Name:_____ Date:_____

Blood pressure_____/_____ Pulse:_____

Height:_____ Weight:_____

CONFIDENTIAL

Health Survey for Adolescents

Everyone faces choices and situations that are complicated. By answering these questions, you give your doctor or nurse information that will help them care for you. If you have any questions about these subjects , please ask your doctor or nurse.

The information you share here or during your visit will be kept **private** between you and your doctor or nurse unless the information is needed to protect you from immediate danger.

Please leave blank any question that you do not want to answer.

What would you like to talk about today?

_____

_____

Do you have forms for camp, sports or school that need to be completed? _____

Do you have any health problems?

_____

Do you take any medications? (include vitamins, over the counter medicines and birth control)

_____

Do you have any of these health concerns? (please circle any you have)

trouble seeing
trouble hearing
headaches
chest pain
stomach pain
change in appetite
constipation (hard poop)
diarrhea
back pain
fatigue
allergies
acne or other skin problems
trouble breathing
coughing
Other:

dizziness or passing out
pain in joints
trouble with urination (peeing)
wetting the bed
discharge from vagina or penis
trouble sleeping
trouble paying attention
trouble sitting still
feeling irritable
loosing your temper
being over or under weight
pain with your periods
irregular or missed periods

Your health choices:

What did you eat yesterday? (include all meals snacks and beverages)	
How often do you exercise for 1 hour or more?	Never Rarely Sometimes Most days Everyday
What do you do for exercise?	
Do you spend **less** that 2 hours a day watching TV, movies, or video games?	Never Rarely Sometimes Most days Everyday
Do you feel OK about your weight?	Never Rarely Sometimes Most days Everyday
Do you wear a seat belt?	Never Rarely Sometimes Most days Everyday
Do you wear a helmet if you ride a bike, skateboard, roller blades, horse or ATV?	Never Rarely Sometimes Most days Everyday
Do you protect yourself from the sun?	Never Rarely Sometimes Most days Everyday
Do you protect your hearing from loud noises like motors, guns and music?	Never Rarely Sometimes Most days Everyday
Do you brush your teeth?	Never Rarely Sometimes Most days Everyday
Do you see a dentist for dental cleanings?	Never Rarely Sometimes Once a year or more

Substance Use:

Have you smoked or chewed tobacco?	Never Once A few times Frequently Daily
Have you drunk alcohol?	Never Once A few times Frequently Daily
Have you used illegal drugs?	Never Once A few times Frequently Daily
Have you ridden with a driver who was using alcohol or drugs?	Never Once A few times Frequently Daily
Do you have friends who are using tobacco, alcohol, or drugs?	No Maybe Yes

Sexual Health:

Have you ever had sex? (oral, vagina or anal)	Never Once A few times Many times
If never, have you considered having sex?	Never Once A few times Many times
Have your partners been?	Male Female Both
Have you ever had sex without a condom?	Never Once A few times Many times
Have you had vaginal sex without birth control?	Never Once A few times Many times
Have you or your partner ever been pregnant or ever made someone pregnant?	Never Once A few times Many times
Have you ever had sexual activity when you didn't want to?	Never Once A few times Many times
Have you ever had sexual contact with an adult or someone more than 3 years older than you?	Never Once A few times Many times
Have you thought something is wrong with your sexual feelings?	Never Once A few times Many times

School

Do you have a friend you can really talk to?	Never Rarely Sometimes Most days Daily
Do you get along well with others?	Never Rarely Sometimes Most days Daily
Are you happy with your grades?	Never Rarely Sometimes Most days Daily
Are you having problems behaving in school?	Never Rarely Sometimes Most days Daily
Do you think you have a learning problem?	Never Rarely Sometimes Most days Daily
Have you dropped out or been suspended?	Never Rarely Sometimes Most days Daily

Home

Whom do you live with?	
Have there been changes in your family or household lately?	
Is there an adult in your life that can help you with serious issues?	Never Rarely Sometimes Most days Daily
Does your family eat meals or do some activity together ?	Never Rarely Sometimes Most days Daily
Does your family have enough money to buy the things you need?	Never Rarely Sometimes Most days Daily
Does anyone in your home abuse alcohol or drugs?	Never Rarely Sometimes Most days Daily
Does anyone smoke in your family?	Never Rarely Sometimes Most days Daily
Is anyone in your household abusive to other people or animals?	Never Rarely Sometimes Most days Daily

