



Studying Physical Activity in Childrens Environments across Scotland



We are trying to find out about your level of physical activity from **the last 7 days** (in the last week). This includes sports or dance that make you sweat or make your legs feel tired, or games that make you breathe hard, like tag, skipping, running, climbing, and others.

## Remember

- 1 There are no right or wrong answers  
— this is not a test.
- 2 Please answer all the questions as honestly and accurately as you can  
— this is very important.



The University of Glasgow, charity number SC004401





**1****Physical activity in your spare time:**

Have you done any of the following activities in the past 7 days (last week) and if so, how many times?

Please tick **ONE BOX** on each line

	No	1 – 2 times	3 – 4 times	5 – 6 times	7 times or more
Skipping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rowing/canoeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roller skating/blading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tag/Chases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking for exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bicycling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jogging or running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aerobics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baseball, softball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rugby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Badminton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skateboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Football	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volleyball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick **ONE BOX** on each line

	No	1 – 2 times	3 – 4 times	5 – 6 times	7 times or more
Hockey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basketball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice skating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skiing/Snowboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice hockey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please <b>write in</b> )					
 _____	<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"/>

**2**

In the last 7 days, during your physical education (PE) classes, how often were you very active (playing hard, running, jumping, throwing)?

Please tick **ONE BOX** only

I don't do PE	<input type="checkbox"/>
Hardly ever	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Quite often	<input type="checkbox"/>
Always	<input type="checkbox"/>

**3**

**In the last 7 days, what did you do most of the time AT INTERVAL/BREAK?**

Please tick **ONE BOX** only

Sat down (talking, reading, doing schoolwork)

Stood around or walked around

Ran or played a little bit

Ran around and played quite a bit

Ran and played hard most of the time

**4**

**In the last 7 days, what did you do most of the time AT LUNCH (besides eating lunch)?**

Please tick **ONE BOX** only

Sat down (talking, reading, doing schoolwork)

Stood around or walked around

Ran or played a little bit

Ran around and played quite a bit

Ran and played hard most of the time

**5**

**In the last 7 days, on how many days RIGHT AFTER SCHOOL did you do sports, dance or play games in which you were very active?**

Please tick **ONE BOX** only

None	<input type="checkbox"/>
1 time last week	<input type="checkbox"/>
2 or 3 times last week	<input type="checkbox"/>
4 times last week	<input type="checkbox"/>
5 times last week	<input type="checkbox"/>

**6**

**In the last 7 days, on how many EVENINGS did you do sports, dance or play games in which you were very active?**

Please tick **ONE BOX** only

None	<input type="checkbox"/>
1 time last week	<input type="checkbox"/>
2 or 3 times last week	<input type="checkbox"/>
4 times last week	<input type="checkbox"/>
5 times last week	<input type="checkbox"/>

**7**

**ON THE LAST WEEKEND, how many times did you do sports, dance, or play games in which you were very active?**

Please tick **ONE BOX** only

	None	<input type="checkbox"/>
	1 time	<input type="checkbox"/>
	2 – 3 times	<input type="checkbox"/>
	4 – 5 times	<input type="checkbox"/>
	6 or more times	<input type="checkbox"/>

**8**

**Which ONE of the following describes you best for the last 7 days? Read ALL FIVE statements before deciding on the ONE answer that describes you.**

Please tick **ONE BOX** only

<b>A</b>	All or most of my free time was spent doing things that involve little physical effort.	<input type="checkbox"/>
<b>B</b>	I sometimes (1 – 2 times last week) did physical things in my free time (like played sports, went running, swimming, bike riding, did aerobics)	<input type="checkbox"/>
<b>C</b>	I often (3 – 4 times last week) did physical things in my free time	<input type="checkbox"/>
<b>D</b>	I quite often (5 – 6 times last week) did physical things in my free time	<input type="checkbox"/>
<b>E</b>	I very often (7 or more times last week) did physical things in my free time	<input type="checkbox"/>

**9****Mark how often you did physical activity (like playing sports, games, doing or any other physical activity) for each day last week.**Please tick **ONE BOX** on each line

	None	Little bit	Medium	Often	Very often
Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saturday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10****Were you sick last week, or did anything prevent you from doing your normal physical activities?**Please tick **ONE BOX**Yes No **If YES, what prevented you?**Please **WRITE IN****THANK YOU****Please ensure you have tried your best to complete all 10 questions and that you have not missed any by mistake.**