

Institut National d'Etudes Démographiques, Paris
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TEENAGERS QUESTIONNAIRE

Girls

Self-administered

ID Number:

Date: |__|__| day |__|__| month |_2_|_5_|_5_|_ _| yr

Please introduce the study and ask for ascent

Self administred :

With help:

Site:

Code : |__|__|

YOU ARE LIVING IN AN ORPHANAGE

How old are you? |__|__|years old today

What is your date of birth
(year that you were born) |__|__| |__|__| |__|__|__|__|
Day Month Year

How many brothers and sisters do you have? |__|sisters |__| brothers

How many children are sharing the same bedroom including yourself? |__|__|

Among them, are there children you feel close to

- None
- One or two, only
- Three or four
- Many
- Most of them

How are the relations you have with the adult(s) in charge of you at the orphanage?

- Very good
- Good
- OK
- Difficult
- Very difficult

NOW GO TO PAGE 4

YOU ARE LIVING IN A FAMILY/PRIVATE HOME



How old are you? |__|__|years old today

What is your date of birth
(year that you were born) |__|__| |__|__| |__|__|__|__|

Day Month Year

At home, I live with
(Relationship)

Nobody **Go to Page 4**



	I share my bedroom with her/him?	I feel close to her/him?
1.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
5.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
6.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
7.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
8.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

At home, who is looking after you the most?

Do you help with the household chores
(*cleaning, shopping, cooking, etc.*)?

Yes often
 Yes sometimes
 Rarely
 Not at all

Is there a particular task in the household
that you are personally responsible for?
(*watering the garden, washing, etc...*)?

No
 Yes, what?.....

Do you regularly help the adults with their
work (*in a shop, farm, etc.*)

No
 Yes, what?.....

Is there somebody in the household that
you regularly look after

No
 Yes, who?.....

SCHOOL

Are you currently attending school? Yes, what grade are you in?

No, in which grade did you stop

Do (or did) you like school?

Very much

A little

It is Ok

I don't like it

I don't like it at all

Do (or did) you skip (leave) school because you were ill?

Yes regularly

Yes for a long time

Sometimes

Rarely

What kind of student are (or were) you?

Very good

Good

Fair

Bad

Very bad

Do (or did) you have friends at school?

A lot

Some

2 or 3

None

WORK

Do you regularly work for money?

No Yes

What do you do ?

How many days a week do you work? |__|

How much do you earn? |__|__|__|__| per day
or
|__|__|__|__| per month

Do you give money to your household No
 Sometimes
 Regularly

Do you like your work ? No Yes

Do you get tired at work? No Yes

Do you have friends at work? Many
 Some
 Few
 None

FUTURE

Do you plan to go to college, vocational college, university? No
 Yes
 Don't know

What subject would you like to study? Don't know

What kind of occupation would you like to have, ideally? Don't know

Do you think that you will get married or have a partner in the future? No
 Yes Don't know

Do you think that you will get children in the future? No
 Yes Don't know

Do you think that you will live outside your hometown in the future? No
 Yes Don't know

HEALTH

How is your health at the moment?

- Very Good
 Good
 Fair
 Poor
 Very Poor

Compared to your friends, are you :

- | Height | Weight |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Taller | <input type="checkbox"/> Chubbier |
| <input type="checkbox"/> Average | <input type="checkbox"/> Average |
| <input type="checkbox"/> Smaller | <input type="checkbox"/> Skinnier |

Have you been hospitalized No Yes

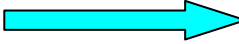
The last time, how old were you? |__|__|

 Don't remember

How long did you stay in hospital?

|__|__|months or |__|__|Days

Do you take regularly any treatment?

- No  **go to page 8**
 Yes

How old were you when you started treatment? |__|__|years old Don't know

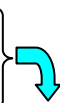
Do you have side effects from your treatment?

- No
 Yes, specify:.....

Is somebody giving you your treatment?

- No, I take it by myself
 Yes
 Who ?

Is somebody reminding you to take your treatment?

- Never
 Sometimes
 Always } 
 Who ?

Do you find it easy or difficult to remember to take your treatment?

- Very Easy
 Easy
 OK
 Difficult
 Very difficult

Do you use any tricks to prepare or remember to take your treatment on time? (tick all that apply)

- None
 Clock/watch alarm
 Cell phone alarm
 National anthem
 TV / radio program
 Use pill box ^w/ compartments
 Other:

During the last week (7 days), did you ever forget to take your treatment?

- Never
 I forgot one dose
 I forgot several doses
 Don't know

If you ever forget to take your medication, what was the main reason?

- I was sick
 I was playing
 I was too busy
 I was fed up
 I was not at home
 It was a festival/holidays
 I was not given them
 There wasn't enough privacy
 Other reasons, specify:

Do you get scolded when you forget to take your treatment (*nurse, doctor, family*)?

