

Today's Date: _____



Name: _____
MRN: _____
DOB: ____/____/____ ID# _____
Sex: M ____ F ____ (or place label here)

Adolescent Health Assessment

(Ages 12-17)

Please answer these questions to help us get to know you and together we can plan the best care for you. It's okay to skip any questions you are not comfortable answering.

I understand confidentiality (privacy) regarding my health information: YES NO

PHYSICAL HEALTH, NUTRITION AND ACTIVITY

Do you brush your teeth 2 times a day? YES NO

Are there times when your family does not have enough food to eat YES NO

Have you tried to lose or control your weight by making yourself throw up or by taking laxatives? YES NO

How happy are you with your weight? Not at all 0__ 1__ 2__ 3__ 4__ 5__ Very happy

What exercise, sport or strenuous activities do you enjoy doing? _____

How many hours per day do you watch TV, go on the Internet or play video games? _____

EMOTIONAL WELL BEING

Who do you live with? _____

Is there anything at home, school or with friends that is making you feel worried, upset or stressed? YES NO

If yes, what? _____

Do you often feel worried, nervous or scared? YES NO

Over the past two weeks, have you been bothered by any of the following problems:

Little interest or pleasure in doing things?

(0) Not at all (1) Several days (2) More than half the days (3) Nearly every day

Feeling down, depressed, irritable or hopeless?

(0) Not at all (1) Several days (2) More than half the days (3) Nearly every day

In the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? YES NO

In the past 30 days, have you actually had any thoughts about killing yourself? YES NO

Have you EVER done anything, started to do anything, or prepared to do anything to end your life? YES NO

IF YES - Was this within the past 3 months? YES NO

Do you have problems with sleep? (e.g., falling asleep, waking up at night or nightmares) YES NO

Are you attracted to: males females both none

Have you ever felt uncomfortable being identified as male or female? YES NO

RISK REDUCTION

Have you had sex? YES NO

Do you want information about how to avoid pregnancy (birth control) and/or sexually transmitted infections? YES NO

Do you ever smoke cigarettes/cigars, vape, e-cigs snuff or chew tobacco? YES NO

In the past 12 months, did you:
 Drink any alcohol (more than a few sips)? YES NO
 Smoke, vape, or eat any kind of marijuana? YES NO
 Use anything else to get high? YES NO

Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs? YES NO

SCHOOL AND FRIENDS

I have at least one good friend or group of friends I am comfortable with..... YES NO

How important is school to you? (skip if not in school)
 Not important at all 0___ 1___ 2___ 3___ 4___ 5___ Very important

In the past 30 days, how often did you skip or cut school? more than 3 times 1-3 times Never

SAFETY AND INJURY PREVENTION

Do you always wear a seatbelt in the car? YES NO

Does anyone bully, harass or pick on you? YES Past NO

Do you or anyone close to you have guns or weapons?..... YES NO

Has anyone ever hurt, touched or treated you or anyone in your house in a way that made you feel scared or uncomfortable? YES NO

CHECK OFF ALL THE ITEMS THAT YOU FEEL ARE TRUE FOR YOU

- I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- I help others on my own or by working with a group in school, a faith-based organization, or the community.
- I am able to bounce back from life's disappointments.
- I feel good about things and I like myself.
- I have become more independent and made more of my own decisions as I have become older.
- I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting.
Describe:
- Anything else?

Signature: _____

for office use only
 Reviewed by: _____ Date: _____