



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?..... No Yes
- Do you eat healthy food most of the time? No Yes
- Are you happy with your current weight?..... No Yes
- Have you tried to control your weight by exercising too much, vomiting, taking diet pills, or starving yourself?..... Yes No
- Do you have concerns or questions about the shape or size of your body or physical appearance?..... Yes No
- Do you exercise for 20 minutes or more at a time at least 3 or more times a week?..... No Yes

- Are you having problems in school this year?..... Yes No
- Have you been told you have a learning problem or do you think you may have a learning problem?..... 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?..... No Yes
- Do you think that your parent(s) usually listen to you and take your feelings seriously?..... No Yes
- Have you ever hurt yourself intentionally (for example, cutting, pinching, punching)?..... Yes No
- Have you ever thought seriously about running away from home?..... 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? Yes No
- Have you ever carried a gun, knife, club, or other weapon for protection? Yes No
- Have you been pushed, hit, kicked, or abused?..... Yes No
- Are you worried about violence or your safety?..... Yes No
- Do you wear a helmet when you ride a bicycle, scooter, or dirt bike?..... No Yes
- Do you wear a seatbelt when you ride in or drive a car?..... No Yes
- For drivers: have you had an accident or ticket? 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?..... Yes No
- Do any of your friends smoke cigarettes, cigars, e-cig devices, vape, or used snuff or chewing tobacco?..... Yes No
- Does anyone who lives with you smoke cigarettes, cigars, e-cig devices, vape, use snuff or chewing tobacco?..... Yes No
- Have you ever been buzzed or drunk from beer, wine, or other alcohol (like vodka, gin, whiskey)?..... Yes No
- Have any of your friends been buzzed or drunk from beer, wine, or other alcohol (like vodka, gin, whiskey)?..... Yes No
- Have you gotten into trouble because of drinking alcohol?..... Yes No
- Have you ever drunk alcohol and then driven a car or other vehicle?..... Yes No
- Have you ever been in a car or other vehicle when the driver had been drinking?..... Yes No
- Does anyone in your family drink or take drugs so much that it worries you?..... Yes No
- Have you ever smoked marijuana, eaten marijuana edibles, or used other drugs (for example: cocaine, ecstasy)?.. Yes No
- Do any of your close friends use marijuana or other drugs (for example: cocaine, ecstasy)?..... Yes No
- Have you used medications that weren't prescribed to you to sleep, stay awake, calm down, or get high?..... Yes No

- Do you think you might be gay, lesbian, bisexual, pansexual, asexual, transgender, or questioning?..... Yes No
- Have you ever had sex? (If yes, how old were you the first time? _____)..... Yes No
- Are you using a method to prevent pregnancy? (If yes, which _____)..... No Yes N/A
- Do you and your partner always use condoms when you have sex?..... No Yes N/A
- Have any of your close friends had sex?..... Yes No
- Have you had a sexually transmitted disease (STD) or infection (STI)? Yes No
- Have you ever been pregnant or gotten someone pregnant?..... Yes No

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