Adolescent Health Questionnaire

Your name: _____ ***Your date of birth:*** _____ ***Date of visit:*** _____

Please fill out this questionnaire. We will appreciate your honest answers, so we can serve you better. This information is part of your confidential medical record. It will be released only after a court order for your records is received.

Please check if questionnaire filled out by healthcare provider by directly collecting the information from the adolescent during the medical evaluation ☐

1. Do you smoke cigarettes? ☐ No ☐ Yes
   If yes, how many cigarettes in a day? _____
2. Do you vape? ☐ No ☐ Yes
   If yes, how often in a day? _____
3. Have you ever tried alcohol? ☐ No ☐ Yes
   If yes, what kind have you tried? _____
4. Are you currently drinking any alcohol? ☐ No ☐ Yes
   If yes, what kind are you drinking? _____
   How many days a week do you drink? _____
   How many drinks during those days? _____
5. Have you ever tried drugs? ☐ No ☐ Yes
   If yes, which drugs have you tried? _____
6. Are you currently using drugs or have used drugs in the last 12 months? ☐ No ☐ Yes
   If yes, what drug(s) are you using? _____
   How often? _____
7. Have you ever run away from home or been "kicked out' of your home? ☐ No ☐ Yes
8. Have you ever had **thoughts** of hurting yourself? ☐ No ☐ Yes
   If yes, when was the last time you had those thoughts? _____
   Did you have a plan of how to hurt yourself? ☐ No ☐ Yes
   (If yes, please describe your plan) _____
   _____
9. Have you ever **tried** to hurt yourself? ☐ No ☐ Yes
   (If yes, how did you try to hurt yourself?) _____
   _____
   (How many times have you tried to hurt yourself?) _____
   Have you ever been admitted to a hospital for these attempts? ☐ No ☐ Yes
   Have you received any treatment or medications? ☐ No ☐ Yes
   If yes, what medications? _____
   _____
   For how long? _____
   Are you still taking the medications? ☐ No ☐ Yes
10. Have you ever had problems with the police? ☐ No ☐ Yes

11. Have you ever willingly had sex? ☐ No ☐ Yes
    If yes, how many different partners have you had sex with? _____
    When was the last time you had sex? _____
    Were the partners ____ Male ____ Female ____ Both?

12. Has anyone ever asked you to pose in a sexy way for a photo or video? ☐ No ☐ Yes
    If asked, did you have to actually do it? ☐ No ☐ Yes

13. Have you ever had sex without a condom? ☐ No ☐ Yes
    If yes, how many partners have you had sex with and not used condoms? _____

14. Have you ever had any sexually transmitted infections, like herpes, gonorrhea, chlamydia or trichomonas?
    ☐ No ☐ Yes

15. Has a boyfriend or girlfriend in a dating or serious s relationship ever physically hurt you or threatened to hurt you (hit, pushed, kicked, choked, burned or something else)? ☐ No ☐ Yes

16. Has a boyfriend, or girlfriend or anyone else ever asked you, or forced you to have sex with ANOTHER person. (for example, a boy asks his girlfriend to have sex with another boy) ☐ No ☐ Yes
    If asked, did you actually have to do it? ☐ No ☐ Yes

17. Have you ever traded sex for money, drugs, a place to stay, a cell phone, or something else? ☐ No ☐ Yes

18. Has anyone ever asked or forced you to do some sexual act in public, like dance at a bar or a strip club?
    ☐ No ☐ Yes
    If asked, did you actually have to do it? ☐ No ☐ Yes

19. Is there anything else that you would like to discuss with the doctor?_____
    _____

----- (for females only)-----

20. How old were you when you had your first period? _____
    What is the date of your last period?_____
    Have you ever used birth control that was prescribed by a doctor? ☐ No ☐ Yes
    If yes, what kind? _____

Reviewed by: _____ ***Date:*** _____
Healthcare Provider