

# STUDENT HEALTH SURVEY

## Year 1 High school

### *Västra Götaland joint regional student health survey*

The questions in this survey are about your health, school situation, lifestyle and how you feel. There are no right or wrong answers. Please choose the answer that best applies to you. You and the school nurse will then meet for a health interview and go through your answers. The information is then entered into your medical record where it is kept confidential. This means that in most cases, the data cannot be disclosed to anyone else without your consent. The exception may be if you are at risk of harm and need help or protection.



#### **This is how you do it:**

- Answer the questions in order. Ask the school nurse or teacher if you need help. Please tick the box for your answer, you can also write down your own comments for some answers.
- Some questions are about how you feel today. Other questions ask about the last 7 days or the past school week, and some questions may ask about the last month or the last 3 months.
- Please take your time and read the questions carefully.
- If you have any comments on the questions, please talk to your school nurse.

**Name** \_\_\_\_\_

**Personal identity number** \_\_\_\_\_

**School year** \_\_\_\_

**Class** \_\_\_\_\_

# STUDENT HEALTH SURVEY Year 1 High school

## SCHOOL ENVIRONMENT

1. If you think about the **last 7 days**, how have you felt about being in school?  
 Very good    Good    Neither good nor bad    Bad    Very bad    I don't want to answer
2. Do you like the school's facilities in terms of noise, lighting, ventilation, furniture, cleaning and toilets?  
 Always    Often    Rarely    Never    I don't want to answer
3. Do you like the school's teachers and staff?  
 Yes, all of them    Yes, most of them    Yes, some of them    No, not any of them    I don't want to answer
4. Do you get along with the other students at school?  
 Yes, all of them    Yes, most of them    Yes, some of them    No, not any of them    I don't want to answer
5. Are you able to concentrate in class?  
 Always    Often    Rarely    Never    I don't want to answer
6. Can you work at your own pace and keep up with your schoolwork?  
 Always    Often    Rarely    Never    I don't want to answer
7. Are you getting the help and support you need at school?  
 Always    Often    Rarely    Never    I don't want to answer
8. Are you happy with the program you are studying?  
 Always    Often    Rarely    Never    I don't want to answer
9. Are you satisfied with your study results?  
 I'm very satisfied    I'm satisfied    I'm dissatisfied    I'm very dissatisfied    I don't want to answer
10. Did you pass all subjects in the **last semester**?  
 Yes    No    I don't know    I don't want to answer
11. Do you feel safe in school?  
 Always    Often    Rarely    Never    I don't want to answer

Personal identity number: \_\_\_\_\_

12. Is there ever a fight at school that makes you feel scared or worried?

- Never     Rarely     Often     Always     I don't want to answer

13. Have you been abused, rejected or mistreated during school hours in the **last month (30 days)**?

- No, never     Yes, occasionally     Yes, repeatedly     I don't want to answer

14. Have you been abused, rejected or mistreated outside school hours in the **last month (30 days)**?

- No, never     Yes, occasionally     Yes, repeatedly     I don't want to answer

## PRESENCE IN SCHOOL

15. Have you been absent from school in the **last month (30 days)**?

*Absent in this case means that you have missed at least one lesson that day.*

- No     Yes, 1–2 days     Yes, 3–5 days     Yes, 6–9 days     Yes, 10 days (or more)     I don't want to answer

16. If you have been absent on some occasion in the **last month (30 days)** was it...

- a.) because you were ill?  No  Yes  I don't want to answer  
b.) to avoid a certain situation?  No  Yes  I don't want to answer  
c.) because there was someone at school you didn't want to see?  No  Yes  
 I don't want to answer  
d.) to hang out with friends?  No  Yes  I don't want to answer  
e.) because you felt mentally unwell?  No  Yes  I don't want to answer  
f.) for any other reason?  No  Yes  I don't want to answer

## PHYSICAL AND MENTAL HEALTH

17. For the **last three months** I have had troublesome

	Never	Rarely	Sometimes	Often	Always	I don't want to answer
a) headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) stomach pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) back/neck/shoulder pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Do you suffer from allergies or hypersensitivity?

- No  Yes, to.....  I don't want to answer

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19. How often do you use painkillers?

