4439 Rowan Rd.
New Port Richey, FL 34653
Phone(727)853-CARE Fax (727)853-2277
www.caringpediatrics.com

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? ______________________________________
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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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Question		
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? ________________

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Signature: ___________________________________ Date: ____________________