ADOLESCENT HEALTH QUESTIONNAIRE
AGES 11-19

This questionnaire is to be completed by you in a private space. Please answer the questions to the best of your knowledge. If you do not know the answer to a question, leave it blank. If there is a question you do not want to answer, leave it blank. We encourage you to fill out the entire form. The form will become a **CONFIDENTIAL AND PRIVATE** part of your medical record. Thank you for taking the time to complete this form.

Date: _____
Name:_____ Birth date: _____
Work: _____ #Hrs./Wk.: _____ Phone: _____

Reason for today's visit:

_____
_____
_____

Social History

Are your parents/caregivers ☐ Married/Partnered ☐ Divorced ☐ Never Married ☐ Divorced (please describe living arrangements)

_____

Do you have step parents? ☐ Yes ☐ No
Are you adopted? ☐ Yes ☐ No

Who lives in your (primary) household? (Please fill in below)

Name	Relationship	Age

Do you have a parent, brothers or sisters who do not live with you? If yes, please list:

Name	Relationship	Age	Do you see on a regular basis?

Number of times you have moved? _____ When was the most recent move? _____
From where? _____ Did you have to change schools? ☐ Yes ☐ No
Are you happy with the way things are at home? ☐ Yes ☐ No If no, what seems to be the problem?
☐ Not having any privacy ☐ Parents interfere with decisions ☐ Being ignored by parents ☐ Parents use of alcohol or drugs ☐ Other

_____
_____

Do you have a pet? ☐ Yes ☐ No If so, what is it? _____

Do you belong to any organized groups or play any sports? ☐ Yes ☐ No If yes, which one?

_____

Do you attend a church, synagogue or mosque regularly? ☐ Yes ☐ No If you identify yourself as a part of a religious group, what is your religious preference? _____

I have ☐ too many friends ☐ just the right number ☐ too few friends

Do you have a best or several close friends? ☐ Yes ☐ No

Do you prefer spending time with others who are ☐ your age ☐ older ☐ younger

What activities/hobbies do you enjoy?

_____

_____

What do you do after school? _____

School History

School _____ School district _____ Grade ___

Do you attend school most days? ☐ Yes ☐ No

Do you like school? ☐ Yes ☐ No

What do you like best at school? _____

What is hardest? _____

Are you bullied? ☐ Yes ☐ No If yes, who have you told?_____

Have you ever repeated a grade? ☐ Yes ☐ No If yes, which one(s)? _____

Have you received any of the following to help you with school? ☐ Academic testing ☐ Study Skills/Lab classes ☐ Tutoring ☐ Other _____

Do you have an IEP (Individualized Education Plan) or a 504 plan? ☐ Yes ☐ No For what: _____

Have you decided what you would like to do after graduation from high school? ☐ Yes ☐ No

If yes, what? _____

Family Health History

Please tell us if a parent, brother or sister or grandparent has had this problem.

	Yes	No	Who		Yes	No	Who
ADHD/ADD				High Cholesterol			
Alcohol Problems				High Blood Pressure			
Anemia				Learning Disability			
Anxiety Problems				OCD (Obsessive Compulsive)			
Bipolar Disorder				Seizures			
Depression				Suicide			
Diabetes				Thyroid Problems			
Drug Problems				Tics			
Heart attack before 50				Tourette's			
Sudden death before 50				Stroke before 50			
				Headaches or migraines			

Other _____

Your Personal Health History

How do you describe your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you had a physical exam in the last year? ☐ Yes ☐ No

Current **prescribed** medications

_____
_____

Current **over the counter** medications

_____

Herb medications, Supplements, Vitamins, etc.

