Adolescent Health Questionnaire

This questionnaire helps you tell us about yourself. **Answers are STRICTLY confidential**. Some statements may not apply to you but please answer as best and honestly as you can.

Name:_____Birthdate:_____Today's Date:_____
School: _____Grade:_____
Job:_____ Hours/ week_____

My parents are (circle one): Married Separated Divorced Never Married

Who do you live with (identify each household if applicable)?

Name:_____ Age:_____ Health problems_____
Name:_____ Age:_____ Health problems_____
Name:_____ Age:_____ Health problems_____
Name:_____ Age:_____ Health problems_____

I would like to talk about: _____

My sports/hobbies/interests are:_____

I would rate my school performance as: (circle one) Excellent, Good, Average, Poor

My plans for the future are:

Y	N	I have allergies (please describe):_____
Y	N	I take medication (list any prescription, over the counter and/or vitamins): _____
Y	N	I routinely see another doctor or specialist (including counselors). Please list:_____
Y	N	I see an eye doctor regularly. (circle one: every year; other)
Y	N	I see a dentist regularly. (circle one: every 6 months; yearly; other)
Y	N	I *always* wear a seat belt
Y	N	I wear a helmet when riding a bike/ scooter/ etc.
Y	N	I have hearing or other ear problems.
Y	N	I have frequent or significant headaches. How often?_____
Y	N	I have stomach aches or problems with going to the bathroom.
Y	N	I have fainting or dizzy spells.
Y	N	I get chest pain or shortness of breath with exercise.
Y	N	I have had a concussion or have been unconscious. When? _____
Y	N	I have (circle which): backaches, neck pain, bone or joint problems.
Y	N	I often sleep poorly.
Y	N	I would like information about acne or other skin problems.
Y	N	I think I may be depressed, anxious or have other emotional concerns.
Y	N	I have concerns about my safety._____
Y	N	I have smoked/ currently smoke cigarettes. If so, how many a day?_____
Y	N	I use/ have used electronic cigarettes (vaping)
Y	N	I have tried (please circle): alcohol/ marijuana/ other drugs_____
Y	N	I use alcohol or drugs regularly. If yes how often?_____
Y	N	I have a boy/ girlfriend and have started dating.
Y	N	I have been or am sexually active.
Y	N	I would like information on sexual matters (birth control, sexually transmitted illnesses, sexual identity, other).