Adolescent Questionnaire

The next two pages give you a chance to tell your doctor about School, Health and Personal Habits, Concerns and how you think about yourself. **Your answers are private** and will help your doctor better understand what is happening with you and what your concerns are. If you are uncomfortable answering any question or if you are unsure what it is asking you may skip the question. You will be given time during the visit to talk privately with the doctor about this form or any other questions or concerns that you might have about your health.

Thank you for completing this form.

Name: _____ **Date of Birth** _____ Date _____

1. Why did you come to the clinic today? _____
_____
2. Do you have any concerns to discuss with the doctor today?_____
_____
3. Who lives in your home?_____
4. Who do you talk to when things aren't going well? _____
5. Have you ever been in counseling? ___ Yes ___ No
6. Are you in counseling now? ___ Yes ___ No
   If yes, who are you seeing?_____

School

1. Are you in school? ___Yes ____ No
   If yes, what school? _____ And what grade? _____
2. What do you like most about school? _____
3. Compared to last year, are your grades ___ the same _____better _____ worse
4. Have you ever cut classes, skipped school, been expelled, or been suspended? ____Yes ____No
5. What do you do after school? _____
6. Do you work? ___ Yes ___ No If yes, on average how many hours per week? ____

Health Habits

1. Have you seen a dentist in the last year? ___ Yes ___ No
2. How many times a week do you exercise? _____ For how long? _____
3. What do you do for exercise? _____
4. Are you satisfied with the size or shape of your body, and your physical appearance? ___ Yes ___ No
5. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills, laxatives, or starving yourself? ___ Yes ___ No
6. Does anyone in your family drink or take drugs so much that it worries you? ___ Yes ___ No
7. Do you regularly use:
   a. Seatbelts? ___ Yes ___ No
   b. Helmets? ___ Yes ___ No
   c. Sunscreen? ___ Yes ___ No

Personal Concerns (Check any items below which concern or trouble you)

__ Stress at home	__ Anger or temper	__ Muscle or Joint Pain
__ Making Friends	__ Skin problems or acne	__ Being Tired all the time
__ Anxiety or Nervousness	__ Diarrhea or constipation	__ Stomach ache
__ Sleeping Problems	__ Headaches or Migraines	__ Dizzy spells or fainting
__ Boyfriends or Girlfriends	__ Other _____	

Thoughts about Yourself

1. If you had four wishes what would they be? _____
_____
2. Is there anything about yourself or your life you would like to be different? ___ Yes ___ No
   If yes, what? _____

3. Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every Day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed or hopeless	0	1	2	3

Personal Habits

During the Past 12 Months, did you:

1. Drink any alcohol (more than a few sips)? ___ Yes ___ No
2. Smoke any marijuana or hashish? ___ Yes ___ No
3. Use anything else to get high? ___ Yes ___ No
   ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")
4. Have you ever 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 use alcohol or drugs to RELAX, feel better about yourself, or fit in? ___ Yes ___ No
6. Do you ever use alcohol or drugs while you are by yourself, or ALONE? ___ Yes ___ No
7. Do you ever FORGET things you did while using alcohol or drugs? ___ Yes ___ No
8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? ___ Yes ___ No
9. Have you ever gotten into TROUBLE while you were using alcohol or drugs? ___ Yes ___ No
10. Do you smoke cigarettes and/or use any other tobacco products? ___ Yes ___ No
11. Has anyone touched you in a way that made you feel uncomfortable or forced you to do something sexual that you did not want to do? ___Yes ___ No

Sexual Health

1. Are you attracted to: ___ Males ___ Females ___ Both ___ Not Sure
2. Have you ever had sexual experiences? ___ Yes ___ No

   If no, go to the next section.

   If yes, what? ___ Kissing ___ Touching Private Parts ___ Oral Sex___
   Sexual Intercourse ___ Other _____
3. How many sexual partners have you had? _____
4. Are you or your partner using a method to prevent pregnancy? ___ Yes ___ No
   If yes, what kind of birth control? _____
5. Do you and your partner(s) always use condoms when you have oral sex and/or intercourse? ___ Yes ___ No
6. Have you ever had a sexually transmitted infection or disease (Herpes, Chlamydia, Gonorrhea, Genital Warts) ___ Yes ___ No
7. Have you been pregnant or gotten someone pregnant? ___ Yes ___ No

For Females

1. At what age did you start your menstrual periods? _____
2. Do you have a period every month? ___ Yes ___ No
3. Any problems with your periods? ___ Yes ___ No
   If yes, what and when _____
4. Are you worried you might be pregnant? ___ Yes ___ No

For Males

1. Have you been taught to do a testicular self exam? ___ Yes ___ No
2. Have you noticed any change in the size or shape of your testicles? ___ Yes ___ No