_____

Allergies to medications ☐ Yes ☐ No If yes, which one(s) _____

Conditions you have had or currently have:

	Yes	No			Yes	No	
ADHD/ADD				Heart Problems			
Arthritis				High Blood Pressure			
Anemia				Herpes			
Anxiety Problems				Knocked out (concussion)			
Asthma				Learning Disability			
Blood Transfusion				Seizures			
Broken Bone				Sexually Transmitted Disease			
Cancer				Thyroid problems			
Depression				Tics			
Diabetes				Bedwetting			
Fainting				Indigestion, stomach pain or ulcers			
Headache				Pain on urination			

Other major illnesses, operations, injuries or conditions (please describe and give the year or your age at the time)

_____
_____

Please check any of the items, which you have experienced and/or have concerns about:

☐ Few friends or very shy	☐ Feeling like running away
☐ Sexual development-body changes	☐ Arguments with boyfriend/girlfriend
☐ Feeling pressured to do what others are doing	☐ Worries about getting pregnant or getting someone pregnant
☐ Being gay or lesbian/feeling attracted to same sex	☐ Questions about drugs, alcohol, smoking

☐ Staying out of fights	☐ Inability to walk away from fights
☐ Family or home life issues	☐ Poor grades
☐ Thoughts of ending your life	☐ Not being part of the "group"
☐ Trouble getting a date	☐ Been arrested
☐ Height	☐ Questions about sex, STD's, AIDS, or birth control
☐ Body shape	☐ Being touched in a way that was uncomfortable or made you afraid
☐ Eating habits, weight control, concerns about weight	☐ Being in a relationship in which you were frequently put down, threatened or physically hurt
☐ Eating in secret/guilty about eating	☐ Not making school team or club
☐ Frequent street fights	☐ Gangs
☐ Feeling like your body doesn't match your gender	☐

Symptoms

Current symptom checklist:

None: This symptom not present at this time
Mild: Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate: Significant impact on quality of life and/or day-to-day functioning
Severe: Profound impact on quality of life and/or functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood most of the day nearly every day for at least 2 weeks	[ ]	[ ]	[ ]	[ ]	Irritable/snappy	[ ]	[ ]	[ ]	[ ]	Restless feeling	[ ]	[ ]	[ ]	[ ]
Loss of interest or pleasure in all or almost all activities	[ ]	[ ]	[ ]	[ ]	Talk too much	[ ]	[ ]	[ ]	[ ]	Muscle tension	[ ]	[ ]	[ ]	[ ]
Decrease in appetite or significant weight loss	[ ]	[ ]	[ ]	[ ]	Racing thoughts	[ ]	[ ]	[ ]	[ ]	Panic attacks	[ ]	[ ]	[ ]	[ ]
Increase in appetite or significant weight gain	[ ]	[ ]	[ ]	[ ]	Energized moods	[ ]	[ ]	[ ]	[ ]	Obsessions	[ ]	[ ]	[ ]	[ ]
Emotional/tearful	[ ]	[ ]	[ ]	[ ]	Distractible	[ ]	[ ]	[ ]	[ ]	Compulsions (acting out your obsessions such as frequent hand washing)	[ ]	[ ]	[ ]	[ ]
Agitated	[ ]	[ ]	[ ]	[ ]	Hypersexual	[ ]	[ ]	[ ]	[ ]	Anxious about everything	[ ]	[ ]	[ ]	[ ]
Fatigue/loss of energy	[ ]	[ ]	[ ]	[ ]	Excessive swearing	[ ]	[ ]	[ ]	[ ]	Panic attacks	[ ]	[ ]	[ ]	[ ]
Feelings of worthlessness	[ ]	[ ]	[ ]	[ ]	Disorganized	[ ]	[ ]	[ ]	[ ]	Phobias/fears	[ ]	[ ]	[ ]	[ ]
Excessive feelings of guilt	[ ]	[ ]	[ ]	[ ]	Misses details/makes mistakes	[ ]	[ ]	[ ]	[ ]	Social anxiety	[ ]	[ ]	[ ]	[ ]
Slowed down/sluggish	[ ]	[ ]	[ ]	[ ]	Difficult to pay attention	[ ]	[ ]	[ ]	[ ]	Social isolation	[ ]	[ ]	[ ]	[ ]
Decrease in concentration or poor	[ ]	[ ]	[ ]	[ ]	Difficult to listen to	[ ]	[ ]	[ ]	[ ]	Nightmares	[ ]	[ ]	[ ]	[ ]

