

Today's Date: _____



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

Adolescent Health Assessment

(Grades 9-12)

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

- How happy are you with your weight? **Not at all** 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ **Very happy**
- How interested are you in changing your eating habits? **Not at all** 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ **Very interested**
- Have you tried to lose or control your weight by making yourself throw up or by taking laxatives? YES NO
- Are there times when your family does not have enough food to eat? YES NO
- 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? _____

ORAL HEALTH

- Do you brush your teeth 2 times a day? YES NO
- Do you floss your teeth daily? 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
If yes, what? _____
- 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**
- On the whole, how much do you like yourself? **Not at all** 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ **A lot**
- 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? YES NO
 - Feeling down, depressed, irritable or hopeless? YES NO
- Have you 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 important is school to you? **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? **Never** **1-3 times** **more than 3 times**
- Did you fail any classes last year or are you worried about failing any classes now? YES NO
- Have you ever been suspended or had a referral? YES NO
- I have at least one good friend or group of friends I am comfortable with. YES NO

SAFETY AND INJURY PREVENTION

- Do you always wear a seatbelt in the car? YES NO
- Does anyone bully, harass or pick on you? YES NO **In the past**
- 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

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
- In the past 12 months, did you:
 - a. Drink any alcohol (more than a few sips)? YES NO
 - b. Smoke any marijuana or hash? YES NO
 - c. Use anything else to get high? YES NO
- Have you ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ... YES NO
- Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? YES NO

PLEASE TELL US MORE ABOUT YOURSELF

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

Student signature: _____

for office use only

Reviewed by: _____ Date: _____

IF 18 YEARS OR OLDER, PLEASE COMPLETE THE FOLLOWING QUESTIONS?

Alcohol - *One drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor (one shot)*

MEN: How many times in the past year have you had 5 or more drinks in a day? **None** **1 or more**

WOMEN: How many times in the past year have you had 4 or more drinks in a day? **None** **1 or more**

Drugs - *Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).*

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? **None** **1 or more**