



**QUESTIONNAIRE FOR FATHER OR STEP- FATHER**

**or person most like father (i.e., someone who is/was very close to "NDIT participant")**

Please note that by returning your completed questionnaire to us, **YOU CONSENT** to participate in the parent questionnaire component of the NDIT Study. If you do not wish to complete the questionnaire, please return the blank copy of the questionnaire to us in the pre-paid envelope, so that we know you have decided not to complete it. Thank you very much for your participation.

1. Your name: \_\_\_\_\_  
First Last

2. Today's date : \_\_\_\_\_  
Day Month Year

3. Your date of birth: \_\_\_\_\_  
Day Month Year

4. What is your relationship with...?

*insert participant's names*

- Biological father
- Step- father
- Grandfather
- Other (specify) \_\_\_\_\_

7. Have you ever smoked cigarettes?

- No → Go to question 10
- Yes

8. At what age did you smoke cigarettes for the first time?

\_\_\_\_\_ years

9. Have you smoked a total of 100 or more cigarettes (about 4 packs) in your lifetime?

- No
- Yes

10. Even if you do not smoke now, how often do you feel like you really need a cigarette?

- Never
- Rarely
- Sometimes
- Often
- Very often

11. Even if you do not smoke now, how often do you have cravings to smoke cigarettes?

- Never → Go to question 13
- Very rarely
- Sometimes
- Often
- Very often

12. How strong are your cravings to smoke cigarettes?

- Not at all strong
- A bit strong
- Quite strong
- Very strong

13. Even if you do not smoke now, do you ever feel addicted to smoking cigarettes ...?

	Not at all addicted	A little bit addicted	Quite addicted	Very addicted
Physically	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mentally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. At the present time, do you smoke cigarettes...?

- Daily
- Occasionally
- Not at all → Go to question 29

**15. On the days that you smoke, about how many cigarettes do you usually smoke each day?**

\_\_\_\_\_ cigarettes each day

**16. When you cut down or stop using cigarettes or when you cannot smoke for a long period (like most of the day), how often do you ...?**

	Never	Rarely	Sometimes	Often	Don't know
Feel irritable or angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel nervous, anxious or tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel a strong urge or need to smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**17. Has your doctor ever...**

	No	Yes	Not applicable
Asked you if you smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advised you to quit smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Given you specific advice or information to help you quit smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**18. Do you find it difficult to refrain from smoking in places where it is forbidden?**

- Not at all difficult
- A bit difficult
- Very difficult
- Don't know

**19. Which cigarette would you most hate to give up?**

- First cigarette of the day
- Another cigarette (specify) \_\_\_\_\_

**20. Do you smoke more frequently during the first hours after waking, compared with the rest of the day?**

- No
- Yes

**21. How true are each of the following for you?**

	Not at all true	A bit true	Very true
Cigarettes are good for dealing with boredom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A cigarette gives me energy when I'm tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I'm feeling down, a cigarette makes me feel good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cigarettes calms me down when I feel nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cigarettes helps me control my weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cigarettes helps me concentrate on my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cigarettes relieves tension when I am stressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I consider myself to be a social smoker.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoid going to a friend's house where I am not allowed to smoke even though I might enjoy being with him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In situations where I need to go outside to smoke, it's worth it even in cold or rainy weather.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have cut down or stopped physical activities or sports because of my smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can function much better in the morning after I've had a cigarette.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compared to when I first started smoking, I need to smoke a lot more now to be satisfied.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compared to when I first started smoking, I can smoke much more now before I start to feel nauseated or ill. OR <input type="checkbox"/> I've never felt nauseated or ill from smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often run out of cigarettes quicker than I thought I would	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I spend a lot of time getting cigarettes (going out of my way to buy cigarettes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I spend a lot of time smoking cigarettes (chain smoking, smoking a lot throughout the day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've stopped socializing with certain people because of my smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**22. On the days that you smoke, how soon after you wake up do you smoke your first cigarette?**

- Within 5 minutes
- 6 - 30 minutes after waking
- 31 - 60 minutes after waking
- More than 1 hour after waking, but before noon
- After noon or in the evening

**23. If you are sick with a bad cold or sore throat, do you continue to smoke?**

- No, I stop smoking when I'm sick
- Yes, but I cut down on the amount I smoke
- Yes, I smoke the same amount as when I'm not sick

**24. Have you ever tried to quit smoking or to reduce the amount of cigarettes that you smoke?**

- No → **Go to question 29**
- Yes

**25. When was the last time you tried to quit smoking or to reduce the amount of cigarettes that you smoke?**

\_\_\_\_\_ months ago **OR** \_\_\_\_\_ years ago

**26. The last time that you tried to quit or to reduce the amount of cigarettes that you smoke, did you...?**

- Cut down a lot
- Cut down a little
- Smoke the same amount
- Quit completely for \_\_\_\_\_ days **OR** \_\_\_\_\_ months
- Quit completely and remain non-smoking