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
concentration					people									
Cannot fall asleep (insomnia)	[ ]	[ ]	[ ]	[ ]	Difficulty following through with things	[ ]	[ ]	[ ]	[ ]	Flashbacks of traumatic event in past	[ ]	[ ]	[ ]	[ ]
Wakes up frequently	[ ]	[ ]	[ ]	[ ]	Dawdles/ waste time	[ ]	[ ]	[ ]	[ ]	Avoiding situations that re-expose you to something that reminds you of trauma	[ ]	[ ]	[ ]	[ ]
Too much sleep	[ ]	[ ]	[ ]	[ ]	Loses things like keys, phone	[ ]	[ ]	[ ]	[ ]	Startle easily	[ ]	[ ]	[ ]	[ ]
Indecisiveness (difficult to make decisions)	[ ]	[ ]	[ ]	[ ]	Easily distracted	[ ]	[ ]	[ ]	[ ]	Feelings of abandonment	[ ]	[ ]	[ ]	[ ]
Thoughts of death	[ ]	[ ]	[ ]	[ ]	Forgetful	[ ]	[ ]	[ ]	[ ]	Self-mutilation	[ ]	[ ]	[ ]	[ ]
Thoughts of killing self	[ ]	[ ]	[ ]	[ ]	Takes a lot of mental effort to get things done	[ ]	[ ]	[ ]	[ ]	Hallucinations	[ ]	[ ]	[ ]	[ ]
Hopeless					Fidgety/squirms					Delusions				
Grief/Loss					Difficulty staying seated					Odd beliefs				
Excessive Guilt					Runs and climbs on things					Food restricting				
Poor grooming	[ ]	[ ]	[ ]	[ ]	Blurts out the answers	[ ]	[ ]	[ ]	[ ]	Overeating/bingeing	[ ]	[ ]	[ ]	[ ]
Morbid thoughts	[ ]	[ ]	[ ]	[ ]	On the go as if run by a motor	[ ]	[ ]	[ ]	[ ]	Purging/vomiting	[ ]	[ ]	[ ]	[ ]
Bullies/Intimidates					Interrupts or intrudes					Laxative/diuretic abuse				
Disrupts family	[ ]	[ ]	[ ]	[ ]	Memory problems	[ ]	[ ]	[ ]	[ ]	Fear lack of control	[ ]	[ ]	[ ]	[ ]
Cruel to animals/destructive	[ ]	[ ]	[ ]	[ ]	Missing school or work	[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]
Rage episodes	[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]
Argumentative	[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]
Oppositional	[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]

Nutrition

Do you eat breakfast? ☐ Yes ☐ No If no, why? _____
Do you eat four or more fruits and vegetables on most days? ☐ Yes ☐ No
Do you have at least 3 servings of dairy products daily (milk, cheese, yogurt or ice cream)? ☐ Yes ☐ No
Are you a vegetarian? ☐ Yes ☐ No If yes, are you a vegan or total vegetarian? ☐ Yes ☐ No
On most days, do you eat more than 2 servings of foods high in fat such as chips, donuts, cookies, French fries, or other fast foods? ☐ Yes ☐ No
Do you take a multivitamin? ☐ Yes ☐ No If female, does it contain iron and folate? ☐ Yes ☐ No
Do you use any "dietary supplements" such as nutrition bars, Slim Fast, etc. more than twice a week? ☐ Yes ☐ No
Do you use laxatives, throw up after eating, or avoid eating to watch your weight? ☐ Yes ☐ No

