12-17 years

To be completed by the PATIENT

Please complete these forms before your visit today.

Thank you!

Staying Healthy Assessment

12-17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	*Nutrition*
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high-fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	*Physical Activity*
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours a day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	*Dental Health*
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	*Mental Health*
19	Do you find interest and pleasure in doing things?	Yes	No	Skip	
20	Do you have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
21	Have you ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
22	Has anything really scary or upsetting happened to you or anyone in your family?	No	Yes	Skip	
23	Do you spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*
24	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	

25	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	
26	Do you use medicines not prescribed to you?	No	Yes	Skip	
27	Do you drink alcohol once a week or more?	No	Yes	Skip	
28	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
29	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
30	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.					
31	Have you ever been forced or pressured to have sex?	No	Yes	Skip	*Sexual Issues*
32	Has anyone ever offered you money, drugs, or a place to stay in exchange for sex?	No	Yes	Skip	
33	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 40*.	No	Yes	Skip	
34	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
35	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
36	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
37	The last time you had sex, did you use birth control?	Yes	No	Skip	
38	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
39	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
40	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as boy, girl, or other gender)?	No	Yes	Skip	
41	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
42	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
43	Do you have any other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Home Environment	☐	☐	☐	☐	
PCP's Signature:		Print Name:			Date:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