The Longest Walk 5- Community Survey

1. What community do you live in? _____ What is your zip code? _____

2. What is your race? __Native American/Alaska Native __African American/Black __Hispanic/Latino __Non-Hispanic White __Asian/Pacific Islander Other_____

3. If Native American, First Nations or Alaska Native, what tribe (s) do you identify with?
_____

4. Are you enrolled in your tribe? ☐ Yes ☐ No ☐ Pending enrollment ☐ Dis-enrolled

5. Age: _____ Gender **(Circle all that apply):** ☐Male ☐ Female ☐Transgender ☐Two-spirit

6. Pregnancy Status: ☐ currently pregnant ☐ not pregnant ☐ I want to become pregnant within the next year

7. Relationship Status (circle one)

___Married or domestic partnership	___Divorced	___Separated
___Single	___Widowed	___In a long term relationship

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8. Are you currently abusing or addicted to drugs and/or alcohol OR have been in the past: ☐Yes ☐ No
If "NO" skip to question 17.

9. Are you currently using drugs or alcohol? ☐ Yes ☐ No If "Yes," check all that apply

___ Alcohol	___ Cocaine	___ Prescription Opiates
___ Marijuana	___ Heroin	___ Huffing
___ Meth	___ Alcohol	___ Ecstasy
___ Crack	___ Benzos	___ Other_____

10. What is your preferred drug or alcohol you like (d) to use (write in)? _____

11. Do you currently have an addiction and abuse problems with alcohol? ☐ Yes ☐ No ☐ I don't know

12. Are you currently in recovery? ☐ Yes ☐ No

13. How long have you been clean from your addiction (months, days or years)? _____

14. Have you ever gone to a drug and alcohol treatment center? ☐ Yes ☐ No

15. Was the treatment center successful in helping you with your addiction? ☐ Yes ☐ No ☐ Somewhat ☐ Doesn't apply to me

16. Have you ever had addiction problems in the past? If so, what did you use?

	___ Heroin	___ Ecstasy
___ Marijuana	___ Alcohol	___ Other_____
___ Meth	___ Benzos	
___ Crack	___ Prescription Opiates	
___ Cocaine	___ Huffing	

17.	Depression	Anxiety	PTSD	Other (write-in)
Do you suspect you may have the following diagnosis?	☐	☐	☐	
Have you ever been diagnosed with?	☐	☐	☐	
Do you receive regular treatment for these diagnoses?	Yes ☐	No ☐		

18. During the first 18 years of your life did you experience any of the situations listed below? (Check Yes or No)	**Yes**	**No**
Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? OR Act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR Attempt to actually have oral, anal, or vaginal intercourse with you?		
Did you often or very often feel that no one in your family loved you or thought you were important or special? OR Your family didn't look out for each other, feel close to each other, or support each other?		
Did you often or very often feel that you didn't have enough to eat, had to wear dirty cloths, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother or step mother often or very often pushed, grabbed, slapped, or had something thrown at her? Sometimes, often or very often kicked, bitten, hit with a fist or hit with something hard? OR Ever repeatedly hit for at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill, or did a household member attempt suicide?		
Did a household member go to prison?		

19. Has anyone every abused you? ☐ Yes ☐ No ☐ I am not sure

20. If "Yes" how? (circle all that apply)

☐ Physically abused me ☐ Sexually abused me
☐ Verbally Abused me ☐ Mentally abused me ☐Other_____

21. If "Yes" who? (circle all that apply)

☐ Mother	☐ Husband	☐ Auntie	☐Grandmother	Other: _____
☐ Father	☐ Wife	☐ Uncle	☐ Grandfather	
☐ Boyfriend	☐ Brother	☐ Cousin	☐ Daughter	
☐ Girlfriend	☐ Sister	☐	☐ Son	

22. Are you in a relationship right now in which you have been physically hurt or threatened by your partner? ☐ Yes ☐ **No**

23. Do you think you are in a healthy relationship with your current partner? ☐ Yes ☐ No ☐ I am not sure

24. Has any health professional ever asked you about domestic violence? ☐ Yes ☐ No ☐ I am not sure

25. Do feel like there is enough help available for you to get out of an abusive relationship? ☐ Yes ☐ No

26. Please explain anything you would like to share with us about your experiences physical, sexual or emotional abuse.

27. What can your tribe or community do to support you, your family and friends to be well?

28. What cultural events or ceremonies are needed to stop drug use and domestic violence in your community?

29. What are the strengths you have seen in your community?

30. What is missing in your community that would help people to be healthy and live quality lives?

31. Please share anything you would like to help us understand your community's needs.