MRN_____
Name_____
DOB_____
Date_____

Confidential Adolescent Questionnaire (15-18yr)

Our Policy on Confidentiality:

Our discussions with you are PRIVATE. We hope that you feel free to talk openly with us about yourself and your health. This information is NOT SHARED with others unless we are concerned that someone is in danger.

We will ask your parents or other support people to leave the room when we discuss sensitive topics to protect your privacy.

What things are confidential?

We will NOT share our discussions about sexual health, reproduction, mental health, and substance use UNLESS you give us permission to.

What must be reported?

- You are being physically or sexually abused
- You are at serious risk of harming yourself or others

Purpose:

We review these questions with you during your appointment to provide you with good advice about keeping yourself healthy. If you have any questions about these subjects, ask your provider.

You do not have to answer these questions if you are uncomfortable with them. We do ask that you read through the questionnaire, so you will be aware of the topics we will talk about during your visit.

Directions:

Please answer the following questions as honestly as possible. There are no "wrong" answers. The format is designed to allow providers to identify areas for discussion, not to be judgmental. If you are uncomfortable with any section, leave it blank and the provider will discuss these areas in person.

Your preferred name: _____

Sex assigned at birth (please circle): Male Female Other _____ Prefer not to answer

Gender you identify with: Male Female Transgender Male Transgender Female

Non-binary Other _____ Prefer not to answer

Preferred pronoun: she/her he/him they/them Other _____

Would you like to talk about your gender identity today? Yes No

Current School or Work: _____

Circle all people you currently live with: Parent(s) Step-parent(s) Foster family
Adoptive family Family members _____ Other _____

Is there anything you would like to discuss today? _____
_____

Strengths/Connectedness			
Do you generally get along with the people you live with?		Yes	No
Do you have at least one adult in your life you can talk to about any problems or worries?		Yes	No
Do you have one or more friends you feel comfortable talking to?		Yes	No
Do you feel like you are becoming more independent and allowed to make your own decisions?		Yes	No
Do you have interests outside of school or work?		Yes	No
Do you do things you are good at or that you are proud of?		Yes	No
Do you help others at home, school, church or in your community?		Yes	No
Social Determinants of Health			
Do you feel safe where you live and at school?		Yes	No
Have you been bullied either in person or online (cyberbulling)?		No	Yes
When you are angry do you do things that get you into trouble?		No	Yes
Have you ever been involved in a gang or had trouble with the law?		No	Yes
Does anyone where you live or spend time smoke cigarettes or vape e-cigarettes?		No	Yes
Does anyone you live with have smoking, drinking or drug use habits that concern you?		No	Yes
Have you ever been touched in a way that made you feel uncomfortable?		No	Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?		No	Yes
Have you ever been in a relationship with someone who threatened or hurt you?		No	Yes
Safety			
Do you wear a seatbelt when you drive or ride in a car, truck or van?		Yes	No
Do you wear a helmet when you bike, ski, snowboard, skateboard or ride an ATV?		Yes	No
If you drive, do you follow the speed limit and avoid texting/talking while driving?		Yes	No
Do you regularly wear sunscreen or clothing to protect yourself from the sun?		Yes	No
Is there a gun in your home?		No	Yes
If yes, are guns stored locked up and unloaded?	N/A	Yes	No

School Performance		
Have you missed 10 or more days of school or work this year?	No	Yes
Are you having any problems at school or work?	No	Yes
Do you get extra help at school (IEP, 504 or behavioral plan)?	No	Yes
Health Habits		
Do you brush your teeth every day?	Yes	No
Do you see the dentist regularly?	Yes	No
Do you eat a strict vegetarian or vegan diet?	No	Yes
Do you eat iron-rich foods such as meat, iron fortified cereals or beans most days?	Yes	No
Do you eat 3 meals most days?	Yes	No
Do you have milk, dairy or other calcium containing foods most days?	Yes	No
Do you eat some fruits and vegetables every day?	Yes	No
Do you drink more than 1 cup of juice, soda, or energy drinks in a day?	No	Yes
Are you currently doing anything to try to gain or lose weight?	No	Yes
Have you used diet pills or laxatives, made yourself throw-up, or starved yourself to lose weight?	No	Yes
Do you exercise an hour a day at least 3 days per week?	Yes	No
Not counting school or work, do you spend more than 2 hours a day watching TV, playing video games, or using other devices (computer, phone or tablet)?	No	Yes
Do you usually get 8 or more hours of sleep at night?	Yes	No
Reproductive Health		
If you have your period, do you have any problems with it (heavy bleeding, lasts longer than 5 days, bad cramping, irregular)? N/A	No	Yes
Who are you attracted to (circle all that apply)? Males Females Transgender males Transgender females Not attracted to anyone Other _____		
Have you ever had any type of sex (including vaginal, oral and anal sex)? ***If yes, please answer the questions below.***	No	Yes

Circle the types of sex you have had:

Oral Vaginal Anal Other _____

Circle the sexual partners you have had:

Males Females Trans males Trans females Other

How many sexual partners have you had in the past 3 months?

