



Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

CHECK ITEM 3.11 For every drug category marked in 1a, mark the corresponding category below and ask 2a-g for each marked drug category.	2a. How old were you when you FIRST used <i>(Name of drug category)</i> ?	b. Did you use <i>(Name of drug category)</i> in the last 12 months only, before the last 12 months only, or during both time periods?	c. During the last 12 months, about how often did you use <i>(Name of drug category)</i> ? SHOW FLASHCARD 41	d. When was the most recent time you used <i>(Name of drug category)</i> ?	e. Think about the time when you were using <i>(Name of drug category)</i> the MOST. At that time about how often did you use <i>(it/them)</i> ? (SHOW FLASHCARD 42)	f. About how old were you when you FIRST BEGAN using <i>(Name of drug category)</i> that frequently?	g. About how long did that period last when you were using <i>(Name of drug category)</i> that frequently? <i>(If less than 1 week enter 1 week)</i>
1 <input type="checkbox"/> Sedatives or Tranquilizers	_____ Age	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to	__ __	_____ Day(s) ago OR _____ Week(s)	__ __	_____ Age	_____ Week(s) OR _____

		last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods		____ ago OR ____ Month(s) ago OR ____ Year(s) ago			Month(s) OR ____ Year(s)
2 <input type="checkbox"/> Painkillers	Age ____	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods	__ __	____ Day(s) ago OR ____ Week(s) ago OR ____ Month(s) ago OR ____ Year(s) ago	__ __	Age ____	____ Week(s) OR ____ Month(s) OR ____ Year(s)
3 <input type="checkbox"/> Marijuana	Age ____	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i>	__ __	____ Day(s) ago OR ____ Week(s) ago OR ____ Month(s) ago OR ____ Year(s)	__ __	Age ____	____ Week(s) OR ____ Month(s) OR ____ Year(s)

		3 <input type="checkbox"/> Both time periods		ago			
4 <input type="checkbox"/> Cocaine or Crack	Age _____	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods	__ __	_____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	__ __	Age _____	_____ Week(s) OR _____ Month(s) OR _____ Year(s)
5 <input type="checkbox"/> Stimulants	Age _____	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods	__ __	_____ Day(s) ago OR _____ Week(s) ago OR _____ Month(s) ago OR _____ Year(s) ago	__ __	Age _____	_____ Week(s) OR _____ Month(s) OR _____ Year(s)
6 <input type="checkbox"/> Club drugs	_____	1 <input type="checkbox"/> Last 12	__ __	_____ Day(s)	__ __	_____	_____

	Age	months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods		____ ago OR ____ Week(s) ago OR ____ Month(s) ago OR ____ Year(s) ago		Age	Week(s) OR ____ Month(s) OR ____ Year(s)
7 <input type="checkbox"/> Hallucinogens	Age	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only - <i>Go to next drug category</i> 3 <input type="checkbox"/> Both time periods	__ __	____ Day(s) ago OR ____ Week(s) ago OR ____ Month(s) ago OR ____ Year(s) ago	__ __	Age	____ Week(s) OR ____ Month(s) OR ____ Year(s)
8 <input type="checkbox"/> Inhalants/Solvents	Age	1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Prior to last 12 months only -	__ __	____ Day(s) ago OR ____ Week(s) ago OR ____	__ __	Age	____ Week(s) OR ____ Month(s) OR

		Go to next drug category 3 [] Both time periods		Month(s) ago OR Year(s) ago			Year(s)
9 [] Heroin	Age	1 [] Last 12 months only 2 [] Prior to last 12 months only - Go to next drug category 3 [] Both time periods	__ __	Day(s) ago OR Week(s) ago OR Month(s) ago OR Year(s) ago	__ __	Age	Week(s) OR Month(s) OR Year(s)
10 OTHER	Age	1 [] Last 12 months only 2 [] Prior to last 12 months only - Go to next drug category 3 [] Both time	__ __	Day(s) ago OR Week(s) ago OR Month(s) ago OR Year(s) ago	__ __	Age	Week(s) OR Month(s) OR Year(s)

		periods					
CHECK ITEM 3.12 What is the time period marked in 2b for marijuana? When did respondent use marijuana?				1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before last 12 months only - <i>SKIP to 4</i> 3 <input type="checkbox"/> Both time periods 4 <input type="checkbox"/> Never - <i>SKIP to Check Item 3.13</i>			
3. Now I would like to know a little more about your use of marijuana. On the days that you used marijuana in the last 12 months, about how many joints did you usually smoke in a single day?				_____ Number			
4. (Now I would like to know a little more about your use of marijuana.) At the time you were using marijuana the MOST, about how many joints did you usually smoke in a single day?				_____ Number			
CHECK ITEM 3.13 What is the time period marked in 2b for cocaine or crack? When did respondent use cocaine or crack?				1 <input type="checkbox"/> Last 12 months only 2 <input type="checkbox"/> Before last 12 months only - <i>SKIP to 6</i> 3 <input type="checkbox"/> Both time periods 4 <input type="checkbox"/> Never - <i>SKIP to Check Item 3.13A</i>			
5. Now I would like to know a little more about your use of cocaine or crack. On the days that you used cocaine or crack in the last 12 months, about how many grams, lines or rocks did you usually use in a single day?				_____ Gram(s) OR _____ Line(s) OR			

