

ADOLESCENT QUESTIONNAIRE

This form is **Strictly Confidential**. Its purpose is to help us give you better care. We request that you fill out the form completely, but you may skip questions that you do not wish to answer.

Patients Name _____ **Date** _____

Why did you come in the office today? _____

Are you taking medications? YES NO

Do you go to any other doctors? YES NO

Do you have allergies? YES NO

School Information

What grade are you in? 6 7 8 9 10 11 12

What grade do you usually make in English? _____ Math? _____

How many days were you absent from school last semester? _____

How do you get along in school? (Scale 1-10 with 10 the best) _____

If you are not in school, why did you leave? _____

List hobbies/Interests outside of school? _____

Job/Career Information

Are you working? YES NO

If YES - what is your job? _____ Hours per week _____

What are your plans for the future? _____

Family Information

Who do you live with? _____

Do you get along with your parents? YES NO

Have there been any changes in your family since your last visit here? YES NO

Self Information

Do you eat a healthy diet? YES NO

Describe how you exercise _____

Are there foods that cause you problems? YES NO

What do you do best? _____

Is there anything you would like to change about yourself? YES NO

Are there any habits you would like to break? YES NO

On the whole, do you like yourself? YES NO

Do you feel people expect too much of you? YES NO

Do you get along with your friends/peers? YES NO

Have you lost or gained any weight in the last year? YES NO

Are you dieting? YES NO

Have you ever vomited or spit up food after eating to get rid of it? YES NO

Do you feel you have any friends you can count on? YES NO

Have you ever felt sad or depressed for more than 3 days in a row? YES NO

Do you feel you can't be happy, no matter where you are? YES NO

Have you ever thought of suicide as a solution to your problems? YES NO

Have you gotten into any trouble because of your anger/temper? YES NO

Have you been in a pushing/shoving fight in the last two years?	YES	NO
Have you ever threatened or been threatened with any weapon/knife/gun?	YES	NO
Have you ever been physically or sexually abused?	YES	NO
Are you in a gang?	YES	NO
Is there a gun in your house?	YES	NO

Health behavior information

Do you go to the dentist every 6 months?	YES	NO
Do you use sunscreen?	YES	NO
Do you wear a seatbelt EVERY time you get in a car?	YES	NO
Have you ever been the driver in an auto accident?	YES	NO
Have you ever driven after drinking or when high?	YES	NO
Does anyone in your household smoke?	YES	NO
Does anyone in your household have a problem with drugs or alcohol?	YES	NO
Have you ever smoked cigarettes?	YES	NO
Have you ever smoked marijuana?	YES	NO
Do you ever drink alcoholic beverages?	YES	NO
Have you ever used street drugs/speed, cocaine, acid, crack?	YES	NO
Have you ever been in trouble with the law?	YES	NO
Have you begun dating?	YES	NO
Do you currently have a boyfriend or girlfriend?	YES	NO
Do you think you may be gay/lesbian/homosexual?	YES	NO
Have you ever had sex (sexual intercourse)?	YES	NO
Are you interested in receiving information on preventing pregnancy?	YES	NO
If you have had sex, are you (or your partner) using any birth control?	YES	NO
If you have had sex, have you been treated for any gonorrhea, Chlamydia or STDs?	YES	NO
Do you have any other personal problems that you would like to discuss with us that you would rather not write down?	YES	NO

For Males Only

Have you been taught how to use a condom correctly?	YES	NO
Do you examine your testicles monthly?	YES	NO
If you have had sex, do you use a condom every time?	YES	NO

For Females Only

Have you started your period?	YES	NO
How old were you when you started your period? _____years old		
What date did your last period start? _____		
Are your periods regular once a month?	YES	NO
Do you have painful or excessively heavy periods?	YES	NO
Have you had a vaginal infection or treated for a female disease?	YES	NO
Is there any chance you could be pregnant?	YES	NO
Have you ever been pregnant?	YES	NO
Do you examine your breasts monthly?	YES	NO