CONFIDENTIAL QUESTIONNAIRE FOR **PRETEENS 11-13**

NAME:_____DATE:_____AGE:_____

Phone number [personal cell or home?]: _____optional privacy word_____

These questions are not mandatory. Feel free to discuss any concerns or disagreements with the doctor/nurse practitioner. Your answers are a confidential part of your medical records. However, for your safety, we are required by law to share information involving physical/sexual abuse and suicidality with your parent(s). We will always talk with you before sharing anything.

1. Do you exercise at least 3 times/week?	Yes		Sometimes	No
2. Do you have trouble falling or staying asleep?	Yes		Sometimes	No
3. How many hours per day do you spend on "screens"/devices? _____				
4. Do you wear a seatbelt in vehicles?	Yes		Sometimes	No
5. Do you wear a helmet when you ride a skateboard/bike/snowmobile/ATV/motorcycle or when you ski/snowboard?	Yes		Sometimes	No
6. How often do you eat a well balanced diet which includes: fruits/vegetables, grains, meat/poultry/fish/eggs, dairy	Every day	Most days	Some days	Rarely or Never
7. Are you having any problems with friends?	No		Sometimes	Yes
8. Are you having problems with parents/at home?	No		Sometimes	Yes
9. Are you satisfied with your current grades?	No			Yes
10. Do you have any adult you can talk to?	Yes		Sometimes	No
11. Do you feel you are about the right weight?	Yes		Sometimes	No
12. Are you trying to lose or gain weight?	No		Sometimes	Yes
13. Do you smoke or chew tobacco or vape?	No		Sometimes	Yes
14. Do you drink alcohol?	No		Sometimes	Yes
15. Have you ever tried any drugs not given by parents?	No			Yes
16. Does anyone you live with have a gun?	No			Yes
17. Does worrying effect your sleep, appetite or relationships with people?	No			Yes
18. Have you ever intentionally harmed yourself?	No			Yes
19. Have you ever thought about killing yourself?	No			Yes
20. Have you ever tried to kill yourself?	No			Yes
21. Has anyone threatened/bullied/harmed you? [school, home, social media, texting, snap chat, etc…]	No			Yes

22. **During the last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than 1/2 days	Nearly every day
Little interest or pleasure in doing things?	_____	_____	_____	_____
Feeling down, depressed, hopeless?	_____	_____	_____	_____

23**. Have you tested positive for Covid-19?** No Yes

SPORTS PARTICIPATION SCREEN **In the past year**, have you:

-passed out or gotten dizzy while exercising?	No	Yes
-had breathing problems or chest pain while exercising?	No	Yes
-been knocked out or had a concussion?	No	Yes
Do you have a serious heart problem?	No	Yes
Any family history of sudden death <50yrs old, rhythm problems, pacemakers, Marfan's syndrome, cardiomyopathy.?	No	Yes