ADOLESCENT QUESTIONNAIRE

Name:____ Age:_________ Date:_________

SOCIAL HISTORY

1. With whom do you live? Check all that apply

☐Mother ☐Father ☐Guardian ☐Foster Parent ☐Stepmother ☐Stepfather ☐Brother/Sister(s) ☐Other:___________

2. During the past year have there been any major changes in your family? Check all that apply

☐Marriage ☐Divorce ☐Moved ☐New School ☐Births ☐Deaths ☐Serious Illness ☐Other:__________________

3. Do you think that your parent(s) or guardians(s) listen to you and take your feelings seriously?--------------------☐ Yes ☐No
4. Is there anything you would like to change about your family?--☐ Yes☐ No

SCHOOL

1. Where do you go to school? ____ What grade are you in?_________________
2. Over the past year have your grades been mainly ☐As & Bs ☐Bs & Cs ☐Cs & Ds ☐Ds & Fs
3. What do you like most about school?____

PERSONAL CONCERNS **Check any items below which concern or trouble you:**

☐Cancer ☐Hearing/Vision ☐Stomachaches ☐Teeth or Breath ☐Coughing/Hard to Breathe
☐Skin Problems/Acne ☐Making Friends ☐Chest Pain/Heart Trouble ☐Nausea/Vomiting ☐Anger/Temper
☐Stress ☐Muscle/Joint Pain ☐Sad/Crying a Lot ☐Pregnancy ☐HIV/AIDS
☐Headaches/Migraines ☐Anxious or Nervous ☐Diarrhea/Constipation ☐Sleeping Problems ☐Dying
☐Dizzy Spells/Fainting ☐Tired all the Time ☐Wetting the Bed ☐Feeling Down/Depressed ☐Boyfriends/Girlfriends
☐Height/Weight ☐Physical/Sexual Abuse ☐Sexual Issues ☐Other:____

PERSONAL SAFETY

1. Do you always wear a helmet when you bicycle, rollerblade, skateboard, or ride a motorcycle?----------------- ☐ Yes ☐No
2. Do you always wear a seatbelt when you ride or drive a car?-- ☐Yes ☐No
3. Do you or anyone you live with have a gun, rifle, or other firearm?--- ☐Yes ☐No
4. Are you worried about your personal safety?--- ☐Yes ☐No
5. In the past year have you or a friend carried any kind of weapon for protection?------------------------------- ☐Yes ☐No
6. Have you ever been in trouble with the law?-- ☐Yes ☐No

HEALTH HABITS

1. Have you seen a dentist in the last year?--- ☐Yes ☐No
2. Do you usually wear sunscreen?--- ☐Yes ☐No
3. How many times a week do you exercise?____
4. Are you satisfied with the size or shape of your body, or your physical appearance?------------------------------ ☐Yes ☐No
5. In the past year, have you tried to lose weight by throwing up or starving yourself?------------------------------- ☐Yes ☐No
6. Do you eat: Breakfast: ☐Yes ☐No Lunch: ☐Yes ☐No Dinner: ☐Yes ☐No
7. Do any of your friends drink or use drugs?--- ☐Yes ☐No
8. Have you ever tried any of the following drugs?

   ☐Alcohol ☐Cigarettes ☐Marijuana ☐Cocaine ☐Heroin ☐Diet Pills ☐Chewing Tobacco ☐Sniffing (inhalants) ☐Other___________

9. Does anyone in your family drink or take drugs so much that it worries you?----------------------------------- ☐Yes ☐No

THOUGHTS ABOUT YOURSELF

1. During the past few weeks, have you often felt very sad or down?---☐Yes ☐No
2. Have you ever seriously thought about killing yourself?---☐Yes ☐No
3. When you get angry, do you ever get violent?--☐Yes ☐No
4. Do you think counseling would be helpful for you or anyone in your family?---☐Yes ☐No