- Never    A few times a year    A few times a month    A few times a week    Daily    I don't want to answer

20. For the **last three months**, I have felt

	Never	Rarely	Sometimes	Often	Always	I don't want to answer
a) sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) worried or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) irritable or in a bad mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. If you think about the **last three months**, how much stress (fast pace, mental pressure or similar) have you experienced?

- Not at all    A little bit    Quite a lot    A lot    I don't want to answer

22. How do you feel today (where 0 is as bad as you can imagine, and 10 is as good as you can imagine)?

- 0    1    2    3    4    5    6    7    8    9    10
- I don't want to answer

## SLEEP

23. Think about how you've felt in the **last week of school**

a) When it's school the next day, when would you say you fall asleep? \_\_\_\_\_.

I don't want to answer

b) About what time do you wake up on a typical school day? \_\_\_\_\_.

I don't want to answer

24. The quality of my sleep in **last 7 days** has been

- Very good    Good    Neither good nor bad    Bad    Very bad    I don't want to answer

Personal identity number: \_\_\_\_\_

## FOOD

25. If you think about the **last 7 days**, how often have you eaten

	Every day	5–6 days	3–4 days	1–2 days	No day	I don't want to answer
a) breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) cooked dinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. If you think about the **last 7 days**, how often

	2 times a day or more often	Once a day	3–6 times a week	1–2 times a week	Less than once a week or never	I don't want to answer
a) did you eat fruit and vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) did you eat sweets, ice cream, buns or cakes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) did you drink soft drinks, juice or other sweet drinks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) did you eat salty snacks (crisps, peanuts or popcorn)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) did you drink energy drinks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PHYSICAL ACTIVITY

*Physical activity is any activity that makes you warm and/or short of breath (such as walking, school sports, jogging, gymnastics, weight training, cycling, swimming, ball games, dancing, and so on).*

27. Of the times you have worked out/exercised in the **last 7 days**, how often have they been so intense that you became short of breath and sweaty?

- None     
  1–2 times     
  3–4 times     
  5 times or more     
  I don't want to answer

28. Do you actively participate in physical education and health classes?

- Always     
  Often     
  Rarely     
  Never     
  I don't want to answer

29. How much do you move around on a **normal day**?

*(e.g., during physical education lessons, exercise, outdoor play, walking/biking to and from school.)*

- 1 hour or more  
 More than 30 minutes but less than 1 hour  
 Less than 30 minutes  
 I don't want to answer

Personal identity number: \_\_\_\_\_

## BODY IMAGE AND EMOTIONS

30. How well do the following statements apply to you?

	Agree completely				Disagree completely	I don't want to answer
	4	3	2	1	0	
a) I like myself the way I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My life feels meaningful most of the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am often disappointed in myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Do you identify as a...?

- Girl   
  Boy   
  Other   
  I don't know   
  I don't want to answer

32. Do you identify as a person on the LGBTQ spectrum?

*LGBTQ is an umbrella term for homosexual, bisexual, transgender and people with queer expressions and identities.*

- Yes   
  No   
  Unsure   
  I don't want to answer

33. Everyone has the right to control their own body. Has someone done something to you that didn't feel right?

- No   
  Yes   
  I don't want to answer

34. Do you have any questions about your bodily development or other issues related to emotions, sexuality and relationships?

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## SEXUAL HEALTH AND RIGHTS

*At your age, the most common form of sex is masturbation (sex with oneself).*

35. If you have had sex with someone, did you use a condom to protect yourself from sexually transmitted diseases?

- Yes   
  No   
  Was not needed   
  I haven't had sex   
  I don't want to answer

36. If you have had sex with someone, did you use a condom to protect yourself from pregnancy?

- Yes   
  No   
  Was not needed   
  I haven't had sex   
  I don't want to answer

Personal identity number: \_\_\_\_\_

## VIOLENCE

*Violence is any act which harms, hurts, intimidates, and compels a person to do something against their will or to refrain from doing something they want to do.*

37. Have you seen or experienced violence in your family or around you?

- No       Yes       I don't want to answer

38. a.) Have you **ever** been subjected to **physical** violence?

*Physical violence is when someone touches you or does something physical that hurts and causes physical pain.*

- No    Yes    I don't want to answer

b.) Have you **ever** been subjected to **sexual** violence?

*Sexual violence is when someone is forced to participate in or watch sexual acts against their will.*

- No    Yes    I don't want to answer

c.) Have you **ever** been subjected to **psychological** violence?