0 1 2 3 or more

How often do you and your partner(s) use condoms to prevent sexually transmitted infections?

0% 25% 50% 75% 100% Not applicable

If you have vaginal sex, how often do you and your partner(s) use a form of hormonal birth control to prevent pregnancy (pills, patch, ring, IUD, depo, implant)?

0% 25% 50% 75% 100% Not applicable

Do you think that you or your partner could be pregnant?	No	Yes
Are you aware of emergency contraception (like Plan B or Ella)?	Yes	No
Have you ever been treated for a sexually transmitted infection?	No	Yes
Have you ever been diagnosed with HIV or AIDS?	No	Yes
Have any of your sex partners been infected with HIV or used injection drugs?	No	Yes
Do you trade sex for money or drugs or have sex partners who do?	No	Yes

Mood and Mental Health		
Do you often remember or think about an unpleasant experience that happened in the past?	No	Yes
Have you ever harmed yourself (such as cutting, hitting or pinching)?	No	Yes
Have you used substances (alcohol, marijuana, or drugs) to make yourself feel better?	No	Yes

GAD-2

Over the last 2 WEEKS, how often have you been bothered by any of the following:

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling nervous, anxious or on edge?				
2. Not being able to stop or control worrying?				

PHQ-9 Modified for Teens

Over the last 2 WEEKS, how often have you been bothered by any of the following:

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
3. Feeling down, depressed, irritable or hopeless?				
4. Little interest or pleasure in doing things?				
5. Trouble falling or staying asleep, or sleeping too much?				
6. Feeling tired or having little energy?				
7. Poor appetite, weight loss or overeating?				
8. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?				
9. Trouble concentrating on things, such as school work, reading, or watching television?				
10. Moving or speaking so slowly that other people have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
11. Thoughts that you would be better off dead, or of hurting yourself in some way?				

12. In the ***PAST YEAR***, have you felt depressed or sad most days, even if you felt okay sometimes? Yes ☐ No ☐

13. If you are experiencing any of the problems on this form, how **DIFFICULT** have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely Difficult

12. Has there been a time in the ***PAST MONTH*** when you have had serious thoughts of ending your life? Yes ☐ No ☐

13. Have you ***EVER***, in your ***WHOLE LIFE***, tried to kill yourself or made a suicide attempt? Yes ☐ No ☐

Substance Use		
Do you smoke cigarettes?	No	Yes
Do you use e-cigarettes (vape or Juul)?	No	Yes
Do you chew tobacco?	No	Yes
Have you ever taken medication that was not prescribed for you (ex. pain medicine, stimulants)?	No	Yes

CRAFFT 2.0

During the PAST 12 MONTHS, how many days did you:	
1. Drink more than a few sips of beer, wine or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2. Use any **marijuana** (pot, weed, hash, or in foods) or "**synthetic marijuana**" (like "K2" or "Spice")? Put "0" if none.	☐ # of days
3. Use a**nything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Put "0" if none.	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

	No	Yes
4. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

Please circle any topics you have questions about or you would like more information on:

Alcohol use	HIV/AIDS	Exercise/fitness
Being teased/bullied	Internet/online safety	Health diet/weight problem
Birth control/contraception	Juuling/vaping	Smoking/chewing tobacco
Body piercing/Tattoos	Pregnancy/testing	Worrying/anxiety/panic
Depression/feeling down	Sexual orientation	Gender identity
Drug/opiate/marijuana use	Sexually transmitted infections/testing	

This questionnaire was designed using resources from:

Bright Futures 4th Edition, American Academy of Pediatrics

Rapid Assessment for Adolescent Preventative Services (RAAPS), The Regents of the University of Michigan

Seattle Children's Hospital, Division of Adolescent Medicine, Confidential Adolescent Screen

Vermont Gynecology, Gyn Patient Information Form

PHQ-A: Johnson JG, et al. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002 Mar;30(3):196-204.

CRAFFT: Knight JR, et al. A New Brief Screen for Adolescent Substance Abuse. *Arch Pediatr Adolesc Med.* 1999;153(6):591–596

This questionnaire is not intended to replace existing comprehensive health assessments. It is intended to provide a brief tool addressing high priority adolescent health topics.