PERSONAL HEALTH

1. Have you ever had any sexual experiences?-- ☐Yes ☐No
2. Are you concerned about sexually transmitted diseases or pregnancy?--- ☐Yes ☐No
3. Have you ever been forced to do something sexual that you did not want to?--------------------------------------- ☐Yes ☐No

For Females:

Have you started your periods? ☐Yes ☐No If yes: How old were you?_____ When did your last period start?_______

Number of days your bleeding usually lasts:__________ Are your periods regular (monthly)? ☐Yes ☐No

WORK

1. Do you work?--☐Yes ☐No
2. Doing what?_______________________________________ Hours per week?______________________________
3. Extracurricular Activities:____

Do you have any other questions you would like to discuss with your doctor or nurse?-------------------------------- ☐Yes ☐No

If yes, what? ____

____

Patient MRN:____________________

Patient Name:______________________________

Patient DOB:____________________

Appointment Date:_______________

The CRAFFT Screening

These are a few questions that I ask all my patients.
Please be honest when answering these questions.

Your answers on this form will remain confidential.

Substance use (CRAFFT):

In the last 12 months, did you:

	NO	YES
Drink any alcohol (more than a few sips)?	☐	☐
Smoke, vape or eat any kind of marijuana?	☐	☐
Use anything else to get high?	☐	☐

If you answered **No** to all three questions, **answer #1 below**

If you answered **Yes** to any questions, answer **questions #1-6 below**

	NO	YES
1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or to fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	☐	☐
4. Do you ever forget things you did while using alcohol or drugs?	☐	☐
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into trouble while you were using alcohol or drugs?	☐	☐

Pediatrics
541-476-6644

MRN:__________ Pt. DOB:___________

Pt. Name:___________________Date:_______

Mood (PHQ-9 Modified for Teens):

How often have you been bothered by each of the following symptoms during the past **TWO WEEKS?**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired, or having little energy?	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
	0	1	2	3

In the **PAST YEAR,** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

ADOLESCENT PARENT/GUARDIAN QUESTIONNAIRE

Adolescent's Name:____________________________ Age:________ Birth Date:________
Your name:__________________________ Relationship to Adolescent:________________
Today's Date:____________________

1. Has there been any changes in your adolescent's health during the past year? ☐Yes ☐No If yes, please explain: ______________________
____

2. Please review the topics listed below and check if this is a concern you have about your adolescent or if you would like to discuss the topic:

☐ Physical Complaints	☐ Relationship with Family	☐ Grades/Truancy/Dropout	☐ Birth Control
☐ Physical Development	☐ Choice of Friends	☐ Smoking Cigarettes	☐ Sexual Issues
☐ Weight	☐ Self Image / Self Worth	☐ Chewing Tobacco	☐ HIV/AIDS
☐ Diet / Nutrition	☐ Excessive Moodiness / Rebellion	☐ Drug Use	☐ School
☐ Sleep Patterns	☐ Depression	☐ Alcohol Use	☐ Work or Job
☐ Amount of Exercise	☐ Lying/Stealing/Vandalism	☐ Dating/Parties	☐ Violence
☐ Emotional Development	☐ Other:________________		

3. Do you have any concerns regarding past medical problems?________________________________

4. List any medications or drugs your child is taking now:________________________________

5. Over the past year, your adolescent's grades have been mainly: ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's

6. How many days of school has your child missed since the beginning of the school year?____________________

7. How many hours per week does your adolescent work outside the home?________________________

8. What do you find most rewarding about being the parent of your adolescent? ______________________
____
____

9. What is it about your adolescent that makes you proud of him or her? __________________________
____
____

10. Do you have any additional questions or concerns?______________________________________
____
____
____

PARENT AND GUARDIAN CHALLENGES

Health life styles and preventive measures should be a part of everyone's daily routine. Your decisions about alcohol and other drugs, smoking, food choices, safety, and physical activity can strongly influence your adolescent's behavior and decisions. Parents / Guardians demonstrate by their actions what they believe and value.

Thank you for allowing us to provide medical care for your adolescent.