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

## 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

Adolescent Parent/Guardian Questionnaire

Attached is a questionnaire for you to fill out regarding your adolescent's general health, school, health habits, and how you view parenting. In addition we would like you to complete an assessment form to determine risk for Sudden Cardiac Death.

Your adolescent will be asked to complete a separate confidential questionnaire regarding emotional well being, how he or she is doing in school, general health habits, tobacco, alcohol and drug use and sexual health. During the visit, we will encourage your adolescent to talk privately about any concerns that may affect his or her health. Your adolescent will also receive information about healthy life habits including nutrition and exercise and things that he or she can do to stay healthy and avoid injuries.

With your help we believe that we can help reduce the risk of your adolescent experiencing preventable problems.

Thank you.

Adolescent Parent/Guardian Questionnaire

Adolescent's Name___________________________________ Date of Birth _____________
Your Name ______________________________ Relationship to the Adolescent _________
Today's Date ____________________________

1. Who lives in your household? __________________________________________________
2. Have there been any changes in your family in the last year (example:
   marriage, birth, divorce, move, serious illness)? No ___ Yes ___
   If yes, describe ______________________________________________________________
3. Has there been any change in your adolescent's physical or emotional
   health in the last year? No ___ Yes ___
   If yes, describe ______________________________________________________________

**School**

In the past year have your child's grades been mainly (circle one) A's B's C's D's F's
Compared to last year are your child's grades ___ better ___ the same ___ worse
How many days of school has your child missed this school year? ______
Does your adolescent have a significant amount of unsupervised time
each day, after school or in the evening? No ___ Yes ___

**Health Habits**

1. Have you had discussions with your adolescent about:
   a. Drugs/Alcohol/Tobacco? No ___ Yes ___
   b. Sexual orientation/Sexual behavior? No ___ Yes ___
   c. Passenger and Driver safety? No ___ Yes ___
   d. Injury prevention? No ___ Yes ___
2. Is there a gun in your household? No ___ Yes ___
   If yes, is it secured/locked with ammunition stored separately? No ___ Yes ___

What do you find most challenging about being the parent of your adolescent?
______________________________________________________________________________
______________________________________________________________________________
What do you find most rewarding about being the parent of your adolescent?
______________________________________________________________________________
______________________________________________________________________________
What do you and your adolescent do together on a regular basis (example: meals,
exercise)? ______________________________________________________________________