Children's MINNESOTA

Name: _____

Birthdate: _____

12 - 17 YEAR HEALTH QUESTIONNAIRE

Patient to complete

DATE: _____

CURRENT HEALTH PROBLEMS

Are you worried about, have or had problems with any of these? *(check all that apply)*

❒ Sleep problems: How many hours of sleep do you get? ____

❒ Appetite	❒ Heart racing/skipped beats	❒ Headaches
❒ Energy	❒ Diarrhea	❒ Fainting/blackouts/dizziness
❒ Vision	❒ Constipation	❒ Head injury/Concussion
❒ Hearing	❒ Stomach ache	❒ Bruising or bleeding easily
❒ Allergy symptoms	❒ Heartburn	❒ Joint pain or dislocations
❒ Nose symptoms	❒ Bedwetting	❒ Injuries (fractures, sprains, tears)
❒ Wheezing or cough	❒ Urinary symptoms	❒ Back pain
❒ Shortness of breath	❒ Acne	❒ Exercise problems
❒ Chest pain	❒ Rashes	❒ For females: Periods

_____Provider initials

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

* A D O L H Q U E S *

PLACE PATIENT LABEL HERE