Adolescent Health Questionnaire

Please answer these questions honestly. Your answers are confidential and will not be shared unless we are concerned for someone's safety.

Preferred name: _____

Gender you identify with (please circle): Male Female Transgender Male

Transgender Female Non-Binary Other_____

Preferred pronouns (please circle): she/her he/him they/ them other: _____

Current school/workplace: _____

I would rate my school performance as (please circle): Excellent Good Average Poor

My sports/hobbies/interests are _____

My plans for the future are _____

Is there anything you would like to discuss today? _____

Yes	No	I always wear a seatbelt.
Yes	No	I always wear a helmet when riding a bike/scooter.
Yes	No	I wear sunblock when outdoors.
Yes	No	I think I may be depressed, anxious or have other emotional concerns.
Yes	No	I have concerns about my safety.
Yes	No	I often sleep poorly and I would like information about how to improve my sleep.
Yes	No	I have tried smoking cigarettes.
Yes	No	I currently smoke cigarettes. If so, how many per day? _____
Yes	No	I have used an electronic cigarette (vape, Juul).
Yes	No	I vape regularly. If so, how frequently? _____
Yes	No	I have tried alcohol.
Yes	No	I drink alcohol on a regular basis. If yes, how often? _____
Yes	No	I have used marijuana.
Yes	No	I use marijuana on a regular basis. If yes, how often? _____
Yes	No	I have tried other drugs. If yes, which drug?_____
Yes	No	I use other drugs on a regular basis. Which drug(s)?_____How often? _____
Yes	No	I have started dating
Yes	No	I have been or am sexually active
Yes	No	I would like information on safe sex, birth control, condoms, sexually transmitted illness, other.

This form will be shredded.