

1

Which of these statements apply to you?

Tick all that apply

- I read a daily newspaper 1
- I have a hobby or pastime 2
- I have taken a holiday in the UK in the last 12 months 3
- I have taken a holiday abroad in the last 12 months 4
- I have gone on a daytrip or outing in the last 12 months 5
- I own a mobile phone 6
- None of these statements apply to me 7

2

Are you a member of any of these organisations, clubs or societies?

Tick all that apply

- Political party, trade union or environmental groups 01
 - Tenants groups, resident groups, Neighbourhood Watch 02
 - Church or other religious groups 03
 - Charitable associations 04
 - Education, arts or music groups or evening classes 05
 - Social clubs 06
 - Sports clubs, gyms, exercise classes 07
 - Any other organisations, clubs or societies 08
 - No, I am not a member of any organisations, clubs or societies 09
- Go to **3**
- Go to **4**

3

Thinking about all the organisations, clubs or societies that you are a member of, how many committee meetings, if any, do you attend in a year? If none, please enter '0'.

Please write the number in this box

4

How easy or difficult is it for you to get to each of the following places using your usual forms of transport?

Tick one box on each line

	Very easy	Quite easy	Quite difficult	Very difficult	Unable to go	Do not wish to go
Bank or cash point	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Post Office	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Corner shop	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Medium or large supermarket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Shopping centre	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
General Practitioner (GP)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Chiropodist	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Dentist	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Optician	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Hospital	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

5

Now some questions about your social activities. How often, if at all, do you do any of the following activities?

Tick one box on each line

	Twice a month or more	About once a month	Every few months	About once or twice a year	Less than once a year	Never
Go to the cinema	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Eat out of the house	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Go to an art gallery or museum	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Go to the theatre, a concert or the opera	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

6

Would you like to do any of the following activities more often but feel that, for whatever reason, you cannot?

Tick one box on each line

	Yes	No
Go to the cinema	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Eat out of the house	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Go to an art gallery or museum	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Go to the theatre, a concert or the opera	<input type="checkbox"/> 1	<input type="checkbox"/> 2

7

We would now like to ask you some questions about your use of the Internet and email.

On average, how often do you use the Internet or email?

Tick one box

- Every day, or almost every day 1
 - At least once a week (but not every day) 2
 - At least once a month (but not every week) 3
 - At least once every 3 months 4
 - Less than every 3 months 5
 - Never 6
- Go to **8**
- Go to **11**

8

In which of the following places have you used the Internet or email in the last 3 months?

Tick all that apply

- At home 1
- At places of work (other than home) 2
- At place of education 3
- At another person's home 4
- On the move 5
- Other place (library, Internet cafe) 6

9

On which of the following devices do you access the Internet?

Tick all that apply

- Desktop computer 1
- Laptop computer 2
- Tablet computer (e.g. iPad, Samsung Galaxy Tab) 3
- Smartphone (e.g. iPhone, Blackberry) 4
- TV (e.g. games console or set top box) 5
- Other mobile devices 6
- Don't know 7
- Do not access Internet 8

10

For which of the following activities did you use the Internet in the last 3 months?

Tick all that apply

- Sending/receiving e-mails 01
- Finding information about goods and services 02
- Searching for information for learning, research, fact finding 03
- Finances (banking, paying bills) 04
- Shopping/ buying goods or services 05
- Selling goods or services over the Internet e.g. via auctions 06
- Use social networking sites (Facebook, Twitter, Myspace) 07
- Creating, uploading or sharing content (Youtube, blogging or Flickr) 08
- News/ newspaper/ blog websites 09
- Streaming/downloading live or on demand TV/radio (BBC iplayer, 4OD, ITV player, Demand 5) music (iTunes, Spotify), or ebooks 10
- Games 11
- Looking for a job or sending a job application 12
- Other 13
- None of the above 14

11

The next two questions are about watching television.

How many hours of television do you watch on an ordinary day or evening during the week, that is, Monday to Friday?

Please write in hours (from 0 to 24)

12

And thinking now about an ordinary weekend. How many hours of television do you normally watch **in total** over the weekend, that is, Saturday **and** Sunday?

