

YOUNG ADULT HEALTH QUESTIONNAIRE



Thanks for taking time to fill out this questionnaire before your visit. We ask all young adults these questions to help us discuss your health and safety—not to judge you. Your answers are private.

Date: _____

How are you feeling today? What would you like to make sure you talk about during your visit?

If you've filled this form out in the past 6 months, you're done! Please give it to the Medical Assistant.

QUESTIONS	ANSWERS	CLINIC COUNSELING
1. Is this your first time visiting us in this office?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you currently working, going to school, both, or doing something else?	<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Both <input type="checkbox"/> Other	
3. Does this statement describe you? "On most days of the week, I <u>don't</u> usually exercise enough to sweat or breathe hard."	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Are you concerned about your weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you ever drive or ride in a car without using a seat belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Do you ever drink and drive, or ride with anyone who has been drinking or is high?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do you have a gun or spend time with anyone who does?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Have you ever been physically abused or forced to have sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. In the past 3 months, have you had more than 3 drinks containing alcohol at one time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. In the past 3 months, have you used marijuana, Ecstasy, meth, prescription medication, or any other drugs to get high?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. In the last month, have you often felt problems were piling up so high that you could not deal with them or that you have no one to talk to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12a. During the past month, have you often felt sad, depressed or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12b. During the past month, have you had little interest or pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12c. Have you seriously thought about killing yourself, or made a plan to hurt yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13a. Have you ever had sex (including oral, vaginal, or anal sex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13b. If yes, do you ever have sex without a condom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13c. If you have had sex, do you have sex with men, women, or both?	<input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	

For Young Women Only

1. When was your last period? Write the date it started here: _____
2. Are your periods irregular (do they come more than once a month or more than 2 months apart?) Yes No
3. Do your periods usually last 8 days or longer? Yes No
4. Do you have cramps that interfere with your daily activities? Yes No
5. Do you need help with managing your cramps? Yes No