Name______________________ Age______________ Date______________

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

SOCIAL HISTORY

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

☐ Mother	☐ Stepmother	☐ Shelter
☐ Father	☐ Stepfather	☐ Group Home
☐ Guardian	☐ Brother(s)/ages________	☐ Other:__________
☐ Foster Parent	☐ Sister(s)/ages________	__________

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

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

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

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	☐ chewing tobacco	☐ other:__________
☐ diet pills	☐ marijuana	__________
☐ cigarettes	☐ sniffing (inhalants)	__________

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. If you had three wishes, what would they be?____________________
____
____
2. What four words best describe you?____________________
3. Do you have enough responsibility?.. ☐ No ☐ Yes
4. Do you have enough freedom?.. ☐ No ☐ Yes
5. Do you have enough privacy?.. ☐ No ☐ Yes
6. During the past few weeks, have you often felt very sad or down?.. ☐ No ☐ Yes
7. Have you seriously thought about killing yourself?.. ☐ No ☐ Yes
8. When you get angry, do you ever get violent?.. ☐ No ☐ Yes
9. Do you think counseling would be very helpful for you or anyone in your family?............................... ☐ No ☐ Yes

<u>FOR FEMALES:</u>

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

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