Please write in hours (from 0 to 48)

13

Please say how much you agree or disagree with the following statements.

Tick one box on each line

	Strongly agree	Agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Disagree	Strongly disagree
In most ways my life is close to my ideal	<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
The conditions of my life are excellent	<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
I am satisfied with my life	<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
So far I have got the important things I want in life	<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
If I could live my life again, I would change almost nothing	<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

14

Here are some questions about how you feel about your life in general.

Please say how much you agree or disagree with the following statements.

Tick one box on each line

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
At home, I feel I have control over what happens in most situations	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
I feel that what happens in life is often determined by factors beyond my control	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
In general, I have different demands that I think are hard to combine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
In general, I have enough time to do everything	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Considering the things I have to do at home, I have to work very fast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

15

The next questions are about how you feel about different aspects of your life.

For each one, please say how often you feel that way.

Tick one box on each line

	Hardly ever or never	Some of the time	Often
How often do you feel you lack companionship?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
How often do you feel left out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
How often do you feel isolated from others?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
How often do you feel in tune with the people around you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
How often do you feel lonely?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

16

Here is a list of statements that people have used to describe their lives or how they feel. How often, do you feel like this?

Tick one box on each line

	Often	Some- times	Not often	Never
My age prevents me from doing the things I would like to	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel that what happens to me is out of my control	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel free to plan for the future	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel left out of things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I can do the things that I want to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Family responsibilities prevent me from doing what I want to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel that I can please myself what I do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
My health stops me from doing things I want to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Shortage of money stops me from doing the things I want to do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I look forward to each day	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel that my life has meaning	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I enjoy the things that I do	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I enjoy being in the company of others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
On balance, I look back on my life with a sense of happiness	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel full of energy these days	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I choose to do things that I have never done before	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel satisfied with the way my life has turned out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel that life is full of opportunities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I feel that the future looks good for me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

17

Do you have a husband, wife or partner with whom you live?

Tick one box

Yes ₁ → Go to **18**

No ₂ → Go to **20**

18

We would now like to ask you some questions about your spouse or partner. Please tick the box which best shows how you feel about each statement.

Tick one box on each line

A lot Some A little Not at all

How much do they really understand the way you feel about things?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How much can you rely on them if you have a serious problem?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How much can you open up to them if you need to talk about your worries?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How much do they criticise you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How much do they let you down when you are counting on them?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How much do they get on your nerves?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
How often do they make too many demands on you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

19

How close is your relationship with your spouse or partner?

Tick one box

Very close ₁

Quite close ₂

Not very close ₃

Not at all close ₄

20

Do you have any children?

Tick one box

Yes ₁ → Go to **21**

No ₂ → Go to **24**

21

We would now like to ask you some questions about your children. Please tick the box which best shows how you feel about each statement.

Tick one box on each line

A lot Some A little Not at all

How much do they really understand the way you feel about things? ₁ ₂ ₃ ₄

How much can you rely on them if you have a serious problem? ₁ ₂ ₃ ₄

How much can you open up to them if you need to talk about your worries? ₁ ₂ ₃ ₄

How much do they criticise you? ₁ ₂ ₃ ₄

How much do they let you down when you are counting on them? ₁ ₂ ₃ ₄

How much do they get on your nerves? ₁ ₂ ₃ ₄

How often do they make too many demands on you? ₁ ₂ ₃ ₄

22

On average, how often do you do each of the following with **any** of your children, not counting any who live with you?

Tick one box on each line

Three or more times a week Once or twice a week Once or twice a month Every few months Once or twice a year Less than once a year or never

Meet up (include both arranged and chance meetings) ₁ ₂ ₃ ₄ ₅ ₆

Speak on the phone ₁ ₂ ₃ ₄ ₅ ₆

Write or email ₁ ₂ ₃ ₄ ₅ ₆

Send or receive text messages ₁ ₂ ₃ ₄ ₅ ₆

23

How many of your children would you say you have a close relationship with?

Please write the number in this box

24 Do you have any other immediate family, for example, any brothers or sisters, parents, cousins or grandchildren?

Tick one box

Yes ₁ → Go to **25**

No ₂ → Go to **28**

25 We would now like to ask you some questions about these family members. Please tick the box which best shows how you feel about each statement.

