

Adolescent & Teen Visits: Teen Questionnaire (12-18 yrs old) – cont'd

Teen Questionnaire

Do Not Scan

We ask all teenagers these questions because they are topics that can affect your health and well-being. All the questions may not fit you. You may leave some questions blank if you prefer. Your answers are private.

	Yes	Sometimes	No	Want more info?
1. In general, are you happy with the way things are going for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you get along with your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you go to school regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have at least one adult you can really talk to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you get some exercise at least 3 times a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you think you are about the right weight for your height?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you wear a seat belt in a car/truck?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile or use an ATV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are your grades worse than they used to be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you ever use laxatives or throw up on purpose after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you smoke cigarettes, chew tobacco or vape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you tried any drugs for fun, curiosity or coping (such as marijuana, prescription pills, cocaine, heroin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you or anyone you live with have a gun or carry around a gun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you now or have you ever been in a gang?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you worried about money, a place to live, food or clothing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had sex (with women, men or both)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever traded sex for money, a place to live, food or clothing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever been tested for or diagnosed with a sexually transmitted infection (STI) such as herpes, gonorrhea, chlamydia, genital warts, pelvic inflammatory disease or syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you or do you ever wonder if you are lesbian, gay, bisexual, transgender, queer, questioning, intersex or asexual (LGBTQIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We will only share your confidential information with your parent or guardian if we have a serious concern about your health and safety. Before we share information, we will discuss it with you.				
21. Have you ever thought about killing yourself?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you feel afraid in any of your relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever been physically or sexually abused or mistreated by anyone? (kicked, hit, pushed, forced or tricked into having sex, or touched in a way that made you feel uncomfortable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

*If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your clinician, go to a hospital emergency room or call 911.

22344 (3/2018) ©HealthPartners