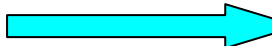
- Yes
 No

REPRODUCTIVE HEALTH

Have you already begun menstruation? No
 Yes, it started at |__|__| years old

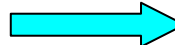
Have you received any sexual education/family planning? No
 Yes

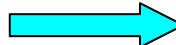
Where: at school
 in a children's camp
 at the Hospital
 At home
 Others, specify:

Have you ever had sexual intercourse? Don't want to answer **go to page 9**
 No  **go to page 9**
 Yes, the first time at |__|__| years

↓
 With whom was it the first time? Spouse Female CSW
 Boy/girl friend Male CSW
 Occasional partner
 Other (specify):

Age of your partner at first sex |__|__| years Don't know

Did you use a condom at this time? No 
 Yes

Did you use a contraception at this time? No  **go to page 9**

What kind of contraception? Condom
 Pill
 Emergency pill
 Withdraw
 Other:

SIGNIFICANT OTHERS

You share affection and support with different persons

In general, with whom do most share these types of moments?

(they can be family members or others)

	<i>Never</i>	<i>Relationship</i> <i>(for exemple uncle, older sister/brother. Don't give their name)</i>	<i>Nobo dy</i>
I laugh and exchange jokes with	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
I get cuddled by	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
I chat over my affairs, boy-friend stories with	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
When I have nightmares or frightening thoughts, I get comforted by	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
When I am sick, I turn to	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
When I have problems at school or work, I discuss with	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
When I have money problems, I discuss issues with	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
I get information about my health, illness or medication from	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
If I do something wrong, I can confide in	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
If somebody does something bad to me, I can confide in	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>
I discuss about the future with	<input type="checkbox"/>	1..... 2.....	<input type="checkbox"/>

RELATIONSHIP WITH ADULTS

How easy/difficult is it to ask any questions to the people at the hospital (nurses and doctors)?

- Very Easy
 Easy
 OK
 Difficult
 Very difficult

In the past year, did you have arguments with your caregiver or parents?

- Very often
 Often
 Sometimes
 Rarely
 Never

YOUR PERSONALITY

Do you think that you are generally

- Joyful
 Intermediate
 Sad
 Up and down

Do you think that you are generally

- Lonely
 Sociable/Friendly

Do you think that you are generally

- Always obese
 Sometimes obese

How do you generally feel?

- Very unhappy
 Unhappy
 Average
 Happy
 Very happy

Do you have a special friend with whom you feel very close?

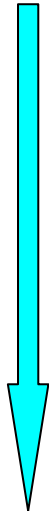
- No
 Yes boy girl

Do you meet often? Yes No

Do you chat together on the internet or mobile phone? Yes No

PEER GROUP

Do you have a group of kids with whom you spend time? No Yes



Where do they mostly come from? School
 Neighborhood
 Family
 Others

Are they Mostly boys
 Mostly girls
 Equally boys and girls

What do you like to do most with your group of peers?

GIRL/BOY FRIENDS/FAVORITE

Do you have a boy/girl friend? No **GO TO PAGE 12**
 Yes boy girl

Since you were |__|__| years old

Do you have sex together? No **GO TO PAGE 12**
 Yes

The last time you had sex, did you use No
 Yes

Do you take contraception No **GO TO PAGE 12**
 Yes

What kind of contraception? Condom
 Pill
 Emergency pill
 Injectable
 Other:

Have you ever been pregnant? ₂ No **GO TO PAGE 12**
 ₁ Yes

If yes, how old were **you**? |__|__| years old

If yes, how old was your partner? |__|__| years old

Did you continue with the pregnancy
 have an abortion

ACTIVITIES

Do you play computer games? No
 Sometimes
 Regularly

Do you smoke cigarettes? No
 Sometimes
 Regularly

Do you like riding motorbike very fast? Don't know how to ride
 No
 Yes

Have you ever had a motorbike accident while you were driving? No
 Yes

Do you spend time chatting on the internet? No
 Sometimes
 Often

Do you listen to music? No
 Sometimes
 Often

Do you read books? No
 Sometimes
 Often

Do you drink energizing drinks, like *Red-Bull*? No
 Sometimes
 Often

Do you drink beer? No
 Sometimes
 Often

Do you drink strong alcohol such as *Sangsom*? No
 Sometimes
 Often

Have you ever been drunk? No
 Once
 Sometimes
 Often

Do you hang out with your friends? No
 Sometimes
 Often

Where do you hang out? At home
 At my friends' house
 At the mall
 In the bar, restaurant, etc.
 Outside such as parks, streets, stadium, etc...
 Other:

Do you know people who take drugs? No
 Yes

Do you practice a sport No
 Sometimes
 Regularly

Which sport?

Do you watch sport on TV? No
 Sometimes
 Often

Was is your favorite sport?

	Do you have a mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Do you watch soap operas on TV? No
 Sometimes
 Often

What is your favorite soap series?

Do you do gardening? No
 Sometimes
 Often

Do you do some cooking? No
 Sometimes
 Often

Do you (have you) attend(ed)
 extra-curriculum school Yes
 No

What is your religion? I do not have a religion
 Buddhist
 Christian
 Muslim
 Other (specify:)

When did you last go to the
 Wat/Church/Mosque/Other? Last week
 Last month
 Last 3 months
 Last year
 For festivals only
 Not for a long time

THANK YOU VERY MUCH FOR YOUR HELP !