Guidelines for Adolescent Preventive Services

Initial Adolescent Questionnaire

Confidential (Your answers will not be given out.) Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School _____ Year in college _____ Sex: Male Female Age _____

Address _____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number _____

What languages are spoken where you live? _____ Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Have you seen a dentist in the last 12 months?
   ☐ No ☐ Yes
3. Are you allergic to any medicines?
   ☐ Yes ☐ No ☐ Not sure Name of medicine _____
4. Do you have any health problems?
   ☐ Yes ☐ No Problem(s) _____
5. Are you taking any medicine now?
   ☐ Yes ☐ No Name of medicine _____
6. Have you ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, how old were you and what was the problem? Age _____ Problem _____
   Age _____ Problem _____
7. Have you had any serious injuries?
   ☐ Yes ☐ No If yes, how old were you and what was the injury? Age _____ Injury _____
   Age _____ Injury _____
8. Have you ever had any of the following illnesses or problems?
   If yes, write down how old you were when the problem or illness started:

	Yes	No	Age		Yes	No	Age
Allergies/hayfever	☐	☐	_____	Headaches/migraines	☐	☐	_____
Asthma	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Bladder or kidney infection	☐	☐	_____	Mononucleosis (mono)	☐	☐	_____
Blood disorder/sickle cell anemia	☐	☐	_____	Pneumonia	☐	☐	_____
Cancer	☐	☐	_____	Rheumatic fever or heart disease	☐	☐	_____
Chicken pox	☐	☐	_____	Scoliosis (curved spine)	☐	☐	_____
Depression	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Diabetes	☐	☐	_____	Severe acne	☐	☐	_____
Eating disorder	☐	☐	_____	Stomach problems	☐	☐	_____
Emotional disorder	☐	☐	_____	Tuberculosis (TB)/lung disease	☐	☐	_____
Hepatitis (liver disease)	☐	☐	_____	Other: _____	☐	☐	_____

For Girls

Age at first period _____ Number of days your period usually lasts _____

Date when last period started _____ Are your periods regular (monthly)? ☐ No ☐ Yes
Month Date

Have you ever had a miscarriage, an abortion, or live birth? ☐ Yes ☐ No

Turn page

Confidential

Name _____

Family Information

9. With whom do you live? (Check all that apply.)

☐ Mother ☐ Stepmother ☐ Brother(s)/ages: _____
☐ Father ☐ Stepfather ☐ Sister(s)/ages: _____
☐ Guardian/Foster parent ☐ Other adult relative ☐ Other: (explain) _____

10. Do you have older brothers and sisters who live away from home? ☐ Yes ☐ No

11. Do you live in more than one household? ☐ Yes ☐ No

12. Have you ever lived away from home? (Do **not** include summer camp.) ☐ Yes ☐ No

If **yes**, please explain: _____

13. During the past year, have there been any major changes in your family such as: (Check all that apply.)

☐ Marriage ☐ Loss of job ☐ Births ☐ Other: (explain)
☐ Separation ☐ Move to a new neighborhood ☐ Serious illness _____
☐ Divorce ☐ A new school or college ☐ Deaths _____

14. Are any of the adults you live with unemployed (without a job)? ☐ Yes ☐ No

15. Do you have any family problems? ☐ Yes ☐ No

16. Have your parents or any of your blood relatives had a stroke or heart attack before age 55? ☐ Yes ☐ No ☐ Not sure

17. Do your parents or any of your blood relatives have "high cholesterol"? ☐ Yes ☐ No ☐ Not sure

Job/Career Information

18. Are you working? ☐ Yes ☐ No

If **yes**, what is your job? _____ Hours per week _____

19. What would you like to be when you are older? _____

Specific Health Issues

20. Please check whether you have questions or are worried about any of the following:

☐ Height/weight
☐ Blood pressure
☐ Diet/food/appetite
☐ Future plans/job
☐ Skin (rash, acne)
☐ Headaches/migraines
☐ Dizziness/fainting
☐ Eyes/vision
☐ Ears/hearing/ear aches
☐ Nose
☐ Lots of colds
☐ Mouth/teeth/breath
☐ Neck/back
☐ Chest pain/trouble breathing
☐ Coughing/wheezing
☐ Breasts
☐ Heart
☐ Stomach ache
☐ Nausea/vomiting
☐ Diarrhea/constipation
☐ Muscle or joint pain in arms/legs
☐ Frequent or painful urination
☐ Discharge from penis or vagina
☐ Wetting the bed
☐ Sexual organs/genitals
☐ Menstruation/periods
☐ Wet dreams
☐ Physical or sexual abuse
☐ Masturbation
☐ HIV/AIDS
☐ Trouble sleeping
☐ Feeling tired a lot
☐ Cancer
☐ Dying
☐ Sad or crying a lot
☐ Stress
☐ Anger/temper
☐ Violence/personal safety
☐ Other (explain)
_____
_____

