



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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorder/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

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Name _____

Family Information

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Brother(s)/ages: _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Sister(s)/ages: _____ |
| <input type="checkbox"/> Guardian/Foster parent | <input type="checkbox"/> Other adult relative | <input type="checkbox"/> 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.)

- | | | | |
|-------------------------------------|---|--|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of job | <input type="checkbox"/> Births | <input type="checkbox"/> Other: (explain) _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to a new neighborhood | <input type="checkbox"/> Serious illness | _____ |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> A new school or college | <input type="checkbox"/> 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:

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

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? _____