Name_____ Age_____ Date_____

1. Why did you come to the office today? _____

SOCIAL HISTORY

With whom do you live? (Check all that apply)

- ☐ Mother
- ☐ Father
- ☐ Guardian
- ☐ Foster Parent
- ☐ Stepmother
- ☐ Stepfather
- ☐ Brother(s)/ages_____
- ☐ Sister(s)/ages_____
- ☐ Shelter
- ☐ Group Home
- ☐ Other:_____

During the past year, have there been any major changes in your family: (Check all that apply)

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of Job
- ☐ Moved
- ☐ A New School
- ☐ Births
- ☐ Serious Illness
- ☐ Deaths
- ☐ Other:_____

1. Do you think your parent(s) or guardian(s) listen to you and take your feelings seriously?..... ☐ Yes ☐ No
2. ☐ Is there anything you would like to change about your family?..... ☐ No ☐ Yes
3. Who do you talk to when things aren't going well?_____
4. ☐ Have you or anyone in your family ever been in counseling?..... ☐ No ☐ Yes

SCHOOL

1. Where do you go to school?_____ What grade are you in?_____
2. What do you like most about school?_____
3. Over the past year have your grades been mainly ☐ A's & B's ☐ B's & C's ☐ C's &D's ☐ D's & F's
4. Have you ever cut classes or skipped school?..... ☐ No ☐ Yes
5. How many days of school have you missed since the beginning of the school year?_____
6. What do you do after school?_____

_____

PERSONAL CONCERNS (Check any items below which concern or trouble you):

- ☐ cancer
- ☐ skin problems or acne
- ☐ stress at school or home
- ☐ headaches or migraines
- ☐ dizzy spells or fainting
- ☐ hearing or vision
- ☐ making friends
- ☐ muscle or joint pain
- ☐ anxious or nervous
- ☐ being tired all the time
- ☐ coughing or difficulty breathing
- ☐ heart trouble or chest pain
- ☐ sad or crying a lot
- ☐ diarrhea or constipation
- ☐ wetting the bed
- ☐ stomach aches
- ☐ nausea or vomiting
- ☐ pregnancy
- ☐ sleeping problems
- ☐ feeling down or depressed
- ☐ teeth or breath
- ☐ anger or temper
- ☐ HIV or AIDS
- ☐ Dying
- ☐ Boyfriends or girlfriends
- ☐ Height or weight
- ☐ Physical or sexual abuse

PERSONAL SAFETY

1. Do you always wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)?..... ☐ Yes ☐ No
2. Do you always wear a seat belt when you ride in or drive a car, truck, or van?..... ☐ Yes ☐ No
3. Do you or anyone you live with have a gun, rifle, or other firearm?..... ☐ No ☐ Yes
4. Are you worried about violence or your safety?..... ☐ No ☐ Yes
5. In the past year, have you or your friend carried a gun, knife, club, or other weapon for protection?..... ☐ No ☐ Yes
6. Have you ever been in trouble with the law?..... ☐ No ☐ Yes

HEALTH HABITS

1. How often do you brush your teeth?_____ Have you seen a dentist in the last year?..... ☐ Yes ☐ No
2. Do you use sunscreen?..... ☐ Yes ☐ No
3. How many times do you exercise per week?_____
4. What do you do for exercise?_____
5. Do you have any physical problems that limit how much you can exercise?..... ☐ No ☐ Yes

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6. Are you satisfied with the size or shape of your body, or your physical appearance?..... ☐ Yes ☐ No
7. In the past year, have you tried to lose or control your weight by vomiting, taking diet pills, laxatives, or starving yourself?..... ☐ No ☐ Yes
8. Do any of your friends drink or use drugs?..... ☐ No ☐ Yes
9. Have you ever tried any of the following drugs?..... ☐ No ☐ Yes

(Check all that apply)

☐ alcohol	☐ sniffing (inhalants)	☐ vitamins
☐ steroids	☐ marijuana	☐ crystal
☐ heroin	☐ snuff	☐ diet pills
☐ crack	☐ PCP	☐ No Doz
☐ speed	☐ pain pills	☐ cigarettes
☐ chewing tobacco	☐ mushrooms	☐ other:_____
☐ angel dust	☐ sleeping pills	_____

10. Have you used steroids or other substances to improve your athletic performance?..... ☐ No ☐ Yes
11. In the past year, have you ridden in a car with someone who was drinking alcohol or using drugs?..... ☐ No ☐ Yes
12. Does anyone in your family drink or take drugs so much that it worries you?..... ☐ No ☐ Yes

THOUGHTS ABOUT YOURSELF

1. Is there anything in your life you would like to be different?_____
   _____
2. During the past few weeks, have you often felt very sad or down?..... ☐ No ☐ Yes
3. Have you seriously thought about killing yourself?..... ☐ No ☐ Yes
4. When you get angry, do you ever get violent?..... ☐ No ☐ Yes
5. Do you think counseling would be very helpful for you or anyone in your family?..... ☐ No ☐ Yes

SEXUAL HEALTH

1. Are you attracted to ☐ males ☐ females ☐ both ☐ not sure
2. Have you ever had sexual experiences? ☐ Yes ☐ No
   If yes, what?_____

(If you have had sexual intercourse, please answer questions 3-6. If not, please skip to question 7)

3. How many sexual partners have you had in the past year?_____
4. Are you or your partner using a method to prevent pregnancy?..... ☐ Yes ☐ No
   If yes, what kind of birth control?_____
5. Do you and your partner(s) always use condoms when you have sex?..... ☐ Yes ☐ No
6. Have you ever been told that you had a sexually transmitted infection or disease?..... ☐ No ☐ Yes
7. Have you ever been forced to do something sexual that you did not want to do?..... ☐ No ☐ Yes

FOR FEMALES:

1. Have your periods started?..... ☐ Yes ☐ No
   If yes, how old were you?_____ When did your last period start?_____
   Number of days your bleeding usually lasts_____
2. Are your periods regular (monthly)?..... ☐ Yes ☐ No
3. Do you have cramps with your periods?..... ☐ No ☐ Yes
4. Have you had a pelvic exam?..... ☐ Yes ☐ No
5. Have you ever been pregnant?..... ☐ No ☐ Yes
6. Could you be pregnant now?..... ☐ No ☐ Yes

FOR MALES:

1. Are you concerned with getting someone pregnant?..... ☐ No ☐ Yes
2. Have you noticed any change in size or shape in your testicles?..... ☐ No ☐ Yes

Do you have any other questions or concerns you would like to discuss with the doctor or nurse?..... ☐ No ☐ Yes
If yes, what?_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

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