	_____ Rock(s)
6. (Now I would like to know a little more about your use of cocaine or crack.) At the time you were using cocaine or crack the MOST, about how many grams, lines or rocks did you usually use in a single day?	_____ Gram(s) OR _____ Line(s) OR _____ Rock(s)
7a. In which of the following ways have you used cocaine or crack? <i>Read each response category.</i> <i>Mark (X) all that apply,</i>	1 <input type="checkbox"/> IV, through the veins? 2 <input type="checkbox"/> Injection under the skin? 3 <input type="checkbox"/> Smoking, freebasing? 4 <input type="checkbox"/> Snorting, sniffing, breathing? 5 <input type="checkbox"/> By mouth, drinking? 6 <input type="checkbox"/> Other method?
CHECK ITEM 3.13A Is respondent only a marijuana user?	1 <input type="checkbox"/> Yes - <i>END QUESTIONS</i> 2 <input type="checkbox"/> No
CHECK ITEM 3.13B Did respondent use stimulants in the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.13C</i>
7b. In the last 12 months, did you use Add'-erall, Concerta, Sy'-lert, Pro-vig'-il, Ritalin, Dexedrine, or any other prescription stimulants ON YOUR OWN?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. In the last 12 months, did you use a stimulant other than a prescription stimulant?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<p>CHECK ITEM 3.13C</p> <p>Did respondent use stimulants before 12 months ago?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 8</i></p>
<p>7d. Did you use Add'-erall, Concerta, Sy'-lert, Pro-vig'-il, Ritalin, Dexedrine, or any other prescription stimulants ON YOUR OWN before 12 months ago?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>e. Did you use a stimulant other than a prescription stimulant before 12 months ago?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>8. Have you EVER taken ANY medicines or drugs that we just talked about ON YOUR OWN by injection with a needle?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>END QUESTIONS</i></p>
<p>9. Did you take ANY medicines or drugs that we just talked about ON YOUR OWN by injection with a needle in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 12</i></p>
<p>10. About how often in the last 12 months, did you inject a medicine or drug with a needle?</p>	<p>1 <input type="checkbox"/> Every day</p> <p>2 <input type="checkbox"/> Nearly every day</p> <p>3 <input type="checkbox"/> 3 to 4 times a week</p> <p>4 <input type="checkbox"/> 1 to 2 times a week</p> <p>5 <input type="checkbox"/> 2 to 3 times a month</p> <p>6 <input type="checkbox"/> Once a month</p> <p>7 <input type="checkbox"/> 7 to 11 times in the last year</p> <p>8 <input type="checkbox"/> 3 to 6 times in the last year</p> <p>9 <input type="checkbox"/> 2 times in the last year</p>

	10 <input type="checkbox"/> Once in the last year
11. Did you take ANY medicines or drugs that we just talked about ON YOUR OWN by injection with a needle BEFORE 12 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i>
(SHOW FLASHCARD 41) 12. Think about a time when you were taking a medicine or drug by injection with a needle the MOST. At that time about how often did you inject a medicine or drug?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 1 to 2 times a week 5 <input type="checkbox"/> 2 to 3 times a month 6 <input type="checkbox"/> Once a month 7 <input type="checkbox"/> 7 to 11 times in the last year 8 <input type="checkbox"/> 3 to 6 times in the last year 9 <input type="checkbox"/> 2 times in the last year 10 <input type="checkbox"/> Once in the last year
13. About how long did that period last when you were taking a medicine or drug by injection the MOST? (If less than 1 week enter 1 week)	____ Week(s) OR ____ Month(s) OR ____ Year(s)
14. About how old were you when you first injected any medicine or drug?	____ Age
CHECK ITEM 3.13D Did respondent inject any medicines or	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16</i>

drugs in the last 12 months?	
<p>15. I would like to ask you a few questions about needle sharing. By needle sharing, I mean using someone else's needles, syringes, or other injection equipment, like filters, spoons, cookers or washers, or letting someone else use yours.</p> <p>In the last 12 months did you take ANY medicines or drugs using a needle or other injection equipment that you knew or suspected had been used by someone else, or did you let someone else use yours?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 3.13E</p> <p>Did respondent inject any medicine or drug before 12 months ago?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>SKIP to 17</i></p>
<p>16. (I would like to ask you a few questions about needle sharing. By needle sharing, I mean using someone else's needles, syringes, or other injection equipment, like filters, spoons, cookers or washers, or letting someone else use yours.</p> <p>BEFORE 12 months ago did you take ANY medicines or drugs using a needle or other injection equipment that you knew or suspected had been used by someone else, or did you let someone else use yours? Did this happen BEFORE 12 months ago?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 3.14</p> <p>Is 15 or 16 marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No - <i>END QUESTIONS</i></p>

17. About how many people shared a needle or other injection equipment the last time you shared?

1 ☐ 1

2 ☐ 2

3 ☐ 3

4 ☐ 4

5 ☐ 5 or more

Protocol source: <https://www.phenxtoolkit.org/protocols/view/510405>