

TEEN QUESTIONNAIRE

13 TO 18 YEARS OLD

Your doctor or other medical professional is asking these questions to discuss your personal health and safety, not to judge you or your friends.

Date: _____

CLINIC NOTES

School: _____

Grade: _____

Most recent GPA: _____

- | | |
|---|--|
| 1. Do you always wear a seat belt when riding in a car? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you ever use a bike, scooter, skateboard, snow board or rollerblades WITHOUT a helmet? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever had a sunburn? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you play sports or get other exercise that makes you breathe hard and makes your heart go faster – for at least 60 minutes a day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. Do you eat 5 or more servings of vegetables and fruits every day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. Do you usually drink more than one soda, juice, or sports drink each day? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Do you usually spend more than 2 hours a day watching TV or movies, playing video games, or using the computer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Are you using supplements (such as creatine, andro, or steroids)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. In the past year, have you used laxatives, diet pills or made yourself vomit to try to lose weight? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have your grades been dropping at school? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Do you, your parents, or any of your friends have a gun? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Have you ever been physically abused by an adult? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Have you ever been forced or pressured to have sex? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Have you ever been in trouble with the law? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Are your close friends gang members? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Does anyone smoke in your home? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Have you smoked cigarettes or chewed tobacco during the past year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Do your close friends drink alcohol or get high? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Have you ever been in a car with a driver who had too much to drink or was high? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- Questionnaire reviewed
- Pertinent topics discussed and advice given

MD/NP
Sign: _____

****IMPORTANT – PLEASE TURN OVER****

TEEN QUESTIONS 20 THROUGH 25 (Fill out in private)

CONFIDENTIAL QUESTIONS: Do not photocopy.

Important! Please read first...

- This information is confidential. Confidentiality is protected by law for certain types of medical treatment.
- It will not be shared with anyone (unless you are being abused sexually or physically or are in danger of hurting yourself or someone else).

20. During the past year did you drink any alcohol? Yes No
- 21a. During the past year did you use marijuana? Yes No
- 21b. During the past year have you used any other drug to get high (such as prescription drugs, meth, ecstasy, glue or cocaine)? Yes No
22. During the past few weeks, have you OFTEN felt sad, down or hopeless? Yes No
23. Have you seriously thought about killing yourself, made a plan, or tried to kill yourself? Yes No
- 24a. Have you ever had sex (including oral, vaginal, or anal sex)? Yes No
- 24b. If yes, do you or your partner always use a condom when you have sex? No Yes
25. Are you attracted to guys, girls, or both? Guys Girls Both

CLINIC NOTES

For young women only.

1. Have you started your period? (If no, you are done!) No Yes
2. When was your last period? Date: _____
- 3a. My periods are:
- less than 1 month apart
 - every 1 to 2 months
 - more than 2 months apart
- 3b. My periods last:
- less than 8 days
 - 8 days or longer
4. Do you have cramps that interfere with your daily activities? Yes No
5. Do you need help with managing your cramps? Yes No

If you have any other concerns, please write them here:

Please let us know how to reach you in case we need to call.

Cell phone number _____

Good times to call you _____

E-mail address _____

Signature _____

Date _____

- Questionnaire reviewed
- Pertinent topics discussed and advice given

MD/NP Sign: _____