Caring Pediatrics
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Adolescent Questionnaire

This document is to gather additional information, in effort to educate and prevent issues related to the health and well-being of our teenage patients. This questionnaire is considered a confidential document to be completed by the patient only. This information will be shared between the patient and treating physician only unless there is potential harm to the patient or others.

Name: _____ **Date of Birth:** _____

Do you have any questions or concerns today? _____
_____
_____

In the past year, has there been any change in your family? (Check all that apply)

Divorce • Marriage •Move to new home or school •Parent separation
Death •Loss of Job • Serious illness • Birth
• Other _____

Do you have any concerns about school? _____

What kind of grades do you have? _____

Have you ever been in trouble with law enforcement? If yes, please explain. _____

_____

Are you worried about violence or your safety? _____
Are you happy with your current weight? •Yes •No
If not, please explain. _____
Have you ever taken: laxatives, pills, skipped meals, or used a special diet to change your weight?
•Yes •No If yes, explain. _____

Do you smoke cigarettes? •Yes •No If yes, how much? _____
Are you interested in quitting? •Yes •No •NA
Do you drink alcohol? •Yes •No If yes, How much and how often? _____
Have you ever been drunk? •Yes •No
Do you use "street drugs" of any sort? •Yes •No If yes explain _____
Have you ever used any substance to get "high?" •Yes •No If yes, explain _____
_____

Are you worried about anyone else in your home that uses drugs or alcohol? •Yes •No
If yes, please explain
_____
_____
_____

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In the past few months, have you felt depressed or extremely sad with nothing to look forward to?	•Yes	•No
Have you ever had thoughts of harming yourself or suicide?	•Yes	•No
Have you ever been abused sexually, physically or emotionally?	•Yes	•No
Do you have a friend you feel comfortable talking to?	•Yes	•No
Are you currently dating someone?	•Yes	•No
Do you have any questions about sex, STDs or puberty?	•Yes	•No
Would you like information about STDs or birth control?	•Yes	•No
Do you think you might be pregnant?	•Yes	•No
Have you ever had sex?	•Yes	•No
Would you like information on homosexuality or bisexuality?	•Yes	•No
Have you ever been forced to have sex against your will?	•Yes	•No
Would you like to be tested for STDs?	•Yes	•No
Do you need birth control now?	•Yes	•No

Is there anything else you would like to talk to the doctor about or receive information?

_____
_____
_____
_____

Signature: _____ Date: _____