Today's Date: _____

Multnomah County Health Department

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

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

ORAL HEALTH

1. Do you brush your teeth 2x daily? **YES ❑ NO ❑** 2. Do you floss your teeth daily? **YES ❑ NO ❑** 3. Do you take fluoride? **YES ❑ NO ❑**

EMOTIONAL WELL BEING

1. Who do you live with? _____
2. Is there anything at home, school or with friends that is making you feel worried, upset or stressed? **YES ❑ NO ❑**
3. How well do you get along with your family/household members: **Not at all** 0___ 1___ 2___ 3___ 4___ 5___ **Great**
4. On the whole, how much do you like yourself? **Not at all** 0___ 1___ 2___ 3___ 4___ 5___ **A lot**
5. Do you feel worried, nervous or scared? **YES ❑ NO ❑**
6. Over the past two weeks have you been: a. Little interest or pleasure in doing things? **YES ❑ NO ❑**
   b. Feeling down, depressed, irritable or hopeless? **YES ❑ NO ❑**
7. Have you ever thought about or tried to kill yourself? **YES ❑ NO ❑**
8. Do you have problems with sleep (e.g., falling asleep, waking up at night or nightmares)? **YES ❑ NO ❑**
9. Are you attracted to: **❑ males ❑ females ❑ both ❑ none**
10. Have you ever felt uncomfortable being identified as male or female? **YES ❑ NO ❑**

SCHOOL AND FRIENDS

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

SAFETY

1. If you ride a bike, board or scooter, do you wear a helmet? **YES ❑ NO ❑**
2. Do you always wear a seat belt in the car? **YES ❑ NO ❑**
3. Do you feel safe in your home, your neighborhood and at school? **YES ❑ NO ❑**
4. Does anyone bully, harass or pick on you? **YES ❑ NO ❑ In the past ❑**
5. Are there any guns or weapons in the home? **YES ❑ NO ❑**
6. Do you know anyone (including yourself) who has been involved with gangs and/or killed or hurt by violence? **YES ❑ NO ❑**
7. 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

1. Do you have, or have you ever had, a girlfriend or boyfriend? **YES ❑ NO ❑**
2. Is there an adult that you feel comfortable talking about relationships, sex, drugs, alcohol, and/or your values and life goals? **YES ❑ NO ❑**
3. 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 ❑**
4. Have you ridden in a car driven by someone who was "high" or had been using alcohol or drugs? **YES ❑ NO ❑**
5. Do you ever smoke cigarettes, use snuff or chew tobacco? **YES ❑ NO ❑**

PLEASE TELL US MORE ABOUT YOURSELF

1. Who is an adult who cares about you? _____
2. What are you able to do alone this year that you did not do before? _____
3. How do you cope with things when life feels hard? _____
4. What are you good at or enjoy doing? _____
5. What do you like about school? _____
6. What is something you do to keep your body healthy? _____
7. What is one thing you do to be helpful at home, school or in your community? _____
8. 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 ❑**	**NO ❑**	Menstrual periods	**YES ❑**	**NO ❑**
Homework help	**YES ❑**	**NO ❑**	Wet dreams	**YES ❑**	**NO ❑**
Puberty/body changes	**YES ❑**	**NO ❑**	Sex	**YES ❑**	**NO ❑**

Student signature: _____

for office use only

Reviewed by: _____ Date: _____