Children's MINNESOTA

12 - 17 YEAR HEALTH QUESTIONNAIRE

Patient to complete

Name: _____

Birthdate: _____

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/weight
- ❒ Energy
- ❒ Vision or hearing
- ❒ Allergy or nasal symptoms
- ❒ Wheezing or cough
- ❒ Shortness of breath
- ❒ Chest pain
- ❒ Diarrhea
- ❒ Constipation
- ❒ Stomach ache/heartburn
- ❒ Bedwetting
- ❒ Urinary symptoms
- ❒ Acne
- ❒ Rashes
- ❒ Headaches
- ❒ Fainting/blackouts/dizziness
- ❒ Head injury/Concussion
- ❒ Bruising or bleeding easily
- ❒ Joint pain or dislocations
- ❒ Injuries(fractures,sprains,tears)
- ❒ Back pain
- ❒ Exercise problems
  - ❒ Headaches
  - ❒ Chest pain
  - ❒ Heart racing/skipped beats

PHQ 9 Modified for Adolescents

How often have you been bothered by ach of the following symptoms during that **past two weeks?** For each symptom put an "X' in the box beneath the answer that best describes how you have been feeling.	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure or 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?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ❒ Yes ❒ No

11. 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

12. Has there been a time in the **past month** when you have had serious thoughts about ending your life? ❒ Yes ❒ No

13. Have you **EVER** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ❒ Yes ❒ No

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your provider, go to a hospital emergency room or call 911

*Office use only: Severity score:*_____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "√" to indicate your answer).	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling nervous, anxious or on edge				
2. Not being able tp stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these problems made it for your 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

_____Provider initials (For office coding: Total Score T = _____ + _____ + _____ + _____)

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B., A brief measure for assessing generalized anxiety disorder. *Arch Inern Med*. 2006; 166: 1092-1097

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

* A D O L H Q U E S *

PLACE PATIENT LABEL HERE