Physical Activity

How many days a week do you exercise for 30 minutes or more?
☐ None ☐ 1-2 ☐ 3-5 ☐ 5+
Ever more than 60 minutes in a day? ☐ Yes ☐ No
What type of exercise do you do? _____

Safety

If you ride a motorcycle or bicycle, do you wear a helmet? ☐ Don't ride ☐ Yes ☐ No
Do you always wear your seatbelt in the car? ☐ Yes ☐ No
Do you ever drive or ride when the driver has had drugs or alcohol? ☐ Yes ☐ No
Do you or your friends have access to guns? ☐ Yes ☐ No
Are there guns in your home? ☐ Yes ☐ No
Have you ever experienced domestic violence (seen someone else be hit, kicked, shoved, yelled at in an abusive manner or experienced any of these yourself?) ☐ Yes ☐ No

Tobacco, Alcohol or other drugs

Have you ever smoked a cigarette, even a puff? ☐ Yes ☐ No
If yes, do you currently smoke? ☐ Yes ☐ No
If yes, how often do you smoke? ☐ Yes ☐ No
How old were you when you started smoking? _____
Have you used chewing tobacco or snuff? _____
Does anyone smoke inside your house? ☐ Yes ☐ No
Have you used pot (marijuana) in the past month? ☐ Yes ☐ No Past year? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks in the past week? (1 drink= 1 glass of beer, wine or 1 ounce of hard liquor)?
☐ 1-5 ☐ 6-8 ☐ 9-13 ☐ 14-17 ☐ 18-22 ☐ 22+
How often do you have 6 or more drinks on one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
Have you ever been drunk? ☐ Yes ☐ No
Have you ever had a blackout (you don't remember what happened while you were drinking?)
☐ Yes ☐ No
Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
☐ Yes ☐ No
Have you ever taken prescription sedatives, stimulants, or painkillers without your own prescription?
☐ Yes ☐ No

Have you ever used any of the following? (check all that apply)

Drug	**How long, much and how often (if you can remember)**
☐ LSD, mushrooms, PCP, Ecstasy "E"/MDMA, Salvia	
☐ Uppers (stimulants like Ritalin or Adderall)	
☐ Cocaine, crack or ice	

☐ Heroin smoked or injected	
☐ Downers (sedatives, Xanax, tranquilizers, pain killers)	
☐ Inhalants (glue, paint, spray cans, gasoline, nitrous oxide, poppers/amyl nitrate)	
☐ "Shooting up" anything including steroids	
☐ Speed (crystal meth, amphetamines, Tina, meth, "T"	
☐ Marijuana	
☐ Bath salts, ketamine, GHB	
☐ Other	

Sexuality

Females
Have your periods started? ☐ Yes ☐ No
If yes, are they regular? ☐ Yes ☐ No
Do you know the signs of pregnancy? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
Is there a chance you could be pregnant now? ☐ Yes ☐ No

Males
Have you ever gotten someone pregnant? ☐ Yes ☐ No

Male and Female:
Are you currently dating? ☐ Male ☐ Female ☐ Both
Do you have questions about sexuality that you would like to discuss today? ☐ Yes ☐ No
Have you ever had sex? ☐ Yes ☐ No
When you have sex, how often do you use birth control (birth control pills, condoms, etc.)? ☐ Always ☐ Sometimes ☐ Never
How often do you use condoms when you have sex? ☐ Always ☐ Sometimes ☐ Never
Do you ever have sex or feel pressured to have sex when you are drinking alcohol or using other drugs? ☐ Yes ☐ No
Do you have any questions about birth control, pregnancy, and other reproductive health care issues? ☐ Yes ☐ No

Please tell us about yourself during the last month. How often did you experience the following?

	Not at all	A little bit	Moderately	Quite a bit	extremely
Feeling low in energy					
Blaming yourself for things					
Feeling lonely or blue					
Restless/disturbed sleep					
Feeling hopeless about the future					
Feeling everything is an effort					