

(Project Name / Activity Name)
Pre-activity Evaluation Questionnaire

Participant no.: _____

The following questions concern information about your personal involvement with drugs (not including alcoholic drinks and cigarette) during the past 3 months.

Carefully read each item and decide the most accurate answer to each item. All your answers will be kept confidential. (*Delete as appropriate)

1. In the past 3 months, how many times have you used the following substances:	In the past 3 months		
	Never used	Used occasionally	Used regularly
A. Cannabis / Marijuana / Grass	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
B. Heroin / White Powder	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
C. Ecstasy / E / XTC	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
D. Ketamine / K / K Zai	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
E. Ice	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
F. MX / Methaqualone	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
G. Ng Chai / Give-me-five	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
H. Blue Gremlin	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
I. Zopiclone / Triazolam	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
J. Cocaine / Crack / Coke	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
K. Cough Medicine / Codeine	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
L. Organic Solvents (Thinner)	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
M. Other Drugs (not include drinking alcoholic beverage or smoking cigarette) please specify: _____	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*

Gender: 1 Male 2 Female

Age: _____ years old

Have you joined any of the following activities: (select all that apply)

- 1 *Please list other activities in the programme* 2 *Please list other activities in the programme*
 3 *Please list other activities in the programme* 4 *Please list other activities in the programme*
 5 *Please list other activities in the programme* 6 *Please list other activities in the programme*

~ Thank you ~

(Project Name / Activity Name)
Post-activity Evaluation Questionnaire

Participant no.: _____

The following questions concern information about your personal involvement with drugs (not including alcoholic drinks and cigarette) during the past 3 months.

Carefully read each item and decide the most accurate answer to each item. All your answers will be kept confidential. (*Delete as appropriate)

1. In the past 3 months, how many times have you used the following substances:	In the past 3 months		
	Never used	Used occasionally	Used regularly
A. Cannabis / Marijuana / Grass	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
B. Heroin / White Powder	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
C. Ecstasy / E / XTC	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
D. Ketamine / K / K Zai	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
E. Ice	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
F. MX / Methaqualone	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
G. Ng Chai / Give-me-five	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
H. Blue Gremlin	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
I. Zopiclone / Triazolam	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
J. Cocaine / Crack / Coke	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
K. Cough Medicine / Codeine	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
L. Organic Solvents (Thinner)	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*
M. Other Drugs (not include drinking alcoholic beverage or smoking cigarette) please specify: _____	<input type="checkbox"/>	Tried ___ times	Used ___ times daily / weekly*

Gender: 1 Male 2 Female

Age: _____ years old

Have you joined any of the following activities: (select all that apply)

- 1 Please list other activities in the programme 2 Please list other activities in the programme
3 Please list other activities in the programme 4 Please list other activities in the programme
5 Please list other activities in the programme 6 Please list other activities in the programme

~ Thank you ~