Form approved
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NATIONAL HEALTH INTERVIEW SURVEY – TEEN (NHIS-TEEN)
Updated May 6, 2021

Sponsored and conducted by the National Center for Health Statistics
and the Centers for Disease Control and Prevention

Section 1: Your Health

PHSTAT - Would you say your health in general is excellent, very good, good, fair, or poor?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

LSATIS11 - Using a scale of 0 to 10, where 0 means "very dissatisfied" and 10 means "very satisfied", how do you feel about your life as a whole these days?

<Enter value>

SPORT - In the past 12 months, did you play or participate on a sports team or club or take sports lessons either at school or in the community?

1. Yes
2. No

PEGYM - In the past 12 months, did you take a physical education, PE, or gym class?

1. Yes
2. No

PADAYS - In a typical week during the school year, how often do you exercise, play a sport, or participate in physical activity for at least 60 minutes a day?

1. Never
2. Some days
3. Most days
4. Every day

STRENGTH - In a typical week during the school year, how often do you do exercises to strengthen or tone your muscles, such as sit-ups, push-ups, or weight lifting?

1. Never
2. Some days
3. Most days
4. Every day

WALK - In a typical week during the school year, how often do you walk for at least 10 minutes at a time?

1. Never
2. Some days
3. Most days
4. Every day

BIKE - In a typical week during the school year, how often do you ride a bike for at least 10 minutes at a time?

1. Never
2. Some days
3. Most days
4. Every day

RESTED - In a typical week during the school year, how often do you wake up well-rested?

1. Never
2. Some days
3. Most days
4. Every day

OUTOFBED - In a typical week during the school year, how often do you have difficulty getting out of bed in the morning?

1. Never
2. Some days
3. Most days
4. Every day

TIRED - In a typical week during the school year, how often do you complain about being tired during the day?

1. Never
2. Some days
3. Most days
4. Every day

NAPS - In a typical week during the school year, how often do you nap or fall asleep during the day, such as in school, watching TV, or riding in a car?

1. Never
2. Some days
3. Most days
4. Every day

BEDTIME - In a typical week during the school year, on nights you have school the next day, how often do you go to bed at the same time?

1. Never
2. Some days
3. Most days
4. Every day

WAKETIME - In a typical week during the school year, on school days, how often do you wake up at the same time?

1. Never
2. Some days
3. Most days
4. Every day

TSCREENTIME - On most weekdays, how many hours do you spend a day in front of a TV, computer, cellphone, or other electronic device watching programs, playing games, accessing the Internet, or using social media?

Do not include time spent doing schoolwork

1. Less than 1 hour
2. 1 hour
3. 2 hours
4. 3 hours
5. 4 or more hours

HEIGHT - How tall are you without shoes?

<Enter value for feet> <Enter value for inches>

WEIGHT - How much do you weigh now?

<Enter value for pounds>

WEIGHTPER - How do you describe your weight?

1. Very underweight
2. Slightly underweight
3. About the right weight
4. Slightly overweight
5. Very overweight

WEIGHTCON- Are you concerned about your weight?

1. Yes, it's too high
2. Yes, it's too low
3. No

TBILOSTCON - As a result of a blow or jolt to the head, have you ever been knocked out or lost consciousness?

Please think about all head injuries, for example, from playing sports, car accidents, falls, or being hit by something or someone.

1. Yes [goto TBICHKCONC]
2. No

TBIDAZED - As a result of a blow or jolt to the head, have you ever been dazed or had a gap in your memory?

Please think about all head injuries, for example, from playing sports, car accidents, falls, or being hit by something or someone.

1. Yes
2. No

TBIHEADSYM - As a result of a blow or jolt to the head, have you had headaches, vomiting, blurred vision, or changes in mood or behavior?

Please think about all head injuries, for example, from playing sports, car accidents, falls, or being hit by something or someone.

1. Yes
2. No

TBICHKCONC - Have you ever been checked for a concussion or brain injury by a doctor, nurse, athletic trainer, or other health care professional?

