Multnomah County Health Department

Public Health
Prevent. Promote. Protect.

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

Adolescent Health Assessment

(Grades 9-12)

Today's Date: _____

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

1. How happy are you with your weight? **Not at all** 0___ 1___ 2___ 3___ 4___ 5___ **Very happy**
2. How interested are you in changing your eating habits? **Not at all** 0___ 1___ 2___ 3___ 4___ 5___ **Very interested**
3. Have you tried to lose or control your weight by making yourself throw up or by taking laxatives? YES ❑ NO ❑
4. Are there times when your family does not have enough food to eat? YES ❑ NO ❑
5. What exercise, sport or strenuous activities do you enjoy doing? _____
6. How many hours per day do you watch TV, go on the Internet or play video games? _____

ORAL HEALTH

1. Do you brush your teeth 2 times a day? YES ❑ NO ❑
2. Do you floss your teeth daily? YES ❑ NO ❑

EMOTIONAL WELL BEING

1. Who do you live with? _____
2. Is there anything at home, school or with friends that is making you feel worried, upset or stressed? YES ❑ NO ❑
   If yes, what? _____
3. How well do you get along with your household members/family? **Don't get along at all** 0___ 1___ 2___ 3___ 4___ 5___ **Get along great**
4. On the whole, how much do you like yourself? **Not at all** 0___ 1___ 2___ 3___ 4___ 5___ **A lot**
5. Do you often feel worried, nervous, or scared? YES ❑ NO ❑
6. Over the past two weeks, have you been bothered by any of the following problems?
   - Feeling down, depressed, irritable or hopeless? YES ❑ NO ❑
   - Little interest or pleasure in doing things? YES ❑ NO ❑
7. Have you thought about or tried to kill yourself? YES ❑ NO ❑
8. Do you have problems with sleep? (e.g., falling asleep, waking up at night or nightmares) YES ❑ NO ❑
9. Are you attracted to: ❑ males ❑ females ❑ both ❑ none
10. Have you ever felt uncomfortable being identified as male or female? YES ❑ NO ❑

SCHOOL AND FRIENDS

1. How important is school to you? **Not important at all** 0___ 1___ 2___ 3___ 4___ 5___ **Very important**
2. In the past 30 days, how often did you skip or cut school? Never ❑ 1-3 times ❑ more than 3 times ❑
3. Did you fail any classes last year or are you worried about failing any classes now? YES ❑ NO ❑
4. Have you ever been suspended or had a referral? YES ❑ NO ❑
5. I have at least one good friend or group of friends I am comfortable with. YES ❑ NO ❑

SAFETY AND INJURY PREVENTION

1. Do you always wear a seatbelt in the car? YES ❑ NO ❑
2. Does anyone bully, harass or pick on you? YES ❑ NO ❑ In the past ❑
3. Do you or anyone close to you have guns or weapons? YES ❑ NO ❑
4. 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 ❑

RISK REDUCTION

1. Have you had sex? YES ❑ NO ❑
2. Do you want information about how to avoid pregnancy (birth control) and/or sexually transmitted infections? YES ❑ NO ❑
3. During the past 12 months, did you:
   - Drink any alcohol (more than a few sips)? YES ❑ NO ❑
   - Smoke any marijuana, hashish or anything else to get high? YES ❑ NO ❑
4. Have you ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? YES ❑ NO ❑
5. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? YES ❑ NO ❑

PLEASE TELL US MORE ABOUT YOURSELF

1. Who is an adult you feel cares about and supports you? _____
2. What is something now that you are more independent at than a year ago? _____
3. How do you cope when life feels hard? _____
4. What is something you are good at or enjoy doing? _____
5. What is something you do to stay healthy? _____
6. What is one thing that makes a healthy dating relationship? _____
7. What is something you do to keep yourself safe from injury and violence? _____
8. What school, community, employment or volunteer activity are you involved in? _____

Student signature:_____

for office use only
Reviewed by:_____ Date:_____