Tick one box on each line

A lot Some A little Not at all

How much do they really understand the way you feel about things? ₁ ₂ ₃ ₄

How much can you rely on them if you have a serious problem? ₁ ₂ ₃ ₄

How much can you open up to them if you need to talk about your worries? ₁ ₂ ₃ ₄

How much do they criticise you? ₁ ₂ ₃ ₄

How much do they let you down when you are counting on them? ₁ ₂ ₃ ₄

How much do they get on your nerves? ₁ ₂ ₃ ₄

How often do they make too many demands on you? ₁ ₂ ₃ ₄

26 On average, how often do you do each of the following with any of these family members, not counting any who live with you?

Tick one box on each line

Three or more times a week Once or twice a week Once or twice a month Every few months Once or twice a year Less than once a year or never

Meet up (include both arranged and chance meetings) ₁ ₂ ₃ ₄ ₅ ₆

Speak on the phone ₁ ₂ ₃ ₄ ₅ ₆

Write or email ₁ ₂ ₃ ₄ ₅ ₆

Send or receive text messages ₁ ₂ ₃ ₄ ₅ ₆

27 How many of these family members would you say you have a close relationship with?

Please write the number in this box

28

Do you have any friends?

Tick one box

Yes ₁ → Go to **29**

No ₂ → Go to **32**

29

We would now like to ask you some questions about your friends.
Please tick the box which best shows how you feel about each statement.

Tick one box on each line

A lot Some A little Not at all

How much do they really understand the way you feel about things? ₁ ₂ ₃ ₄

How much can you rely on them if you have a serious problem? ₁ ₂ ₃ ₄

How much can you open up to them if you need to talk about your worries? ₁ ₂ ₃ ₄

How much do they criticise you? ₁ ₂ ₃ ₄

How much do they let you down when you are counting on them? ₁ ₂ ₃ ₄

How much do they get on your nerves? ₁ ₂ ₃ ₄

How often do they make too many demands on you? ₁ ₂ ₃ ₄

30

On average, how often do you do each of the following with **any** of your friends, not counting any who live with you?

Tick one box on each line

Three or more times a week Once or twice a week Once or twice a month Every few months Once or twice a year Less than once a year or never

Meet up (include both arranged and chance meetings) ₁ ₂ ₃ ₄ ₅ ₆

Speak on the phone ₁ ₂ ₃ ₄ ₅ ₆

Write or email ₁ ₂ ₃ ₄ ₅ ₆

Send or receive text messages ₁ ₂ ₃ ₄ ₅ ₆

31

How many of your friends would you say you have a close relationship with?

Please write the number in this box

32

The next questions are about paid employment.
Were you in paid employment last month?

Tick one box

Yes ₁ → Go to **33**

No ₂ → Go to **35**

33

Here are some statements people might use to describe their work. We would like to know how strongly you think these apply to the paid employment you did in the last month.

Tick one box on each line

	Strongly agree	Agree	Disagree	Strongly disagree
All things considered I am satisfied with my job	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
My job is physically demanding	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
I receive the recognition I deserve for my work	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
My salary is adequate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
My job promotion prospects are poor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
My job security is poor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
I am under constant time pressure due to a heavy workload	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
I have very little freedom to decide how I do my work	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
I have the opportunity to develop new skills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
I receive adequate support in difficult situations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
At work, I feel I have control over what happens in most situations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Considering the things I have to do at work, I have to work very fast	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

34

At what age would you like to retire?

