(C) PHYSICAL HEALTH INVENTORY

(D) PERSONAL BELIEFS

Please mark one answer for each question below.
Mark your answer like this:

or this

	Answer choices			
	1	2	3	
DURING THE LAST MONTH, HAVE YOU . . .	Never	Some-times	Often	
Had headaches? (Past month)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Felt faint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Felt hot, feverish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Had spells of dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Had difficulty falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48
Had chest pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
Noticed your heart beating fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50
Had difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51
Felt physically ill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52
Had back pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53
Been bothered by itching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54
Had coughing spells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55
Had neck or shoulder pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56
Had pains in legs or arms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57
Had trouble with your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58
Felt exhausted, fatigued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59
Waken from sleep feeling tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60
Had a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61
Been constipated (hard stools)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	62
Had an upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	63
Had nausea (sick to stomach)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64
Had indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65
Had stomach pain after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	66
Had trouble digesting food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67
Had diarrhea (loose bowels)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68

IT IS MY OPINION THAT . . .
(Please answer each statement below)

	Answer choices				
	1	2	3	4	
A person's soul or spirit continues after death	Not Agree	Not Sure	Agree	Agree Strongly	69
People will be reborn to live again on earth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70
Mental telepathy (ESP) is a reality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	71
People have out of body experiences (astral travel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72
There are spiritual or non-physical forces acting in today's world	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	73
Sooner or later people will treat you as you've treated others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	74
Spiritual or psychic healing is often as effective as medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	75
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76 () Subj # () 80					
It's wrong to kill any living thing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Problems in life are really opportunities to learn and grow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
People create their own reality by the kinds of thoughts they let themselves have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3

IT IS MY OPINION THAT THE SOLUTIONS TO MAN'S PROBLEMS IN LIVING WILL BE FOUND IN . . .

	Answer choices				
	1	2	3	4	
More money for scientific research	Not Agree	Not Sure	Agree	Agree Strongly	4
More formal education for people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
Redistributing the wealth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
A return to organized religion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
Social reform through better laws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
Daily meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
Spiritual reawakening (personal enlightenment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
Protecting the environment, natural resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11

(E) LIFE STYLE

(E) LIFE STYLE (CONT'D)

DURING THE PAST MONTH, HOW OFTEN HAVE YOU... (Please answer each question below)	Answer choices				
	Rarely or Never	1-2 Times /Week	3-5 Times /Week	Each Day	
Spent time with a <u>close</u> friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
Shared personal problems with a friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Washed the dishes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Done household cleaning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Prepared meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Washed clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Done physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Taken part in active sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Listened to music you enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20
Taken time to be by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Meditated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Enjoyed contact with animals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Taken care of house plants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24
Eaten red meat (beef, pork)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Eaten fish or poultry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Eaten sweets (candy, cake, pie, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Drunk soft drinks (Coke, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Eaten <u>fresh</u> fruits (apples, oranges, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29
Eaten natural foods (dried fruit, nuts, whole grains)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Kept up with current events, (read newspaper, magazines, watch TV news)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Read something about mystical, spiritual or psychic things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Read something about personal psychological growth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33

DURING THE LAST MONTH, HAVE YOU . . .	Answer choices				
	1 Never	2 1-2 times per month	3 1-2 times per week	4 Almost Daily	
Gone to parties for social activities outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Attended meetings of civic, or other organizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
Entertained friends in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
Attended a religious service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Spent time outdoors enjoying nature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Played cards or other table games?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Visited with the neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Done grocery shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
Danced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
Read fiction for enjoyment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
Participated in a study group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Taken medication for headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Taken medication to help you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Taken medication for your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Taken medication for a cold or allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48
Taken tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
Taken laxatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50
Used alcohol or nonprescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51
Gotten high on alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52
DURING THE LAST MONTH, HAS ALCOHOL OR DRUG USE CAUSED PROBLEMS . . .					
Between you and family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53
With work (difficulty working well or going to work)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54
With your physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55
In your thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56

(F) ARE YOU CURRENTLY LIVING WITH A PARENT, SPOUSE, OR SOMEONE ELSE IN A CLOSE RELATIONSHIP?

