



**Guidelines for Adolescent Preventive Services**  
**Younger Adolescent Questionnaire**

**Confidential**

(Your answers will not be given out.)

Chart# \_\_\_\_\_

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First Middle Initial month day year

Birthdate \_\_\_\_\_ Grade in School \_\_\_\_\_ Boy or Girl (circle one) Age \_\_\_\_\_  
month day year

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Pager/Beeper Number \_\_\_\_\_  
area code

What languages are spoken where you live? \_\_\_\_\_

Are you:  White  African-American  Asian/Pacific Islander  
 Latino/Hispanic  Native American  Other \_\_\_\_\_

**Medical History**

1. Why did you come to the clinic/office today? \_\_\_\_\_  
\_\_\_\_\_

2. Are you allergic to any medicines?  
 No  Yes, name of medicine(s): \_\_\_\_\_  Not Sure

3. Do you have any health problems?  
 No  Yes, problem(s): \_\_\_\_\_  Not Sure

4. Are you taking any medicine now?  
 No  Yes, name of medicine(s): \_\_\_\_\_  Not Sure

5. Have you been to the dentist in the last year? .....  No  Yes  Not Sure

6. Have you stayed overnight in a hospital in the last year? .....  No  Yes  Not Sure

7. Have you ever had any of the problems below?

	Yes	No	Not Sure		Yes	No	Not Sure
Allergies or hay fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## For Girls Only

8. Have you started having periods? .....  No  Yes  
a. *If yes*, are your periods regular (once a month) ? .....  No  Yes  
b. *If yes*, what was the 1st day of your last period? Month \_\_\_\_\_ Day \_\_\_\_\_
9. Have you ever been pregnant? .....  Yes  No

## Family Information

10. Who do you live with? (Check all that apply).  
 Mother  Stepmother  Brother(s)/ages \_\_\_\_\_  
 Father  Stepfather  Sister(s)/ages \_\_\_\_\_  
 Guardian  Other adult relative  Other/(explain) \_\_\_\_\_
11. Do you have older brothers or sisters who live away from home? .....  Yes  No  Not Sure
12. During the past year, have there been any changes in your family such as: (Check all that apply)  
 Marriage  Loss of job  Births  Other changes \_\_\_\_\_  
 Separation  Moved to a new neighborhood  Serious Illness/Injury \_\_\_\_\_  
 Divorce  A new school  Deaths \_\_\_\_\_

## Specific Health Issues

13. Please check whether you have questions or are worried about any of the following:
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Height                     | <input type="checkbox"/> Neck or back                    | <input type="checkbox"/> Muscle or pain in arms/legs | <input type="checkbox"/> Anger or temper      |
| <input type="checkbox"/> Weight                     | <input type="checkbox"/> Breasts                         | <input type="checkbox"/> Menstruation or periods     | <input type="checkbox"/> Feeling tired        |
| <input type="checkbox"/> Eyes or vision             | <input type="checkbox"/> Heart                           | <input type="checkbox"/> Wetting the bed             | <input type="checkbox"/> Trouble sleeping     |
| <input type="checkbox"/> Hearing or earaches        | <input type="checkbox"/> Coughing or wheezing            | <input type="checkbox"/> Trouble urinating or peeing | <input type="checkbox"/> Fitting in/belonging |
| <input type="checkbox"/> Colds/runny or stuffy nose | <input type="checkbox"/> Chest pain or trouble breathing | <input type="checkbox"/> Drip from penis or vagina   | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Mouth or teeth or breath   | <input type="checkbox"/> Stomach ache                    | <input type="checkbox"/> Wet dreams                  | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Vomiting or throwing up         | <input type="checkbox"/> Skin (rash/acne)            | <input type="checkbox"/> Dying                |
| <input type="checkbox"/> Other _____                |  |  |   |

