

Today's Date: \_\_\_\_\_



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

# Child/Early Adolescent Health Assessment

(Grades 6 – 8)

Please answer these questions to help us get to know you. It is 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

- How happy are you with your weight? **Not at all** 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ **Very happy**
- Would you like to make any changes in your diet? YES  NO
- Are there times when your family does not have enough food to eat? YES  NO
- What sport, exercise or physical activity do you do? \_\_\_\_\_
- How many hours a day do you play video games/watch television/use a computer? \_\_\_\_\_

### ORAL HEALTH

- Do you brush your teeth 2x daily? YES  NO
- Do you floss your teeth daily? YES  NO
- Do you take fluoride? YES  NO

### 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
- How well do you get along with your family/household members: **Not at all** 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ **Great**
- On the whole, how much do you like yourself? **Not at all** 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ **A lot**
- Do you feel worried, nervous or scared? YES  NO
- Over the past two weeks have you been:
  - Feeling down, depressed, hopeless, irritable or moody? YES  NO
  - Not having as much fun as you usually do, or not felt interested in doing things? YES  NO
- Have you ever thought about or tried to kill yourself? 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

### SCHOOL AND FRIENDS

- How do you feel you are you doing in school? **Doing terrible** 0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ **Doing great**
- About how much time do you spend doing homework? \_\_\_\_\_
- Have you ever been suspended or had a referral? YES  NO
- Do you have a good friend (or friends)? YES  NO

### SAFETY

- If you ride a bike, board or scooter, do you wear a helmet? ..... YES  NO
- Do you always wear a seat belt in the car? ..... YES  NO
- Do you feel safe in your home, your neighborhood and at school? ..... YES  NO
- Does anyone bully, harass or pick on you? ..... YES  NO  **In the past**
- Are there any guns or weapons in the home? ..... YES  NO
- Do you know anyone (including yourself) who has been involved with gangs and/or killed or hurt by violence? 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

### RISK REDUCTION

- Do you have, or have you ever had, a girlfriend or boyfriend? ..... YES  NO
- Is there an adult that you feel comfortable talking about relationships, sex, drugs, alcohol, and/or your values and life goals? YES  NO
- In the past 12 months did you ever:
  - Drink alcohol? ..... YES  NO
  - Smoke any marijuana, hashish or anything else to get high? ..... YES  NO
- Have you ridden in a car driven by someone who was "high" or had been using alcohol or drugs? ..... YES  NO
- Do you ever smoke cigarettes, use snuff or chew tobacco? ..... YES  NO

### PLEASE TELL US MORE ABOUT YOURSELF

- Who is an adult who cares about you? \_\_\_\_\_
- What are you able to do alone this year that you did not do before? \_\_\_\_\_
- How do you cope with things when life feels hard? \_\_\_\_\_
- What are you good at or enjoy doing? \_\_\_\_\_
- What do you like about school? \_\_\_\_\_
- What is something you do to keep your body healthy? \_\_\_\_\_
- What is one thing you do to be helpful at home, school or in your community? \_\_\_\_\_
- How do you keep yourself safe from injury or violence? \_\_\_\_\_

### DO YOU HAVE QUESTIONS OR WOULD LIKE MORE INFORMATION ON ANY OF THESE TOPICS?

- |                                       |  |                        |  |
|---------------------------------------|--|------------------------|--|
| Healthy eating/physical activity..... | YES <input type="checkbox"/> NO <input type="checkbox"/> | Menstrual periods..... | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Homework help.....                    | YES <input type="checkbox"/> NO <input type="checkbox"/> | Wet dreams.....        | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Puberty/body changes.....             | YES <input type="checkbox"/> NO <input type="checkbox"/> | Sex.....               | YES <input type="checkbox"/> NO <input type="checkbox"/> |

Student signature: \_\_\_\_\_

for office use only

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_