

Adolescent Health Questionnaire

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

Biological Sex: ☐ Female ☐ Male

Preferred Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/Them/Theirs ☐ Just my name, please

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 the questionnaire was 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 _____

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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. Have you ever had sex without a condom? ☐ No ☐ Yes

If yes, how many partners have you had sex with and not used condoms? _____

13. Have you ever had any sexually transmitted infections, like herpes, gonorrhea, chlamydia or trichomonas?

☐ No ☐ Yes

14. 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

15. Has a boyfriend or girlfriend in a dating or serious 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

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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? _____

Additional Comments by Healthcare Provider:

Reviewed by: _____ **Date:** _____

Healthcare Provider