**27. What is/are the reason(s) that you tried to quit or to reduce the amount of cigarettes that you smoke? Check all that apply.**

- To maintain or improve your health
- To avoid exposing others to secondhand smoke
- Pressure from family
- Pressure from friends
- Pressure from people in general
- Because smoking in public places is restricted
- To save money
- Other (specify) \_\_\_\_\_

**28. Did you use any of the following to help you quit or to reduce the amount of cigarettes that you smoke? Check all that apply.**

- J'Arrête telephone quit-line
- J'Arrête website
- Quit-Smoking Center
- Consulted a physician
- Nicotine patch or gum
- Zyban, bupropion, other medication
- Other (specify) \_\_\_\_\_
- I did not use anything to help me

**29. Do/did any of the following people smoke cigarettes?**

Your...	Never	Occasionally	Daily	Not applicable
Biological mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Step-mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Step-father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, step-sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, step-brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**30. Are there any restrictions on smoking cigarettes in your home?**

- No
- Smoking is not allowed at all → **Go to question 32**
- Smoking is allowed in certain rooms only
- Other (specify) \_\_\_\_\_

**31. About how many people smoke daily or almost every day inside your home?**

- None **OR** \_\_\_\_\_ people

**32. How often are/do you...?**

	Never	Rarely	Some-times	Often	Very often
Wide awake and alert most of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired and grumpy during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble getting out of bed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall back to sleep after being awakened in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need someone to wake you in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Think you need more sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop breathing for short time periods while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have an irresistible urge to move your legs while sleeping, to relieve abnormal sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. On weekdays during the past month, at what time did you usually...

Go to sleep \_\_\_\_\_ o'clock in the evening  
 Wake up \_\_\_\_\_ o'clock in the morning

34. Which statement best describes your usual daily activities or work habits in the past 3 months?

- Usually sit during the day and don't walk around very much
- Stand or walk quite a lot during the day but don't have to carry or lift things very often
- Usually lift or carry light loads, or have to climb stairs or hills often
- Do heavy work or carry very heavy loads

35. During the last 7 days, on how many days did you do **vigorous** physical activities (heavy lifting, digging, aerobics, fast bicycling) for at least 10 minutes at a time?

None → Go to question 37  
 \_\_\_\_\_ days in the last 7 days

36. On the days that you did **vigorous** physical activities, how many minutes did you usually do per day?

\_\_\_\_\_ minutes per day

37. In the last 7 days, on how many days did you do **moderate** physical activities (carrying light loads, bicycling at a regular pace, doubles tennis) for at least 10 minutes? Do not include walking.

None → Go to question 39  
 \_\_\_\_\_ days in the last 7 days

38. On the days that you did **moderate** physical activities, how many minutes did you usually do per day?

\_\_\_\_\_ minutes per day

39. In the last 7 days, on how many days did you walk for at least 10 minutes at a time?

None → Go to question 41  
 \_\_\_\_\_ days in the last 7 days

40. On the days that you walked, how many minutes did you usually spend walking per day?

\_\_\_\_\_ minutes per day

41. How tall are you without shoes on?

\_\_\_\_\_ feet \_\_\_\_\_ inches OR \_\_\_\_\_ meters  
 Don't know

42. How much do you weigh?

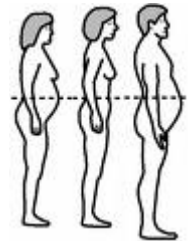
\_\_\_\_\_ pounds OR \_\_\_\_\_ kilograms  
 Don't know

43. Do you consider yourself...?

- Too thin
- Just about right
- A little overweight
- Moderately overweight
- Very overweight

44. What is your waist circumference? Please use the measuring tape provided in your package.

- (i) Locate the top of your hip bone.
- (ii) Place the tape measure evenly around your bare abdomen at the level of this bone. Relax your abdomen and **do not hold your breath**. Make sure the tape is not too tight. HINT: To make it easier, level the measuring tape to your navel and hold it parallel to the floor.
- (iii) Read the tape measure and record your waist circumference in centimetres or inches.



\_\_\_\_\_ centimeters OR \_\_\_\_\_ inches

45. In general, how would you rate your...?

	Excellent	Very good	Good	Fair	Poor
Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to handle unexpected problems (family or personal crisis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to handle day-to-day demands (work, family responsibilities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**46. Have you ever been diagnosed by a health professional with any of the following? How old were you when first diagnosed? Have you ever been prescribed medication for this problem?**

	No	Yes	Age first diagnosed	Prescribed medication	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cholesterol or lipid problems	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cancer (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
COPD (chronic bronchitis or emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Back problem	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gum or periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Learning disability (dyslexia)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bowel disorder (Crohn's disease, ulcerative colitis, irritable bowel)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eating disorder (anorexia, bulimia)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Intestinal or stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Separation anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other anxiety disorder (phobia, obsessive-compulsive disorder, panic attacks, generalized anxiety disorder)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ADHD (attention deficit-hyperactivity disorder)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Behavioral problems (oppositional defiant disorder, conduct disorder)	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Schizophrenia or psychosis	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Drug problem	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gambling problems	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>	___ years	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**47. How often do you...?**