Write in years

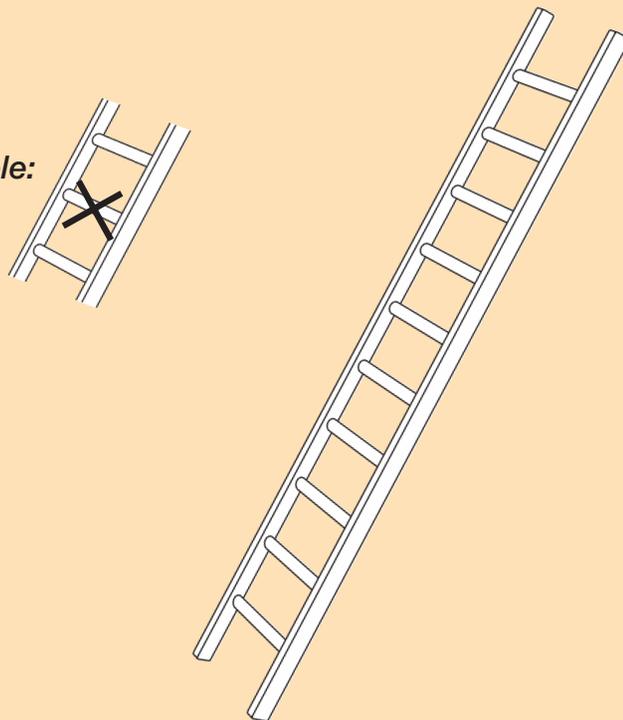
I have already retired ₁

35

Think of this ladder as representing where people stand in our society. At the top of the ladder are the people who are the best off – those who have the most money, most education and best jobs. At the bottom are the people who are the worst off – who have the least money, least education, and the worst jobs or no jobs. The higher up you are on this ladder, the closer you are to the people at the very top and the lower you are, the closer you are to the people at the very bottom.

Please mark a cross on the **rung** on the ladder where you would place yourself.

Example:



36

Now, please pause briefly to think about **yesterday**, from the morning until the end of the day. Think about where you were, what you were doing, who you were with, and how you felt.

What day of the week was it **yesterday**?

Tick one box

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<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

37

What time did you wake up **yesterday**?

For example, if you woke up at 4:00AM, please write 04 in the hour boxes, 00 in the minutes boxes and AM in the last boxes.

Hours Minutes AM or PM

38

What time did you go to sleep at the end of the day **yesterday**?

For example, if you went to sleep at 11:30PM, please write 11 in the hour boxes, 30 in the minutes boxes and PM in the last boxes

Hours Minutes AM or PM

39 Yesterday, did you feel any pain?

Tick one box

None 1

A little 2

Some 3

Quite a bit 4

A lot 5

40 Did you feel well-rested yesterday morning (that is you slept well the night before)?

Tick one box

Yes 1

No 2

41 Was yesterday a normal day for you or did something unusual happen?

Tick one box

Yes – just a normal day 1

No, my day included unusual bad (stressful) things 2

No, my day included unusual good things 3

42 Please think about the things you did yesterday. How did you spend your time and how did you feel?

Yesterday did you watch TV?

Tick one box

Yes 1 → Go to **43**

No 2 → Go to **45**

43 How much time did you spend watching TV yesterday?

For example, if you spent one and a half hours, write 1 in the hours box and 30 in the minutes boxes.

Hours Minutes

44 How did you feel when you were **watching TV** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Interested	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Frustrated	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Sad	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

45 Yesterday did you **work or volunteer**?

Tick one box

Yes 1 → Go to **46**

No 2 → Go to **48**

46 How much time did you spend **working or volunteering** yesterday?

For example, if you spent nine and a half hours, write 9 in the hours box and 30 in the minutes box.

Hours Minutes

47 How did you feel when you were **working or volunteering** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Interested	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Frustrated	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Sad	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

48 Yesterday did you **go for a walk or exercise**?

Tick one box

Yes ₁ → Go to **49**

No ₂ → Go to **51**

49 How much time did you spend **walking or exercising** yesterday?

Hours Minutes

50 How did you feel when you were **walking or exercising** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Interested	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Frustrated	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Sad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

51 Yesterday did you do any **health-related activities other than walking or exercise**?
For example, visiting a doctor, taking medications or doing treatments.

Tick one box

Yes ₁ → Go to **52**

No ₂ → Go to **54**

52 How much time did you spend doing **health-related activities** yesterday?

Hours Minutes

53 How did you feel when you were doing **health-related activities** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Interested	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Frustrated	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Sad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

54

Yesterday did you **travel or commute**? E.g. by car, train, bus etc.

Tick one box

Yes ₁ → Go to **55**

No ₂ → Go to **57**

55

How much time did you spend **travelling or commuting** yesterday?

Hours Minutes

56

How did you feel when you were **travelling or commuting** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Interested	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Frustrated	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Sad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

57

Yesterday did you **spend time with friends or family**?