1. Yes
2. No [goto LASTDR]

TBIDRCONC - Did a doctor, nurse, athletic trainer, or other health care professional ever say that you had a concussion or brain injury?

1. Yes
2. No

Section 2: Your Health Care

LASTDR - Not including dental care, about how long has it been since you last saw a doctor or other health professional about your health?

1. Within the past 12 months
2. A year ago or more, but less than 2 years ago
3. 2 or more years ago
4. Never [goto USUALPL]

TIMEALONE - At this LAST medical care visit, did you have a chance to speak with a doctor or other health professional privately, without a parent or guardian in the room?

1. Yes
2. No

WELLNESS - Was this a wellness visit, physical, or general purpose check-up?

This kind of visit typically includes: height and weight measurements, vaccinations, and vision or hearing checks. The doctor or other health professional may also discuss topics related to your health such as growth and development, diet and exercise, safety, and sleep patterns. These visits are usually scheduled in advance and occur when you are not sick.

If a wellness exam was combined with a sick care visit, include this visit.

An obstetrician/gynecologist (OB/GYN) may perform this visit.

1. Yes [goto NEWCHANGES if LASTDR=1; OTHERVISIT if LASTDR=2,3]
2. No

WELLVIS - About how long has it been since you last saw a doctor or other health professional for a wellness visit, physical, or general purpose check-up?

This kind of visit typically includes: height and weight measurements, vaccinations, and vision or hearing checks. The doctor or other health professional may also discuss topics related to your health such as growth and development, diet and exercise, safety, and sleep patterns. These visits are usually scheduled in advance and occur when you are not sick.

If a wellness exam was combined with a sick care visit, include this visit.

An obstetrician/gynecologist (OB/GYN) may perform this visit.

1. Within the past 12 months
2. A year ago or more, but less than 2 years ago
3. 2 or more years ago
4. Never [goto NEWCHANGES if LASTDR=1; OTHERVISIT if LASTDR=2,3]

PTIMEALONE – At this LAST wellness visit, physical, or general purpose check-up, did you have a chance to speak with a doctor or other health professional privately, without a parent or guardian in the room?

1. Yes [goto OTHERVISIT if WELLVIS=2,3,4 and LASTDR=2,3]
2. No [goto OTHERVISIT if WELLVIS=2,3,4 and LASTDR=2,3]

NEWCHANGES - During the past 12 months, has a doctor or other health professional talked to you about understanding the changes in health care that happen at age 18?

This can include understanding changes in privacy, consent, access to information, or decision-making

1. Yes
2. No

GAINSKILLS - During the past 12 months, has a doctor or other health professional talked to you about gaining skills to manage your health and health care?

1. Yes
2. No

TALKSMK - During the past 12 months, has a doctor or other health professional asked you about using tobacco products or smoking?

This can include asking about using e-cigarettes (electronic cigarettes) or vaping.

1. Yes
2. No

SCRNMENTAL - During the past 12 months, has a doctor or other health professional asked you about your mental or emotional health?

This could include you filling out a questionnaire about how you have been feeling recently.

1. Yes
2. No

SHEALTH - During the past 12 months, has a doctor or other health professional talked with you about changes to your developing body, or safe sex practices?

1. Yes
2. No

OTHERVISIT - Have you ever had a visit with a doctor or other health professional that your parents or guardians didn't know about?

1. Yes
2. No [goto USUALPL]

OTHERTYPE - What type of doctor visit or health service was it? (Please select all that apply)

1. Mental health professional visit
2. Women's health specialist visit
3. Other (specify)

USUALPL - Is there a place that you usually go to if you are sick and need health care?

1. Yes, there is ONE or MORE THAN ONE place
2. No, there is NO place [goto PERSONALDOC]

USPLKIND - What kind of place do you go to most often?

A doctor's office or health center is a place where you see the same doctor or the same group of doctors every visit, where you usually need to make an appointment ahead of time, and where your medical records are on file.

Urgent care centers, and clinics in a drug store or grocery store are places where you do not need to make an appointment ahead of time, and do not usually see the same health care provider at each visit.

