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. This form will be shredded after the visit.

Preferred name: _____

My gender identity is (please circle): Male Female Transgender Male Transgender Female Non-Binary Genderqueer/Queer Questioning/Unsure Other_____ Prefer not to answer

My sexual orientation is (please circle): Heterosexual/Straight Gay/Lesbian/Homosexual Asexual Bisexual Pansexual Queer Questioning/Unsure Other_____ Prefer not to answer

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/skateboard.
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 would like information about how to improve my sleep.
Yes	No	I have tried smoking cigarettes.
Yes	No	I smoke cigarettes on a regular basis. If yes, how often?_____
Yes	No	I have tried using an electronic cigarette (vape, Juul).
Yes	No	I vape on a regular basis. If yes, how often?_____
Yes	No	I have tried alcohol.
Yes	No	I drink alcohol on a regular basis. If yes, how often?_____
Yes	No	I have tried marijuana.
Yes	No	I use marijuana on a regular basis. If yes, how often?_____
Yes	No	I have tried other drugs, If yes, which drugs? _____
Yes	No	I use other drugs regularly. If yes, which drugs? _____ How often?_____
Yes	No	I have started dating.
Yes	No	I have been or am sexually active.
Yes	No	I would like info on safe sex, birth control, condoms, sexually transmitted illnesses.