*Psychological violence is abuse with words and actions directed at you as a person.*

- No    Yes    I don't want to answer

d.) Have you **ever witnessed** violence?

*Witnessed violence is seeing or hearing someone else being subjected to some form of violence.*

- No    Yes    I don't want to answer

## SPARE TIME AND RELATIONSHIPS

39. Are you active in any associations/clubs?

*(such as dance, music, theater, games club, scouts, football, floorball)*

- Yes       No       I don't want to answer

40. On average, how many hours **a day** do you spend playing computer games, video games or mobile games?

- I don't play    Less than an hour    1–3 hours    More than 3 hours    I don't want to answer

41. Are you happy at home?

- Always    Often    Rarely    Never    I don't want to answer

42. Do you have peace and quiet at home when you have to do things such as homework or sleep?

- Always    Often    Rarely    Never    I don't want to answer

43. Do you have someone who can help you with your homework if you need it?

- Always    Often    Rarely    Never    I don't want to answer

44. Do you feel that adults are listening to you?

- Always    Often    Rarely    Never    I don't want to answer

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45. Do you have an adult to talk to about the things that are important to you?

- Yes       No       I don't want to answer

46. Do you feel that your parents/guardians understand you and help you make important decisions?

- Always       Often       Rarely       Never       I don't want to answer

47. Is there ever a fight at home that makes you feel scared or worried?

- Never       Rarely       Often       Always       I don't want to answer

48. Do you feel worried or concerned about someone around you, such as a friend or family member?

- No       Yes       I don't want to answer

49. Are you a victim of honor-related oppression?

*Honor-related violence and oppression is about demanding that everyone in the family must follow certain rules, so as not to destroy the family's reputation and standing, its honor. Breaking the rules can mean punishment such as ostracism, isolation, blaming and shaming, humiliation or physical violence.*

- No       Yes       I don't want to answer

50. Do you have any friends to talk to about the things that are important to you?

- Always       Often       Rarely       Never       I don't want to answer

## ALCOHOL, DRUGS AND TOBACCO

51. a) Have you **ever** tried smoking (cigarettes, e-cigarettes, hookah, and so on)?

- No       Yes       I don't want to answer

b) If you have ever tried smoking, how old were you when you first tried smoking? \_\_\_\_\_ years old.

- I don't want to answer

52. How often have you smoked in the **last month** (30 days)?

- Never       On some occasion       A few times a week       Every day       I don't want to answer

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53. a) Have you **ever** tried snus/snuff?

- No       Yes       I don't want to answer

b) If you have ever tried snus/snuff, how old were you when you first tried it? \_\_\_\_\_ years old.

I don't want to answer

54. How often have you used snus/snuff in the **last month** (30 days)?

- Never     On some occasion     A few times a week     Every day     I don't want to answer

55. a) Have you **ever** drunk alcohol to the point of being intoxicated?

- No       Yes       I don't want to answer

b) If you have ever drunk alcohol to the point of becoming intoxicated, how old were you when you first became intoxicated? \_\_\_\_\_ years old.

I don't want to answer

56. How often have you drunk alcohol (medium and strong beers, cider, wine, alcoholic soft drinks or spirits) in the **last month (30 days)**?

- Never     On some occasion     Every week     Every day     I don't want to answer

57. If you were offered drugs, unprescribed drugs or anabolic steroids, what would you say?  
(Examples of drugs include cannabis, amphetamines, ecstasy, GHB, LSD, cocaine and heroin)

- Firmly no       Probably no       Maybe yes       Yes       I don't want to answer

## MY LIFE

58. Do you feel you can live as the person you want to be and feel like?

- Yes, always     Yes, often     No, rarely     No, never     I don't want to answer

59. If you think about your life in general, where do you think you are right now?  
(10 equals the best life you can imagine.)

- 0     1     2     3     4     5     6     7     8     9     10

I don't want to answer

Personal identity number: \_\_\_\_\_

## **THE FUTURE**

**60.** Here's what I think about my future. Please write your thoughts here:

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**Thank you for answering the questions!**

**Personal identity number:** \_\_\_\_\_

(Not visible to the student. The school nurse fills this in after the health interview)

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

**School unit:** \_\_\_\_\_

**Grade/year:** \_\_\_\_\_

**Class:** \_\_\_\_\_

**Personal identity number:** \_\_\_\_\_