1. A doctor's office or health center
2. An urgent care center
3. A clinic in a drug store or grocery store
4. A hospital emergency room
5. Some other place

PERSONALDOC - Do you have one or more persons you think of as your personal doctor or nurse?

A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.

1. Yes
2. No

MEDITATE - Meditation includes mindfulness, mantra, and spiritual meditation. During the past 12 months did you use any of these types of meditation?

1. Yes
2. No

YOGA - During the past 12 months did you practice yoga?

1. Yes
2. No

CHIRO - During the past 12 months did you see a chiropractor?

1. Yes
2. No

Section 3: Your Mental Health and Supports

MHRX - During the past 12 months, did you take any prescription medication to help with your emotions, concentration, behavior, or mental health?

1. Yes
2. No

MHTHRPY - During the past 12 months, did you receive counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker?

1. Yes
2. No

MHTHND - During the past 12 months, was there any time when you needed counseling or therapy from a mental health professional, but DID NOT GET IT because of cost?

1. Yes
2. No

MHTHNDSGMA - During the past 12 months, was there any time when you needed counseling or therapy from a mental health professional, but DID NOT GET IT because you were afraid of what others would think of you?

1. Yes
2. No

MHTHNDDKH - During the past 12 months, was there any time when you needed counseling or therapy from a mental health professional, but DID NOT GET IT because you didn't know where to go or how to get help?

1. Yes
2. No

SUPPORT - How often do you get the social and emotional support you need?

1. Always
2. Usually
3. Sometimes
4. Rarely
5. Never

FRIENDSHELP - How much can you rely on your friends for help if you have a serious problem?

1. A lot
2. Some
3. A little
4. Not at all

FRIENDSOPEN - How much can you open up to your friends if you need to talk about your worries?

1. A lot
2. Some
3. A little
4. Not at all

PARENTSHELP - How much can you rely on your parents or guardians for help if you have a serious problem?

1. A lot
2. Some
3. A little
4. Not at all

PARENTSOPEN - How much can you open up to your parents or guardians if you need to talk about your worries?

1. A lot
2. Some
3. A little
4. Not at all

COMSUPPORT - Other than parents or adults living in your home, is there at least one adult in your school, neighborhood, or community who makes a positive and meaningful difference in your life?

1. Yes
2. No

LEARNDF – Compared with other people your age, do you have difficulty learning things?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

REMEMBERDF – Compared with other people your age, do you have difficulty remembering things?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

BEHDFCNTR - Compared with other people your age, do you have difficulty controlling your behavior?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

BEHDFFCS - Do you have difficulty concentrating on an activity you enjoy doing?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

BEHDFCHG – Do you have difficulty accepting changes in your routine?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

BEHDFMKFR – Do you have difficulty making friends?

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Cannot do at all

PHQ1 - Over the last two weeks, how often have you been bothered by having little interest or pleasure in doing things?

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

PHQ2 - Over the last two weeks, how often have you been bothered by feeling down, depressed, or hopeless?

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

GAD1 - Over the last two weeks, how often have you been bothered by feeling nervous, anxious, or on edge?

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

GAD2 - Over the last two weeks, how often have you been bothered by not being able to stop or control worrying?

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

Section 4: Your Experiences

VIOLENEV - The next set of questions are about events that may have happened during your life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

Have you ever been the victim of violence or witnessed violence in your neighborhood?

1. Yes
2. No

JAILEV1 - Have you ever been separated from a parent or guardian because they went to jail, prison, or a detention center?

1. Yes
2. No

MENTDEPEV - Have you ever lived with someone who was mentally ill or severely depressed?

1. Yes
2. No

ALCDRUGEV - Have you ever lived with someone who was having a problem with alcohol or drug use?

1. Yes
2. No

PGDIE - Have you ever had a parent or guardian die?

1. Yes
2. No

PGDIVSEP - Have you ever had a parent or guardian divorce or separate?

1. Yes
2. No

PUTDOWN - Have you ever lived with a parent or adult who frequently swore at you, insulted you, or put you down?

