

STUDENT HEALTH SURVEY

Year 4

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:

Personal identity number: _____

STUDENT HEALTH SURVEY Year 4

SCHOOL ENVIRONMENT

1. If you think about the **last 7 days**, how have you felt about being in school?

<input type="checkbox"/> Very good	<input type="checkbox"/> Good	<input type="checkbox"/> Neither good nor bad	<input type="checkbox"/> Bad	<input type="checkbox"/> Very bad	<input type="checkbox"/> I don't want to answer
------------------------------------	-------------------------------	---	------------------------------	-----------------------------------	---

2. Do you use the toilets at school?

<input type="checkbox"/> Yes, when I need to	<input type="checkbox"/> No, I hold myself	<input type="checkbox"/> I don't want to answer
--	--	---

3. Do you like the school's teachers and staff?

<input type="checkbox"/> Yes, all of them	<input type="checkbox"/> Yes, most of them	<input type="checkbox"/> Yes, some of them	<input type="checkbox"/> No, not any of them	<input type="checkbox"/> I don't want to answer
---	--	--	--	---

4. Do you get along with the other students at school?

<input type="checkbox"/> Yes, all of them	<input type="checkbox"/> Yes, most of them	<input type="checkbox"/> Yes, some of them	<input type="checkbox"/> No, not any of them	<input type="checkbox"/> I don't want to answer
---	--	--	--	---

5. Are you able to concentrate in class?

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

6. Can you work at your own pace and keep up with your schoolwork?

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

7. Are you getting the help and support you need at school?

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

8. Do you feel safe in school?

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

10. Have you been teased, rejected or mistreated in any other way during school hours in the **last month (30 days)**?

<input type="checkbox"/> No, never	<input type="checkbox"/> Yes, occasionally	<input type="checkbox"/> Yes, repeatedly	<input type="checkbox"/> I don't want to answer
------------------------------------	--	--	---

11. Have you been teased, rejected or mistreated in any other way outside school hours in the **last month (30 days)**?

<input type="checkbox"/> No, never	<input type="checkbox"/> Yes, occasionally	<input type="checkbox"/> Yes, repeatedly	<input type="checkbox"/> I don't want to answer
------------------------------------	--	--	---

Personal identity number: _____

PHYSICAL AND MENTAL HEALTH

12. 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"/>

13. Do you suffer from allergies or hypersensitivity?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, to.....	<input type="checkbox"/> I don't want to answer
-----------------------------	---------------------------------------	---

14. 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"/>

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

<input type="checkbox"/> Not at all	<input type="checkbox"/> A little bit	<input type="checkbox"/> Quite a lot	<input type="checkbox"/> A lot	<input type="checkbox"/> I don't want to answer
-------------------------------------	---------------------------------------	--------------------------------------	--------------------------------	---

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

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
<input type="checkbox"/> I don't want to answer										

SLEEP

17. 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

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

<input type="checkbox"/> Very good	<input type="checkbox"/> Good	<input type="checkbox"/> Neither good nor bad	<input type="checkbox"/> Bad	<input type="checkbox"/> Very bad	<input type="checkbox"/> I don't want to answer
------------------------------------	-------------------------------	---	------------------------------	-----------------------------------	---

Personal identity number: _____

FOOD

19. 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"/>

20. 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).

21. 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?

<input type="checkbox"/> None	<input type="checkbox"/> 1–2 times	<input type="checkbox"/> 3–4 times	<input type="checkbox"/> 5 times or more	<input type="checkbox"/> I don't want to answer
-------------------------------	------------------------------------	------------------------------------	--	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

23. 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.)

<input type="checkbox"/> 1 hour or more
<input type="checkbox"/> More than 30 minutes but less than 1 hour
<input type="checkbox"/> Less than 30 minutes
<input type="checkbox"/> I don't want to answer

Personal identity number: _____

BODY IMAGE AND EMOTIONS

24. Do you identify as a...?

<input type="checkbox"/> Girl	<input type="checkbox"/> Boy	<input type="checkbox"/> Other	<input type="checkbox"/> I don't know	<input type="checkbox"/> I don't want to answer
-------------------------------	------------------------------	--------------------------------	---------------------------------------	---

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> I don't want to answer
-----------------------------	------------------------------	---

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

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.

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> I don't want to answer
-----------------------------	------------------------------	---

28. 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.

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> I don't want to answer
-----------------------------	------------------------------	---

SPARE TIME AND RELATIONSHIPS

29. Are you active in any associations/clubs?

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't want to answer
------------------------------	-----------------------------	---

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

<input type="checkbox"/> I don't play	<input type="checkbox"/> Less than an hour	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> More than 3 hours	<input type="checkbox"/> I don't want to answer
---------------------------------------	--	------------------------------------	--	---

Personal identity number: _____

31. Who do you live with? What is your living situation?

<input type="checkbox"/> With parent/ guardian	<input type="checkbox"/> In familyhome/HVB (Home for care or residence)	<input type="checkbox"/> Other arrangements	<input type="checkbox"/> I don't want to answer
--	--	---	---

32. Are you happy at home?

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't want to answer
------------------------------	-----------------------------	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> I don't want to answer
-----------------------------	------------------------------	---

38. 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.

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> I don't want to answer
-----------------------------	------------------------------	---

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

<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never	<input type="checkbox"/> I don't want to answer
---------------------------------	--------------------------------	---------------------------------	--------------------------------	---

MY LIFE

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

<input type="checkbox"/> Yes, always	<input type="checkbox"/> Yes, often	<input type="checkbox"/> No, rarely	<input type="checkbox"/> No, never	<input type="checkbox"/> I don't want to answer
--------------------------------------	-------------------------------------	-------------------------------------	------------------------------------	---

41. If you think about your life in general, where do you think you are right now?

(10 equals the best life you can imagine.)

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
<input type="checkbox"/> I don't want to answer										

Personal identity number: _____

THE FUTURE

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

Thank you for answering the questions!

Personal identity number: _____

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

Height:
Weight:
School unit:
Grade/year:
Class:

Personal identity number: _____