Medical Record Number

Patient Name

Addressograph or Label

CONFIDENTIAL HISTORY

PRONOUNS: _____ Are parents aware? □ Yes □ No

Best phone number to call with confidential information? _____ OK to leave messages? □ Yes □ No

HOME: Current living situation & recent changes:

Smokers in the home? □ No □ Yes Feel safe at home? □ No □ Yes

EDUCATION:

Current School & Grade Level:	Grades (Improving/Worsening/Stable):
Favorite Subjects: Hardest Subjects:	School Difficulties:

Goals/Career Plans:

ACTIVITIES/FRIENDS:

Social media use (any problems, concerns?)

DRUGS: How much? How often? When? Where?

Smoking	□ Current use	□ Tried in past	□ None	Tobacco? Marijuana?
Vaping	□ Current use	□ Tried in past	□ None	Tobacco? Marijuana?
Alcohol:	□ Current use	□ Tried in past	□ None	
Other Drugs:	□ Current use	□ Tried in past	□ None	Type of drug?

Comments:

CONFIDENTIAL PROTECTED NOTES

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SEXUAL ACTIVITY:				
Sexual preference:	□ Opposite sex	□ Same sex	□ Both	□ Not sure
Ever had sex?	□ No □ Yes	□ Oral	□ Vaginal	□ Anal

Age of onset: _____ Last intercourse: _____ # Partners/60 days: _____ Lifetime: _____

Contraceptive use:

STI History (Last STI testing):

Pregnancy? (self or partner)

History of abuse/unwanted sex/survival sex: □ No □ Yes

STRENGTHS:

EATING/BODY IMAGE:		
Any concerns about weight? Things about your body you want to change? Growth chart review: any concerns?	□ No □ Yes □ No □ Yes □ No □ Yes	
Skipping meals, avoiding certain foods, strictly controlling calories to manage weight?	□ No □ Yes	24hr Diet Recall:
Excessive exercise	□ No □ Yes	
Binging or ourging	□ No □ Yes	
Laxatives/Diet Pills	□ No □ Yes	

SUICIDE/MOOD/SAFETY:		
Gang/Legal Trouble	□ No □ Yes	
Sadness/Depression	□ No □ Yes	
Anxiety	□ No □ Yes	
Sleeping problems	□ No □ Yes	
SI or SA	□ No □ Yes	
Self-harm Behaviors	□ No □ Yes	

Comments:

Do you have someone to talk to if sad/worried/anxious/depressed/in trouble? Who?

NAME: SIGNATURE: DATE: