Pediatric Health Care Associates
Teen and Young Adult Questionnaire

Sometimes it is easier to tell your doctor your problems in this way. Complete the form. Hand this paper directly to your doctor at the beginning of your appointment. All conversations are strictly confidential which means that your answers do not have to be discussed with your parents unless you indicate otherwise.

Please Check One:

- ❑ **I would not like this information shared with my parents.**
- ❑ **I am willing to have this information shared with my parents.**

Circle "yes" or "no" and fill in the blanks if needed.

1. Do you ever worry about your health (physical or mental health)? yes no
2. Do you get depressed or upset easily? yes no
3. Have you ever thought about hurting yourself? yes no
4. Do you think something is wrong with your skin? yes no
5. Do you think something is wrong with your weight? yes no
6. Are you having any problems at school? yes no
7. Have you ever been hit, injured, or threatened by anyone? yes no
8. Have you been in any fights (pushing, hitting) in the last year? (how many) 0 1 2-4 5-10 10+
9. Is there any conflict or fighting in your home? yes no
10. Have you been hit or injured by anyone at home in the last year? (how many times) 0 1 2-4 5-10 10+
11. Have there been any important changes in your family? yes no
12. Have you ever used alcohol without your parents being aware of it? yes no
13. Do you smoke cigarettes? How many per day:_____ yes no
14. Do you have any questions about drinking, drugs, or smoking? yes no
15. Do any of your friends use drugs? yes no
16. Have you ever used marijuana, cocaine, acid, P.C.P., steroids, inhalants, heroin, ecstasy, or similar substances? (please circle) yes no Do you use any now? yes no How Often?_____
17. Do you, or does anyone you know, drive after drinking or using drugs or have you ever ridden with a driver who has used drugs or alcohol ? yes no
18. Have you ever had sex? yes no
19. Have you ever experienced any unwanted sexual contact? (For example, touch, fondling, or sexual intercourse that was against your will?) yes no
20. Do you have any questions about your sexual development, pregnancy, birth control, sexually transmitted disease, or AIDS? yes no
21. Is there a gun in your home? yes no
22. Do you, or does anyone you know, ever carry a weapon? yes no
23. Do you wear a seatbelt? yes no
24. Do you ride a ...? (please circle) Mini-bike/moped Motorcycle Snowmobile ATV Scooter
25. Do you wear a helmet during outdoor activities? yes no
26. Do you have a job? yes no
27. Do you have any other questions you would like to discuss with the doctor? yes no

    If yes, please list _____