

CONFIDENTIAL

HEALTH SURVEY FOR ADOLESCENTS

Everyone is faced with choices and situations that are complicated. The purpose of these questions is to give your health care provider (HCP) information to care for you. If you have any questions about these subjects, ask your HCP.

YOU DO NOT HAVE TO ANSWER THE QUESTIONS. If you choose not to fill it out, please read the questions anyway because your HCP will want to talk about any questions you may have. The information you share will be kept PRIVATE between you and your HCP unless the information is needed to protect you from immediate danger.

Medical History

1. Why did you come to the clinic today? _____
2. Are you taking any medications (this includes prescription or over the counter medicines that are available at grocery or drug stores)?
 No Yes Name of medicine _____
 Circle all that apply.... Tylenol, Aspirin, Ibuprofen (Motrin), Sudafed, Other _____
- 2a. Are you taking any herbs or home remedies? What is the name of it and what is it used for? _____

For Girls

Age at first period _____ Number of days your period lasts _____ Are your periods regular? _____ First day of your last period _____

Family Information

3. Who do you live with at home? (Check all that apply)
 Mother Stepmother Brother(s)/ages _____
 Father Stepfather Sister(s)/ages _____
 Guardian/Foster parent other adult relative other: (explain) _____
4. During the past year, have there been any major changes in your family such as: (check all that apply)
 Marriage Loss of job Births
 Separation Serious illness Deaths
 Divorce A new school or college Other (explain) _____
5. Do you have any family problems? Yes No

Specific Health Issues

6. Do you have any questions about any of these topics?
 Please 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
weight problem	steroids	HIV/AIDS	diet pills/laxatives	exercise/fitness
sexual diseases (STDs)		Sexual or gender identity (gay, lesbian, bisexual, transgender, homosexual, unsure)		
body piercing/tattoos		other _____		

7. Are you having any problems in school? Rarely or never Sometimes Always
 Circle all that apply grades, fighting, missing school

8. Do you have at least one adult that you can really talk to? Always Sometimes Rarely or never

9. Do you get some exercise at least 3 times a week? Always Sometimes Rarely or never

10. Do you think you are Just right Thin Fat

11. Have you ever had a problem with your weight? (Underweight, overweight, using vomiting and/or medications to gain or lose weight?)
Rarely or never Sometimes Always

12. Do you and your family eat meals together ___ 1 time/week ___ 2 times/week ___ 3 or more times/week

13. Do you smoke cigarettes or chew tobacco?	Rarely or never	Monthly	Weekly	Daily
14. Do you drink any alcohol? (beer, wine, liquor, other)	Rarely or never	Monthly	Weekly	Daily
15. Did you ever use drugs? Circle all that apply... marijuana, cocaine, crack, heroin, acid, speed, ecstasy, sniffed inhalants, steroids, methamphetamines, "glass"	Rarely or never	Monthly	Weekly	Daily
16. Do you wear a seatbelt in a car/truck?	Always	Sometimes		Rarely or never
17. Have you ever ridden in a vehicle when the driver is under the influence of alcohol or drugs?	Never	Once		3 or more times
18. Have you ever done something violent because you were angry?	Never	Once		3 or more times
19. Have you ever had someone at home, school, or anywhere else, who made you feel afraid, threatened you, or hurt you?	Never	Once		3 or more times
20. Have you ever had sexual contact? (with women, men, or both) If yes, how many partners have you had?	Yes 1	No 2-3		4 or more
21. If you have had sex, how often do you use a condom?	Almost always	Sometimes		Never
22. Have you ever felt sad or down for more that 2 weeks?	Never	Sometimes		Often
23. Have you ever felt as though you had nothing to look forward to?	Never	Sometimes		Always
24. Have you ever thought about killing or hurting yourself?	Never	Once		3 or more times
25. Have you ever tried to kill yourself?	Never	Once		3 or more times
26. Have you ever been physically or sexually abused or mistreated by anyone (kicked, hit, pushed, forced or tricked into having sex, touched on your private part(s)?)	Never	Once		3 or more times
27. Do you participate in religious activities? Circle all that apply... Navajo traditional ceremonies, Native American Church, Christian, Mormon, Catholic, Other _____	Always	Sometimes		Never
27a. Do you find this helpful?	Yes	Sometimes		No
28. What four words best describe you?				
29. If you could change one thing about yourself or your life, what would it be?				
30. Do you participate in school-related activities? (e.g. sports, clubs/teams, student government, ROTC)				
Do these activities ___ introduce you to new people ___ increase your interest in school ___ increase your school-related stress?				