Tick one box

Yes ₁ → Go to **58**

No ₂ → Go to **60**

58

How much time did you spend **with friends or family** yesterday?

Hours Minutes

59

How did you feel when you were **with friends or family** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick one box on each line

	Did not experience the feeling at all					Feeling was extremely strong
	1	2	3	4	5	6
Happy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Interested	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Frustrated	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Sad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

60

Yesterday did you **spend time at home by yourself**? Without a spouse, partner, or anyone else present.

Tick *one* box

Yes ¹ → Go to **61**

No ² → Go to **63**

61

How much time did you spend **at home by yourself** yesterday?

Hours Minutes

62

How did you feel when you were **at home by yourself** yesterday?

Rate each feeling on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.

Tick *one* box on each line

	Did not experience the feeling at all						Feeling was extremely strong					
	1	2	3	4	5	6	1	2	3	4	5	6
Happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

63

Overall, how **happy** did you feel **yesterday**?

Not at all	0	1	2	3	4	5	6	7	8	9	10	Very	Don't know
	<input type="checkbox"/>												

64

Overall, how **anxious** did you feel **yesterday**?

Not at all	0	1	2	3	4	5	6	7	8	9	10	Very	Don't know
	<input type="checkbox"/>												

65

Overall, how **satisfied** are you with your life nowadays?

Not at all	0	1	2	3	4	5	6	7	8	9	10	Very	Don't know
	<input type="checkbox"/>												

66 Overall, to what extent do you feel the things you do in your life are worthwhile?

Not at all Very Don't know

0 1 2 3 4 5 6 7 8 9 10 11

⁰⁰ ⁰¹ ⁰² ⁰³ ⁰⁴ ⁰⁵ ⁰⁶ ⁰⁷ ⁰⁸ ⁰⁹ ¹⁰ ¹¹

67 How many portions of vegetables – excluding potatoes – do you eat on a typical day?

If none, please enter '0'.

A serving or portion of vegetables means three heaped tablespoons of green or root vegetables such as carrots, parsnips, spinach, small vegetables like peas, baked beans or sweet corn, or a medium bowl of salad (lettuce, tomatoes, etc).

Please write in portion

How many portions of fruit – of any kind – do you eat on a typical day?
If none, please enter '0'.

A portion of fruit is an apple or banana, a small bowl of grapes, or three tablespoons of tinned or stewed fruit. If you drink fruit juice, you can count one glass per day, but additional glasses of fruit juice do not count as additional portions.

Please write in portion

68 Thinking now about all kinds of drinks, how often have you had an alcoholic drink of any kind during the last 12 months?

Tick one box

Almost every day	<input type="checkbox"/> 1	} → Go to 69
Five or six days a week	<input type="checkbox"/> 2	
Three or four days a week	<input type="checkbox"/> 3	
Once or twice a week	<input type="checkbox"/> 4	
Once or twice a month	<input type="checkbox"/> 5	
Once every couple of months	<input type="checkbox"/> 6	
Once or twice a year	<input type="checkbox"/> 7	
Not at all in the last 12 months	<input type="checkbox"/> 8	} → Go to 74

69 Did you have an alcoholic drink in the seven days ending yesterday?

Tick one box

Yes ¹ → **Go to 70**

No ² → **Go to 74**

70 On how many days out of the last seven did you have an alcoholic drink?

Tick one box

1	2	3	4	5	6	7
<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

71 During the last seven days, how many measures of spirits did you have? Drinks poured at home may be larger than a pub single measure – please estimate number of singles. If none, please enter '0'.

Please write the number in this box

72 During the last seven days, how many glasses of wine did you have? Include sherry, port, vermouth. If none, please enter '0'.

Please write the number in this box

73 During the last seven days, how many pints of beer, lager or cider did you have? If none, please enter '0'.

Please write the number in this box

74 If there is anything else you would like to tell us, please write in the space below. We shall be very interested to read what you have to say.

Thank you very much for taking the time to answer our questions.

Please give the questionnaire to the interviewer, or post back in the envelope provided. All your answers will remain confidential in accordance with the Data Protection Act 1998.