

TEEN QUESTIONNAIRE 13 TO 18 YEARS OLD



Your doctor or other medical professional is asking these questions to discuss your personal health and safety, not to judge you or your friends.

Date: _____

How are you doing in school? Do you have any questions or concerns?

School: _____ Grade: _____ Most recent GPA: _____

1. Do you always wear a seat belt when riding in a car? No Yes
2. Do you ever use a bike, scooter, skateboard, rollerblades, or rollerskates WITHOUT a helmet? Yes No
3. Have you ever had a sunburn? Yes No
4. Do you play sports or get other exercise that makes you sweat and breathe hard for over 30 minutes most days? No Yes
5. Do you usually eat at least 5 helpings of fruits and vegetables each day? No Yes
6. Do you usually drink more than one soda or juice drink each day? Yes No
7. Do you usually watch TV, play video games, or spend time on the computer for more than one hour per day? Yes No
8. Are you using supplements (such as creatine, andro, or steroids)? Yes No
9. In the past year, have you used laxatives, diet pills, or made yourself vomit to try to lose weight? Yes No
10. Have your grades been dropping at school? Yes No
11. Do you, your parents, or friends have a gun? Yes No
12. Have you ever been physically abused by an adult? Yes No
13. Have you ever been forced or pressured to have sex? Yes No
14. Have you ever been in trouble with the law? Yes No
15. Are your close friends gang members? Yes No
16. Does anyone smoke in your home? Yes No
17. Have you smoked cigarettes or chewed tobacco during the past year? Yes No
18. Do your close friends drink alcohol or use drugs? Yes No
19. Have you ever been in a car with a driver who had too much to drink or was on drugs? Yes No

CLINIC NOTES

Questionnaire reviewed

Pertinent topics discussed and advice given

MD/NP
Sign: _____

****IMPORTANT – PLEASE TURN OVER****

TEEN QUESTIONS 20 THROUGH 25 (Fill out in private)

Do not photocopy.

Important! Please read first...

- This information is personal and private. It will not be shared with anyone unless you are being abused (sexually or physically) or are in danger of hurting yourself or someone else.
- Your doctor or other medical professional is asking these questions to discuss your personal health and safety, not to judge you or your friends.

20. Have you had any alcohol (beer, wine, or liquor) during the past year? Yes No
21. Have you ever tried drugs (such as marijuana, cocaine, ecstasy, glue, or meth)? Yes No
22. During the past few weeks, have you OFTEN felt sad, down, or hopeless? Yes No
23. Have you seriously thought about killing yourself, made a plan, or tried to kill yourself? Yes No
- 24a. Have you ever had sex (including oral, vaginal, or anal sex)? Yes No
- 24b. If yes, do you or your partner always use a condom when you have sex? No Yes
25. Do you sometimes have sexual feelings for someone of your own sex (gay or lesbian feelings)? Yes No

For young women only

1. Have you started your period? (If no, you are done!) No Yes
2. When was your last period? Date: _____
- 3a. My periods are: less than 1 month apart
 every 1 to 2 months
 more than 2 months apart
- 3b. My periods last: less than 8 days
 8 days or longer
4. Do you have cramps that interfere with your daily activities? Yes No
5. Do you need help with managing your cramps? Yes No

If you have any other concerns, please write them here:

Please let us know how to reach you in case we need to call.

Phone/pager number

Good times to call you

E-mail address

Signature

Date

CLINIC NOTES

- Questionnaire reviewed
- Pertinent topics discussed and advice given

MD/NP Sign: _____