CONFIDENTIAL QUESTIONNAIRE FOR TEENS **14-19**

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 wear a seatbelt in vehicles? Yes Sometimes No
3. Do you wear a helmet when riding a skateboard, bike, snowmobile, ATV, motorcycle or when you ski/snowboard? Yes Sometimes No
4. Are you having any problems with friends? No Sometimes Yes
5. Are you having problems with parents/at home? No Sometimes Yes
6. Do you have any adult you can talk to? Yes Sometimes No
7. Do you feel you are about the right weight? Yes Sometimes No
8. Are you trying to lose or gain weight? No Sometimes Yes
9. Do you smoke or chew tobacco or vape? No Sometimes Yes
10. Do you drink alcohol? No Sometimes Yes
11. Have you ever tried any drugs? IF YES, circle: No Sometimes Yes
(weed, synthetic marijuana, K2, spice, dabs, crack, cocaine, heroin, acid, speed, anyone else's prescription drugs)
12. Do you or does anyone you live with have a gun? No Yes
13. How do you identify yourself? male female both neither
14. Are you attracted to: boys girls both neither
15. Have you ever had sex? No Yes
16. IF YES, are/were your sexual partners? male female both
17. What type of sex? vaginal oral anal
18. IF YES do you use birth control [condoms,birth control pills, IUD, Depo, implant?] N/A Always Occas. Never
19. Do you want to be tested for HIV? No Yes
20. Does worrying effect your sleep, appetite or relationships with people? No Yes
21. Have you ever intentionally harmed yourself? No Yes
22. Have you ever thought about killing yourself? No Yes
23. Have you ever tried to kill yourself? No Yes
24. Has anyone threatened/bullied/harmed you? [school/home/social media/ texting/etc.] No Yes
25. Have you ever sent inappropriate pictures/sexting? No Yes
26. Do you have trouble falling/staying asleep? No Sometimes Yes
27. How many hours per day do you spend on "screens"/devices? _____
28. **During the last 2 weeks**, how often have you been bothered by any of the following problems

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

29. **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