1. Yes
2. No

BNEEDS - Has there ever been a time when your basic needs were NOT met, such as having enough to eat, being able to go to a doctor when you were sick, or having a safe place to stay?

1. Yes
2. No

UNFAIRRE – Has anyone ever treated or judged you unfairly because of your race or ethnic group?

1. Yes
2. No

UNFAIRSO – Has anyone ever treated or judged you unfairly because of your sexual orientation or gender identity?

1. Yes
2. No

BULLYVIC - The next four questions are about your experiences with bullying. The first two questions are about if you have **been bullied** by other children or teenagers and the next two questions are about if you have **bullied others**.

During the past 12 months, how often were you bullied, picked on, or excluded by other children or teenagers?

If how often you were bullied changed throughout the year, tell us about when you were bullied the most.

1. Never in the past 12 months
2. 1-2 times in the past 12 months
3. 1-2 times per month
4. 1-2 times per week
5. Almost every day

CYBERVIC - During the past 12 months, have you ever been electronically bullied?

Count being bullied through texting, Instagram, Facebook, Snapchat, or other social media.

1. Yes
2. No

BULLYPERP - During the past 12 months, how often did you bully others, pick on them, or exclude them?

If how often you bullied others changed throughout the year, tell us about when you bullied others the most.

1. Never in the past 12 months
2. 1-2 times in the past 12 months
3. 1-2 times per month
4. 1-2 times per week
5. Almost every day

CYBERPERP - During the past 12 months, have you ever electronically bullied others?

Count being bullied through texting, Instagram, Facebook, Snapchat, or other social media.

1. Yes
2. No

RESPECT – In your day-to-day life, how often do any of the following things happen to you?

You are treated with less courtesy or respect than other people your age.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

POORSERVICE – You receive poorer service than other people your age at restaurants or stores.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

NOTSMART - People act as if they think you are not smart.

1. Almost everyday
2. At least once a week
3. A few times a month
4. A few times a year
5. Less than once a year
6. Never

Section 5: About You

AGE – How old are you?

<Enter value>

NATORG - Do you consider yourself to be Hispanic or Latino?

1. Yes
2. No

RACE - What race or races do you consider yourself to be? (Select all that apply)

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Native Hawaiian or Other Pacific Islander
5. Asian
6. Some other race

ORIENT – Which of the following best represents how you think of yourself?

1. Gay or lesbian
2. Straight, that is not gay or lesbian
3. Bisexual
4. Something else
5. I am not sure / I don't know the answer

SEXBIRTH – What sex were you assigned at birth, on your original birth certificate?

1. Male
2. Female
3. I don't know

GENDERID – How do you currently describe yourself?

1. Male
2. Female
3. Transgender
4. None of these
5. I am not sure / I don't know the answer

SCHSTATUS - Are you currently enrolled in school?

1. Yes, a public school
2. Yes, a private school
3. I am homeschooled
4. No, I am not currently enrolled in school

DEVICES - What device or devices did you use to complete this survey? (Select all that apply)

1. Smart phone
2. Tablet or iPad
3. Computer

HOME - Did you complete this survey while you were in your home?

1. Yes
2. No

HELPER - Did anyone help you answer questions in this survey? (Select all that apply)

1. No one helped me
2. Parent or guardian helped me
3. Other family member helped me (NOT a parent or guardian)
4. Friend helped me
5. Someone else helped me

ALONE – Was anyone else in the room when you completed this survey?

1. Yes
2. No

BURDEN - How burdensome was this survey to you?

1. Not at all burdensome
2. A little burdensome
3. Moderately burdensome
4. Very burdensome
5. Extremely burdensome

DIFFICULTY - How easy or difficult was it for you to answer the questions in this survey?

1. Very easy
2. Somewhat easy
3. Somewhat difficult
4. Very difficult

SENSITIVITY - How sensitive were the questions in this survey?

1. Not at all sensitive
2. A little sensitive
3. Moderately sensitive
4. Very sensitive
5. Extremely sensitive

LENGTH - How would you describe the length of this survey?

1. Very long
2. Somewhat long
3. A little long
4. Not at all long