Emotional Health:

Do you worry a lot or get stressed out easily?	Never Rarely Sometimes Most days Everyday
Have you felt sad or down or like you have nothing to look forward to?	Never Rarely Sometimes Most days Everyday
Have you ever thought of hurting yourself?	Never Rarely Sometimes Most days Everyday
Have you ever done something violent?	Never Rarely Sometimes Most days Everyday
Do you find yourself continuing to remember or think about something unpleasant that happened in the past?	Never Rarely Sometimes Most days Everyday
Does something get in the way of you doing your best?	Never Rarely Sometimes Most days Everyday
Has anyone threatened you or made you feel afraid ?	Never Rarely Sometimes Most days Everyday
Has any one hit or physically hurt you?	Never Rarely Sometimes Most days Everyday

About You:

What are your interests or hobbies?	
Do you play sports or do other activities for exercise?	
Do you have a job or work that you do?	
What do you do particularly well?	
What do you do to help others?	
What is your greatest challenge?	
What are your goals in life?	
What do you think you will do when you are done with school?	

Would you like to talk about any of these issues today?
(your questions may be about you, a friend or just curiosity)

diet and healthy food choices
getting exercise
gaining weight
loosing weight
your height
puberty
bed wetting
future plans
learning or school issues
your immune system
sex or sexual feelings
pregnancy/birth control
sexually transmitted diseases/safe sex
unwanted sexual attention
Any other topics:

anxiety
depression
anger
hyperactivity
fighting or bullying
how to stay safe
being hurt by another person
domestic violence
coping with stress
dying
medical problems in your family
living with someone who abuses alcohol
living with someone who has emotional problems
living with someone who is violent or abusive

Would you like to get counseling for anything that is on your mind?

Would you like help talking with your family about your concerns?

Name_____ Date_____

Parent's Questionnaire

What concerns do you want us to address at today's visit?

_____

_____

Does your child take any medicines? _____

Does your child have any allergies to medicines?_____

Has your child been to the emergency room this year?_____

Has your child been to another health care provider this year?_____

Has your child ever been hospitalized? _____

Has you child ever had any serious injuries?_____

Has there been any changes in your child's health this year?_____

Has your child received any vaccines outside our office?_____

Does you child need any vaccines? _____

Has your child had any of the following problems:

ADHD
anemia
anxiety
asthma
allergies
urinary infection
cancer
chicken pox
drug or alcohol abuse
depression
diabetes
eating disorder
emotional problems
fatigue
frequent illness
heart disease
hepatitis
headaches
learning disabilities
pneumonia
heart disease
scoliosis
seizures
severe acne
stomach problems
tuberculosis
weight change
Other:

Has your child's blood relatives had any of these problems?

Please note the age of onset and the relationship to you child

ADHD
arthritis
birth defects
learning disabilities
asthma
allergies
urinary infection
blood disorders/sickle cell
cancer
depression
diabetes
drug abuse problem
alcoholism/drinking problem
thyroid problem
heart attack
high blood pressure
high cholesterol
kidney disease
learning disability
liver disease
mental health trouble
mental retardation
obesity
seizures/epilepsy
smoking
tuberculosis
other

How does your child spend his or her time?

_____

With whom does your child live with?

_____

Have there been changes in your family in the last year such as marriage, separation, divorce, loss of job, move to new home, new school, new family members, serious illness, deaths or others?

_____

Do you have any of the following concerns about your child?

pain in joints or back
head ache
other pain
rash or spot on skin
vision
hearing
cough
breathing troubles
physical development
weight
eating disorder
appetite
stomach pain
constipation
bed wetting
sleep
energy level
nutrition
physical activity
emotional development
emotional problems
moodiness
depression
anxiety
relationship with family
physical abuse
sexual abuse
emotional abuse
choice of friends
self image
rebellious behavior
lying or stealing
violence
guns, weapons
learning troubles
grades
trouble at school
smoking
alcohol
drug use
dating
sexual behavior
sexually spread disease
pregnancy
sexual identity
work outside school
other

Please explain:

_____

_____

_____

What seems to be the greatest challenge for your child?

_____

_____

What is it about your child that you are most proud?

_____

_____

Other comments or concerns:

_____

_____

Can we share the answers to this questionnaire with you child?_____