

Elementary Student Questionnaire Regarding The Choking Game

Do not write your name on this survey unless you would like to be contacted regarding the choking game or a similar game.

1. How old are you now? a. 10 yrs. b. 11 yrs. c. 12 yrs. d. 13 yrs.
2. Are you male or female? a. Male b. Female
3. Have you ever heard of the "choking game", "black out" or any similar "game" by any other name?
a. Yes b. No
4. How old were you when you heard about it? a. 4-6 yrs. b. 7--8 yrs. c. 9-11 yrs. d. 12+ yrs.
5. Have you ever tried the choking game or a similar game?
a. Yes (If you answered yes to this question, please answer Questions 6-9 and skip Question 10.)
b. No (If you answered no to this question, please skip Questions 6-9.)

If YES:

6. If so, was there anyone with you? a. Yes b. No
7. Do you still do it? a. Yes b. No
8. If you still do it, how often do you do it? a. only tried it once
b. only occasionally/2-3 times/year
c. on a regular basis/2-3 times/month
9. When you tried it, did you think there was any risk in doing it? a. Yes b. No

If NO:

10. If you've never tried it, has anyone ever tried to get you to do it? a. Yes b. No
11. If someone has tried to get you to do it, who? a. friend your own age
b. person older than you
c. adult
d. no one individual tried to get me to do it
12. Do you know of someone who has played the choking game? a. Yes b. No
13. If you know someone who has played the choking game, how often do they do it?
a. only tried it once
b. only occasionally/2-3 times/year
c. on a regular basis/2-3 times/month
d. don't know
14. Do you know someone who died from this game? a. Yes b. No
15. If you would like to talk with a counselor or teacher about the choking game or a similar game, please write your name and grade below. (This information will be kept confidential.)

Name: _____ Grade: _____

(Do not write your name on this survey unless you would like to discuss concerns with the counselor or staff member.)