	Never	Rarely	Sometimes	Often	Very often
Smoke cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke a pipe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke cigarillos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Bidis (a tobacco product from India)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use snuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a water pipe (hubble bubble, nargilé, shisha)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcoholic beverages (beer, wine, liquor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink 5 or more alcoholic beverages on one occasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play games (cards, bingo, dice) for money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bet money (slot machines, sports pool, casino, over the Internet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buy lottery tickets (6-49, Sports Select, Instant lottery, Scratch and win)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use marijuana, cannabis, hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use other illicit drug(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Almost done!

**49. The following statements are about families and family relationships. For each one, please indicate which response best describes your family.**

	Strongly disagree	Dis-agree	Agree	Strongly agree
Planning family activities is difficult because we misunderstand each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In times of crisis we can turn to each other for support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We cannot talk to each other about sadness we feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals (in the family) are accepted for what they are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We avoid discussing our fears and concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We express feelings to each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are lots of bad feelings in our family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We feel accepted for what we are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making decisions is a problem for our family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are able to make decisions about how to solve problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We don't get along well together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We confide in each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**50. Canadians come from many cultural and racial backgrounds. Which best describes your background and that of your biologic parents?**

	You	Your biological mother	Your biological father
White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South Asian (East Indian, Pakistani, Sri Lankan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latin American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Southeast Asian (Cambodian, Indonesian, Laotian, Vietnamese)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arabic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
West Asian (Afghan, Iranian)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**51. What is your current marital status?**

- Single
- Married
- Living as married (common-law)
- Divorced
- Separated
- Other (specify) \_\_\_\_\_

**52. What is the highest level of education that you have attained?**

- Attended high school, but did not graduate
- Graduated from high school
- Attended CEGEP, community college, or technical program, but did not graduate
- Graduated from CEGEP, community college, technical program
- Attended university but did not graduate
- Graduated from university with a Bachelor degree
- Graduated from university with a Master's degree
- Graduated from university with a PhD
- Other (specify) \_\_\_\_\_

**53. At the present time, which of the following best describes your main occupation?**

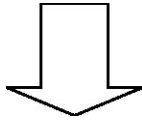
- Full-time job (35 or more hours a week)
- Part-time job (less than 35 hours a week)
- Full-time student
- Part-time student
- Homemaker
- Not working for health reasons
- Unemployed
- On welfare (social assistance)
- Other (specify) \_\_\_\_\_

**54. What is your best estimate of the total income, before taxes and deductions, of all household members from all sources in the past 12 months?**

- |  |  |
|--|--|
| <input type="checkbox"/> Less than \$20,000  | <input type="checkbox"/> \$80 000 - \$99 999   |
| <input type="checkbox"/> \$20 000 - \$29 999 | <input type="checkbox"/> \$100,000 - \$124,999 |
| <input type="checkbox"/> \$30 000 - \$39 999 | <input type="checkbox"/> \$125 000- \$149 999  |
| <input type="checkbox"/> \$40 000 - \$49 999 | <input type="checkbox"/> \$150 000 - \$249 999 |
| <input type="checkbox"/> \$50 000 - \$59 999 | <input type="checkbox"/> More than \$250 000   |
| <input type="checkbox"/> \$60 000 - \$69 999 | <input type="checkbox"/> Don't know            |
| <input type="checkbox"/> \$70 000 - \$79 999 |  |

The next questions are about “NDIT participant”  
 “NDIT participant” refers to:

*NDIT participant’s name*



5. How old was “NDIT participant” when you first began living with him/her at least half (50%) of the time?

\_\_\_\_\_ months old    **OR**    \_\_\_\_\_ years old  
 I lived with “NDIT participant” all his/her life

6. How many years did/have you live(d) with “NDIT participant” at least half (50%) of the time?

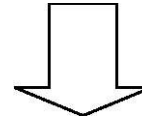
\_\_\_\_\_ years

48. How often have you...

	Never	Rarely	Some-times	Often	Very often
Talked to “NDIT participant” about the risks or consequences of gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambled with “NDIT participant”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried about “NDIT participant’s” gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried or been stressed about your relationship with “NDIT participant”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried or been stressed about financial problems in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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\_\_\_\_\_ months old    **OR**    \_\_\_\_\_ years old  
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\_\_\_\_\_ years

48. How often have you...

	Never	Rarely	Some-times	Often	Very often
Talked to “NDIT participant” about the risks or consequences of gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambled with “NDIT participant”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried about “NDIT participant’s” gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried or been stressed about your relationship with “NDIT participant”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried or been stressed about financial problems in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**End of questions. Thank you very much!**