Name: ______________________________
Birthdate: ___________________________

11 YEAR HEALTH QUESTIONNAIRE

Patient to complete

DATE: __________________

MEDICAL HISTORY UPDATE - *Since your last physical have you had:*

Any major illnesses or injuries? ❑ N ❑ Y   Any surgeries or hospitalizations? ❑ N ❑ Y   Changes in your family's medical history? ❑ N ❑ Y

CURRENT HEALTH PROBLEMS

What would you like to ask us about your health, your body or your feelings today?

____

____

PEDIATRIC SYMPTOM CHECKLIST – YOUTH REPORT - Please put an X in the column that best fits you for each question

	Never	Sometimes	Often
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with others			
17. Absent from school			
18. School grades dropping			

	Never	Sometimes	Often
19. Down on yourself			
20. Visit doctor with doctor finding nothing			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			

Office use only: Score: ____________Provider Initials: _______

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Children's MINNESOTA

Adolescent Health Assessment – CONFIDENTIAL

Date:__________ Preferred Name:__________________________ Pronouns: ____________________

If you have your own cell phone, please write your number here: ________________________________

Why do we ask these questions and what do we do with the information?

- We ask every patient questions about things that can affect their health. It is okay to leave some questions blank if you don't want to answer.
- Please answer the questions on your own without help from your parent/caregiver or friends.
- Your answers are private between you and your health care provider. We will only talk to your parent/guardian about this information if we have a serious concern about your health and safety. Before we talk to a parent/guardian, we will talk about it with you.

Personal Health

Yes | No Do you eat fruits and vegetables every day?

Yes | No Do you exercise at least 3 times per week? (work out, walk, bike, play a sport)

Yes | No Do you get at least 8 hours of sleep most nights?

Yes | No Do you have at least one adult you can talk to about problems or worries?

Yes | No Is there something you are really good at?

Yes | No Is your family proud of you?

Yes | No Are you happy?

No | Yes Have you missed more than 7 days of school in the last year?

No | Yes In the past 3 months, have you tried to lose weight?

No | Yes Do you ever skip meals, use laxatives or diet pills, or throw up on purpose to lose weight?

No | Yes Have you ever had any kind of sex (with anyone of any gender)?

Are you, or do you wonder if you are, gay, lesbian, bisexual, pansexual, asexual, or questioning your sexuality in any other way?__________

Are you, or do you wonder if you are, transgender, non-binary, gender fluid, or gendernonconforming? ______________

Tobacco, Alcohol, and Drugs

In the past year, check if you have used any of the following, even if it was just once:

______ Alcohol
______ Vaping products
______ Tobacco
_______ Pain pills (Percocet, Vicodin, Norco, or other opioids) not prescribed to you
_______ Stimulants (Ritalin, Adderall) not prescribed to you
_______ Marijuana (including edibles/gummies, smoking dried plant, vaping, or dabbing

Safety

No | Yes Have you ever been bullied, threatened, stalked or hurt by someone?

No | Yes Have you ever been physically or emotionally abused or hurt by anyone? (such as kicked, hit, been called worthless)?

No | Yes Have you ever sent or received a sexual message or picture, either texting or through social media?

No | Yes Has anyone forced or tricked you into having sex or doing sex things?

No | Yes Do you or anyone you live with have a gun or carry a gun?

Yes | No Do you feel safe at school, home, and in your community?

Yes | No Do you have a safe place to live?

Yes | No Do you always wear a seat belt when in a car?

Yes | No Do you always wear a helmet when biking or skateboarding?

What are three words that describe you? ____

_________Provider initials

PLACE PATIENT LABEL HERE

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