

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: _____

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, snow board or rollerblades 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 breathe hard and makes your heart go faster – for at least 60 minutes a day? No Yes
5. Do you eat 5 or more servings of vegetables and fruits every day? No Yes
6. Do you usually drink more than one soda, juice, or sports drink each day? Yes No
7. Do you usually spend more than 2 hours a day watching TV or movies, playing video games, or using the computer? 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 any of your 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 get high? Yes No
19. Have you ever been in a car with a driver who had too much to drink or was high? 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)

CONFIDENTIAL QUESTIONS: Do not photocopy.

Important! Please read first...

- This information is confidential. Confidentiality is protected by law for certain types of medical treatment.
- 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).

20. During the past year did you drink any alcohol? Yes No
- 21a. During the past year did you use marijuana? Yes No
- 21b. During the past year have you used any other drug to get high (such as prescription drugs, meth, ecstasy, glue or cocaine)? 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. Are you attracted to guys, girls, or both? Guys Girls Both

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.

_____ Cell phone number

_____ Good times to call you

_____ E-mail address

_____ Signature

_____ Date

CLINIC NOTES

- Questionnaire reviewed
- Pertinent topics discussed and advice given

MD/NP Sign: _____