- (1) No (If you marked "No", skip to Section G below)
 (2) Yes (If you marked "Yes", answer the 8 questions below)

57

DURING THE PAST MONTH, HAVE YOU AND YOUR SIGNIFICANT OTHER (spouse, parent, etc.) . . .

	Answer choices				
	1	2	3	4	
	Rarely	Some-times	Often	Almost Always	
1. Shared personal feelings with each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58
2. Been able to talk it through when angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59
3. Agreed about finances and budget?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60
4. Spent enjoyable times together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61
5. Discussed important matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	62
6. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	63
7. Agreed about social activities and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64
8. Shared daily events that happened to each of you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65

(G) ARE THERE CHILDREN WHERE YOU LIVE? (Mark one)

- (1) No (If you marked "No", skip to Section H below)
 (2) Yes (If you marked "Yes", answer the next 6 questions)

66

DURING THE LAST MONTH, HAVE YOU AND THE CHILD(REN) . . .

	Answer choices				
	1	2	3	4	
	Rarely	Some-times	Often	Almost Always	
1. Spent time talking with each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67
2. Spent time doing things together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68
3. Openly expressed feelings to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	69
4. Treated each other with respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70
5. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	71
6. Done things for each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72

(H) DO YOU HAVE ENOUGH MONEY TO . . .

- Pay your bills? (Mark one)
 Handle unexpected expenses? (Mark one)

	1	2	3	4	
	Rarely	Some-times	Usually	Always	
Pay your bills? (Mark one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	73
Handle unexpected expenses? (Mark one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	74

FROM WORKING, DID YOU EARN AN ADEQUATE AMOUNT OF MONEY LAST MONTH? (Mark one)

- (1) Earned no money from working last month
 (2) Earned enough to take care of my personal needs (spending money)
 (3) Earned enough to partially support a family
 (4) Earned enough to adequately support a family

75

(I) BACKGROUND

76 () Subj # 80

1. MAJOR SOURCE OF INCOME?

(Check only one answer)

- (1) Money earned from work I do now
 (2) From spouse, relative, or friend
 (3) Investments or inheritance
 (4) Welfare or public assistance
 (5) Retirement or social security
 (6) Unemployment compensation
 (7) Scholarship or student stipend
 (8) Alimony or child support
 (9) Veterans benefits

2. YOUR MARITAL STATUS (Check one)

- (1) Currently married
 (2) Separated, divorced, or widowed
 (3) Never married

3. SEX (Check one)

- (1) Male
 (2) Female

4. EDUCATION (Check one)

- (1) Less than high school
 (2) High school graduate
 (3) Some college
 (4) College graduate (Type of degree _____)

5. SMOKE CIGARETTES?

- (1) Not at all
 (2) Less than 1/2 pack per day
 (3) About 1/2 pack per day
 (4) About 1 pack per day
 (5) Over 1 1/2 pack per day

6. DRINK COFFEE?

- (1) None or rare cup
 (2) About 1-2 cups per day
 (3) 3-4 cups per day
 (4) 5 or more cups per day

7. WATCH TV?

- (1) None or rarely
 (2) Less than 1 hour per day
 (3) 1-2 hours per day
 (4) 3-4 hours per day
 (5) 5+ hours per day

8. AVERAGE HOURS OF SLEEP

- (1) 4-5 hours
 (2) 5-6 hours
 (3) 6-7 hours
 (4) 7-8 hours
 (5) 8 or more hours

AGE _____ 9-10

TODAY'S DATE: _____ 17-22

HEIGHT _____ feet _____ in. 11-13

Month _____ Day _____ Year _____

WEIGHT _____ pounds 14-16

76 () Subj # 80

Thank you for completing the questionnaire. Your help is very much appreciated. Please check back to make sure you have not left any questions unanswered.