Children's MINNESOTA

Name: _____

Birthdate: _____

YOUNG ADULT HEALTH QUESTIONNAIRE

(18 years and older)

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

Within the past 12 months, you worried that your food would run out before you got money to buy more.

❒ Often true ❒ Sometimes true ❒ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

❒ Often true ❒ Sometimes true ❒ Never true

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? (Check all that apply)

❒ Yes, it has kept me from medical appointments or getting medications
❒ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
❒ No

Would you like information regarding these concerns? ❒ Yes, have someone contact me ❒ Yes, I would like written information ❒ No

DYSLIPIDEMIA RISK

Do any of your parents, grandparents, aunts/uncles, or siblings have a history of early heart disease (< 55 years in males, < 65 years in females)? ..... N Y

Do either of your biological parents have high cholesterol (total greater than 240 mg/dL)? ..... N Y

TUBERCULOSIS (TB) RISK

Have you had recent close contact with someone with active TB disease? ..... N Y

Were you born in or had extensive travel to Asia, Africa, Eastern Europe or Latin America? ..... N Y

Do you have any chronic illnesses (including HIV, diabetes, cancer, kidney disease, intestinal disease)? ..... N Y

Have you been exposed to homeless shelters, refugee camps or prison/jail? ..... N Y

PHQ 9

How often have you been bothered by each of the following symptoms during ***the last 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. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in someway				

If you checked off any problems, 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

★★ CONTINUE TO QUESTIONS ON PAGE 2 ★★

Children's MINNESOTA

Generalized Anxiety Disorder 7 – Item (GAD-&) Scale

Instructions: Over the **last two weeks,** how often have you been bothered by the following problems? For each question 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 nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Add score for each column	+	+	+	
Total Score (add together the scores from each column) =				

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

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

★★ **CONTINUE TO QUESTIONS ON PAGE 3** ★★

Name: _____

Birthdate: _____

_____ Provider initials

Children's MINNESOTA

Adolescent Health Assessment – CONFIDENTIAL

31356 (10/23)

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