Confidential

Name _____

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

21. Are you satisfied with your eating habits? ☐ No ☐ Yes
22. Do you ever eat in secret? ☐ Yes ☐ No
23. Do you spend a lot of time thinking about ways to be thin? ☐ Yes ☐ No
24. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ☐ Yes ☐ No
25. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? ☐ No ☐ Yes

School

26. Are your grades this year worse than last year? ☐ Yes ☐ No ☐ Not in school
27. Have you either been told you have a learning problem or do you think you have a learning problem? ☐ Yes ☐ No
28. Have you been suspended from school this year? ☐ Yes ☐ No ☐ Not in school

Friends & Family

29. Do you have at least one friend who you really like and feel you can talk to? ☐ No ☐ Yes
30. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ☐ No ☐ Yes
31. Have you ever thought seriously about running away from home? ☐ Yes ☐ No ☐ Not sure

Weapons/Violence/Safety

32. Do you or anyone you live with have a gun, rifle, or other firearm? ☐ Yes ☐ No ☐ Not sure
33. In the past year, have you carried a gun, knife, club, or other weapon for protection? ☐ Yes ☐ No
34. Have you been in a physical fight during the *past 3 months*? ☐ Yes ☐ No
35. Have you ever been in trouble with the law? ☐ Yes ☐ No
36. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not sure
37. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? ☐ No ☐ Yes
38. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? ☐ No ☐ Yes

Tobacco

39. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
40. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
41. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No

Alcohol

42. In the past month, did you get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
43. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
44. Have you ever been criticized or gotten into trouble because of drinking? ☐ Yes ☐ No ☐ Not sure
45. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? ☐ Yes ☐ No ☐ Does not apply
46. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? ☐ Yes ☐ No
47. Does anyone in your family drink or take drugs so much that it worries you? ☐ Yes ☐ No

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Drugs

48. Do you ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
49. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
50. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) ☐ Yes ☐ No
51. Have you ever used steroid pills or shots without a doctor telling you to? ☐ Yes ☐ No ☐ Not sure

Development

52. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ☐ Yes ☐ No ☐ Not sure
53. Do you think you may be gay, lesbian, or bisexual? ☐ Yes ☐ No ☐ Not sure
54. Have you ever had sexual intercourse? (How old were you the first time? _____) ☐ Yes ☐ No ☐ Not sure
55. Are you using a method to prevent pregnancy? (Which: _____) ☐ No ☐ Yes ☐ Not active
56. Do you and your partner(s) *always* use condoms when you have sex? ☐ No ☐ Yes ☐ Not active
57. Have any of your close friends ever had sexual intercourse? ☐ Yes ☐ No ☐ Not sure
58. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? ☐ Yes ☐ No ☐ Not sure
59. Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No ☐ Not sure
60. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? ☐ Yes ☐ No ☐ Not sure
61. Would you like to know how to avoid getting HIV/AIDS? ☐ Yes ☐ No ☐ Not sure
62. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No ☐ Thinking about it

Emotions

63. Have you had fun during the past two weeks? ☐ No ☐ Yes
64. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? ☐ Yes ☐ No
65. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? ☐ Yes ☐ No
66. Have you ever been physically, sexually, or emotionally abused? ☐ Yes ☐ No ☐ Not sure
67. When you get angry, do you do violent things? ☐ Yes ☐ No
68 Would you like to get counseling about something you have on your mind? ☐ Yes ☐ No ☐ Not sure

Special Circumstances

69. In the past year, have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not sure
70. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
71. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

72. What four words best describe you? _____
73. If you could change one thing about your life or yourself, what would it be? _____
_____
74. What do you want to talk about today? _____

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