

Name _____ Age _____ Date _____

1. Why did you come to the office today? _____

SOCIAL HISTORY

With whom do you live? (Check all that apply)

- | | | | |
|-----------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Foster Parent | <input type="checkbox"/> Brother(s)/ages _____ | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Father | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sister(s)/ages _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Shelter | |

During the past year, have there been any major changes in your family: (Check all that apply)

- | | | | |
|-------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of Job | <input type="checkbox"/> Births | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Moved | <input type="checkbox"/> Serious Illness | |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> A New School | <input type="checkbox"/> Deaths | |

1. Do you think your parent(s) or guardian(s) listen to you and take your feelings seriously? Yes No
2. Is there anything you would like to change about your family? No Yes
3. Who do you talk to when things aren't going well? _____
4. Have you or anyone in your family ever been in counseling? No Yes

SCHOOL

1. Where do you go to school? _____ What grade are you in? _____
2. What do you like most about school? _____
3. Over the past year have your grades been mainly A's & B's B's & C's C's & D's D's & F's
4. Have you ever cut classes or skipped school? No Yes
5. How many days of school have you missed since the beginning of the school year? _____
6. What do you do after school? _____

PERSONAL CONCERNS (Check any items below which concern or trouble you):

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> being tired all the time | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> skin problems or acne | <input type="checkbox"/> coughing or difficulty breathing | <input type="checkbox"/> feeling down or depressed |
| <input type="checkbox"/> stress at school or home | <input type="checkbox"/> heart trouble or chest pain | <input type="checkbox"/> teeth or breath |
| <input type="checkbox"/> headaches or migraines | <input type="checkbox"/> sad or crying a lot | <input type="checkbox"/> anger or temper |
| <input type="checkbox"/> dizzy spells or fainting | <input type="checkbox"/> diarrhea or constipation | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> hearing or vision | <input type="checkbox"/> wetting the bed | <input type="checkbox"/> dying |
| <input type="checkbox"/> making friends | <input type="checkbox"/> stomach aches | <input type="checkbox"/> boyfriends or girlfriends |
| <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> nausea or vomiting | <input type="checkbox"/> height or weight |
| <input type="checkbox"/> anxious or nervous | <input type="checkbox"/> pregnancy | <input type="checkbox"/> physical or sexual abuse |

PERSONAL SAFETY

1. Do you always wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all terrain vehicle (ATV)? Yes No
2. Do you always wear a seat belt when you ride in or drive a car, truck or van? Yes No
3. Do you or anyone you live with have a gun, rifle, or other firearm? No Yes
4. Are you worried about violence or your safety? No Yes
5. In the past year, have you or your friend carried a gun, knife, club, or other weapon for protection? No Yes
6. Have you ever been in trouble with the law? No Yes

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Ages 11 & 1

HEALTH HABITS

- 1. How often do you brush your teeth? _____ Have you seen a dentist in the last year?..... Yes No
- 2. Do you use sunscreen? Yes No
- 3. How many times do you exercise per week? _____
- 4. What do you do for exercise? _____
- 5. Do you have any physical problems that limit how much you can exercise? No Yes
- 6. Are you satisfied with the size or shape of your body, or your physical appearance? Yes No
- 7. In the past year, have you tried to lose weight by throwing up or starving yourself? No Yes
- 8. Do any of your friends drink or use drugs? No Yes
- 9. Have you ever tried any of the following drugs? No Yes

(Check all that apply)

- alcohol cigarettes marijuana other: _____
- diet pills chewing tobacco sniffing (inhalants)

- 10. In the past year, have you ridden in a car with someone who was drinking alcohol or using drugs? No Yes
- 11. Does anyone in your family drink or take drugs so much that it worries you? No Yes
- 12. Have you ever been forced to do something sexual that you did not want to do? No Yes

THOUGHTS ABOUT YOURSELF

- 1. If you had three wishes, what would they be? _____
- 2. What four words best describe you? _____
- 3. Do you have enough responsibility? Yes No
- 4. Do you have enough freedom? Yes No
- 5. Do you have enough privacy? Yes No
- 6. During the past few weeks, have you often felt very sad or down? No Yes
- 7. Have you seriously thought about killing yourself? No Yes
- 8. When you get angry, do you ever get violent? No Yes
- 9. Do you think counseling would be very helpful for you or anyone in your family? No Yes

FOR FEMALES:

- 1. Have your periods started? Yes No
If yes, how old were you? _____ When did your last period start? _____
Number of days your bleeding usually lasts _____
- 2. Are your periods regular (monthly)? Yes No
- 3. Do you have cramps with your periods? No Yes

Do you have any other questions or concerns you would like to discuss with the doctor or nurse? No Yes
If yes, what? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

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Ages 11 & 12