ADOLESCENT SURVEY – TO BE FILLED OUT BY THE PATIENT

**This worksheet gives your doctor information to help take better care of your health. Leave questions blank if you feel they don't apply to you. Your answers are confidential, and we will not share with others without your permission unless we are concerned about your safety.

Name: _____ Preferred pronouns: _____

Your cell phone: _____

SCHOOL & ACTIVITIES

- What school do you attend? _____What grade/year? _____
- Are you having a hard time in school? YES NO
- Do you have a job? YES NO If yes, what is it, and how many hours per week?

  _____
- What sport, activities or hobbies do you do? _____
- About how many hours of screen time do you spend most days? _____
- Do you get at least 30 minutes of exercise at least 3 times a week? YES NO

NUTRITION

- Do you eat breakfast every day? YES NO
- Do you eat fruits and vegetables every day? YES NO
- Do you eat or drink dairy products? YES NO
- Are you a vegetarian or do you restrict your diet in any other way? YES NO
- Do you ever eat in secret or feel guilty about eating? YES NO
- Have you ever tried to lose weight by vomiting, taking pills, or starving yourself? YES NO

FAMILY & PEERS

- Who lives with you at home? _____
- Do you get along with the people you live with? YES NO
- Are you having a hard time with kids at school or other peers? YES NO
- Do you have at least one trusted friend you can talk to about any problems? YES NO
- Do you have at least one caring adult you feel comfortable talking to? YES NO

SAFETY

- Do you feel safe at home? YES NO
- Do you feel safe at school and/or your job? YES NO
- Do you always wear a seatbelt in the car? YES NO
- Do you always wear a helmet when riding a bike, scooter, or skateboard? YES NO
- Are there any guns in your home? YES NO
- Do you feel afraid in any of your relationships? YES NO
- Have you ever been physically or sexually abused by anyone? YES NO

OVER →

SEXUALITY

- Are you attracted to: MALES FEMALES BOTH NOT SURE
- Are you, or do you wonder if you are gay, lesbian, bisexual or transgender? YES NO
- Are you currently in a relationship? YES NO
- Have you ever had sex? YES NO
    - If so, were your partners: MALE FEMALE BOTH
    - If you have sex, do you always use a condom? YES NO

HEALTH ISSUES

Please check if you have questions or are worried about any of the following:

- HEIGHT or WEIGHT
- DIET/FOOD/APPETITE
- CONGESTION/COUGH
- CHEST PAIN/HEART/TROUBLE BREATHING
- HEADACHES
- CONSTIPATION or DIARRHEA
- STOMACH ACHE or VOMITING
- BIRTH CONTROL or STDs
- SKIN
- FATIGUE (feeling tired) or SLEEP PROBLEMS
- STRESS or EMOTIONS
- OTHER_____