



Teen Questionnaire - CONFIDENTIAL

Name: _____ Date of Birth: _____ Date: _____

Your answers will only be seen by your doctor and his/her staff. We will not show your parents. It's okay to skip a question if you don't want to talk about something.

What four words best describe you? _____

If you could change one thing about your life or yourself, what would it be? _____

Are you satisfied with your eating habits? D No D Yes

Do you eat healthy food most of the time?..... No D Yes

Are you happy with your current weight? D No D Yes

Have you tried to control your weight by exercising too much, vomiting, taking diet pills, or starving yourself?..... D Yes No

Do you have concerns or questions about the shape or size of your body or physical appearance? D Yes No

Do you exercise for 20 minutes or more at a time at least 3 or more times a week? D No D Yes

Are you having problems in school this year?..... D Yes No

Have you been told you have a learning problem or do you think you may have a learning problem? D Yes No

How many days of school have you missed this year? _____

Do you have at least one friend who you really like and feel you can talk to?..... D No D Yes

Do you think that your parent(s) usually listen to you and take your feelings seriously? D No D Yes

Have you ever hurt yourself intentionally (for example, cutting, pinching, punching)?..... D Yes No

Have you ever thought seriously about running away from home? D Yes No

What is the most stressful thing in your life right now? _____

Do you, or anyone you live with, have a gun, rifle, or other firearm? D Yes No

Have you ever carried a gun, knife, club, or other weapon for protection?..... D Yes No

Have you been pushed, hit, kicked, or abused? D Yes No

Are you worried about violence or your safety? D Yes No

Do you wear a helmet when you ride a bicycle, scooter, or dirt bike? D No D Yes

Do you wear a seatbelt when you ride in or drive a car? D No D Yes

For drivers: have you had an accident or ticket? D Yes No N/A

For drivers: what do you do with your cell phone while driving? _____

Have you ever smoked cigarettes, cigars, e-cig devices, vaped, or used snuff or chewing tobacco?..... D Yes D No

Do any of your friends smoke cigarettes, cigars, e-cig devices, vape, or used snuff or chewing tobacco?..... D Yes D No

Does anyone who lives with you smoke cigarettes, cigars, e-cig devices, vape, use snuff or chewing tobacco?..... D Yes D No

Have you ever been buzzed or drunk from beer, wine, or other alcohol (like vodka, gin, whiskey)?..... D Yes D No

Have any of your friends been buzzed or drunk from beer, wine, or other alcohol (like vodka, gin, whiskey)?..... D Yes D No

Have you gotten into trouble because of drinking alcohol?..... D Yes D No

Have you ever drunk alcohol and then driven a car or other vehicle?..... D Yes D No

Have you ever been in a car or other vehicle when the driver had been drinking?..... D Yes D No

Does anyone in your family drink or take drugs so much that it worries you?..... D Yes D No

Have you ever smoked marijuana, eaten marijuana edibles, or used other drugs (for example: cocaine, ecstasy)?.. D Yes D No Do

any of your close friends use marijuana or other drugs (for example: cocaine, ecstasy)?..... D Yes D No Have

you used medications that weren't prescribed to you to sleep, stay awake, calm down, or get high?..... Yes D No

Do you think you might be gay, lesbian, bisexual, pansexual, asexual, transgender, or questioning? D Yes No

Have you ever had sex? (If yes, how old were you the first time? _____) D Yes No

Are you using a method to prevent pregnancy? (If yes, which _____)..... No D Yes ON/A

Do you and your partner always use condoms when you have sex? D No D Yes ON/A

Have any of your close friends had sex?..... D Yes No

Have you had a sexually transmitted disease (STD) or infection (STI)? D Yes No

Have you ever been pregnant or gotten someone pregnant? D Yes No

Is there anything else you'd like to talk about today? _____