Suburban Pediatrics

Adolescent Questionnaire

Name: _____ **DOB**: _____

Today's Date: _____ **Patient Cell Phone Number:** _____

Who do you live with? _____

Please circle your answer to each of the following questions:

1. How often do you use a helmet when you rollerblade, skateboard, bicycle, or ride a motorcycle, minibike or ATV?

Always Sometimes Rarely or never

2. How often do you wear a seat belt when you ride in a car, truck or van?

Always Sometimes Rarely or never

3. Are you having any problems in school?

Rarely or never Sometimes Always

Circle all that apply. . . grades, fighting, missing school

4. Have you ever felt you had a problem with your weight?
(underweight, overweight, anorexia, bulimia)

Rarely or never Sometimes Always

5. Did you ever smoke cigarettes (even if you did not inhale) or chew tobacco?

Never Once or twice 3 or more times

6. Did you ever drink any alcohol? (beer, wine, liquor, other)

Never Once or twice 3 or more times

7. Did you ever use drugs?

Never Once or twice 3 or more times

Circle all that apply. . . marijuana, cocaine, crack, heroin, acid, speed, ecstasy, roofies, sniffed inhalants, steroids, hormones, prescription drugs not ordered for you, or others

8. Have you ever ridden in a vehicle when the driver is under the influence of alcohol or drugs?
(This includes when you were the driver as well as other people).

Never Once or twice 3 or more times

9. Have you ever done something violent because you were angry?

Never Once or twice 3 or more times

10. Have you ever had someone at home, school or anywhere else, who made you feel afraid, threatened you, or hurt you?

Never Once or twice 3 or more times

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Adolescent Questionnaire

Name: _____ **DOB**: _____

Please circle your answer to each of the following questions:

11. Have you had sex?

No Yes

Circle all that apply . . . vaginal sex anal sex oral sex

12. If you have had sex, how often do you use condoms (rubbers)?

Never had sex Always Sometimes Rarely or never

13. Were you ever forced to have sex you did not want, or has someone touched you in a way that made you feel uncomfortable? (touching of breasts, buttocks, or genitals)

Never Not sure Yes

14. Have you ever felt sad or down for more than 2 weeks or felt as though you had nothing to look forward to?

Never Once or twice 3 or more times

15. Have you ever thought about killing yourself or made a plan to kill yourself?

Never Once or twice 3 or more times

DO YOU HAVE ANY QUESTIONS ABOUT ANY OF THESE TOPICS?

There may be subjects that you would like to know more about. You may have friends or know people who are making these choices, or you may want more information to help you make choices in the future. CIRCLE any subjects you would like more information about and add any subjects that are not listed below.

tobacco	abstinence (saying no)	depression
quitting smoking	safer sex	suicide
alcohol	birth control	abuse
drugs	homosexuality (gay/lesbian)	weight problem
steroids (bulking up)	HIV/AIDS	diet pills/laxatives
sniffing (glue, aerosol)	sexual diseases (STDs)	exercise/fitness
sharing needles/works	gender issues (transgender/transsexual)	
body piercing/tattoos/branding	other_____	

Office Use Only

I have reviewed the above information with my patient.

Date: ____/_____/_____ Initials: _____

Developed by the Adolescent Quality Improvement Work Group, September 2000.
https://www.health.ny.gov/health_care/managed_care/reports/qui/adolescent/adolescent.htm