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

## Health Profile

### Eating/Weight/Body

14. Do you eat fruits and vegetables every day? .....  No  Yes
15. Do you drink milk and/or eat milk products every day? .....  No  Yes
16. Do you spend a lot of time thinking about ways to be skinny? .....  Yes  No
17. Do you do things to lose weight (skip meals, take pills, starve yourself, vomit, etc) .....  Yes  No
18. Do you work, play, or exercise enough to make you sweat or breathe hard at least 3 times a week? .....  No  Yes
19. Have you pierced your body (not including ears) or gotten a tattoo? .....  Yes  No

**School**

- 20. Is doing well in school important to you? .....  No  Yes
- 21. Is doing well in school important to your family and friends? .....  No  Yes
- 22. Are your grades this year worse than last year? .....  Yes  No  Not Sure
- 23. Are you getting failing grades in any subjects this year? .....  Yes  No  Not Sure
- 24. Have you been told that you have a learning problem? .....  Yes  No
- 25. Have you been suspended from school this year? .....  Yes  No

**Friends and Family**

- 26. Do you know at least one person who you can talk to about problems? .....  No  Yes
- 27. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? .....  No  Yes
- 28. Have your parents talked with you about things like alcohol, drugs, and sex? .....  No  Yes  Not Sure
- 29. Are you worried about problems at home or in your family? .....  Yes  No  Not Sure
- 30. Have you ever thought seriously about running away from home? .....  Yes  No

**Weapons/Violence/Safety**

- 31. Is there a gun, rifle, or other firearm where you live? .....  Yes  No  Not Sure
- 32. Have you ever carried a gun, knife, club, or other weapon to protect yourself? .....  Yes  No
- 33. Have you ever been in a physical fight where you or someone else got hurt? .....  Yes  No
- 34. Have you ever been in trouble with the police? .....  Yes  No
- 35. Have you ever seen a violent act take place at home, school, or in your neighborhood? .....  Yes  No
- 36. Are you worried about violence or your safety? .....  Yes  No  Not Sure
- 37. Do you usually wear a helmet and/or protective gear when you rollerblade, skateboard, or ride a bike? .....  No  Yes
- 38. Do you always wear a seat belt when you ride in a car, truck, or van? .....  No  Yes

**Tobacco**

- 39. Have you ever tried cigarettes or chewing tobacco? .....  Yes  No
- 40. Have any of your close friends ever tried cigarettes or chewing tobacco? .....  Yes  No
- 41. Does anyone you live with smoke cigarettes/cigars or chew tobacco? .....  Yes  No

**Alcohol**

- 42. Have you ever tried beer, wine, or other liquor (except for religious purposes)? .....  Yes  No
- 43. Have any of your close friends ever tried beer, wine, or other liquor (except for religious purposes)? .....  Yes  No
- 44. Have you ever been in a car when the driver has been using drugs or drinking beer, wine or other liquor? .....  Yes  No
- 45. Does anyone in your family drink so much that it worries you? .....  Yes  No  Not Sure

**Drugs**

- 46. Have you ever taken things to get high, stay awake, calm down or go to sleep? .....  Yes  No  Not Sure
- 47. Have you ever used marijuana (pot, grass, weed, reefer, or blunt)? .....  Yes  No  Not Sure
- 48. Have you ever used other drugs such as cocaine, speed, LSD, mushrooms, etc.? .....  Yes  No  Not Sure
- 49. Have you ever sniffed or huffed things like paint, 'white-out', glue, gasoline, etc.? .....  Yes  No  Not Sure

50. Have any of your close friends ever used marijuana, other drugs, or done other things to get high? .....  Yes  No  Not Sure
51. Does anyone in your family use drugs so much that it worries you? .....  Yes  No  Not Sure

**Development/Relationships**

52. Are you dating someone or going steady? .....  Yes  No  Not Sure
53. Are you thinking about having sex (“going all the way “or “doing it”)? .....  Yes  No  Not Sure
54. Have you ever had sex? .....  Yes  No  Not Sure
55. Have any of your friends ever had sex? .....  Yes  No  Not Sure
56. Have you ever felt pressured by anyone to have sex or had sex when you did not want to? .....  Yes  No  Not Sure
57. Have you ever been told by a doctor or a nurse that you had a sexually transmitted disease like herpes, gonorrhea, or chlamydia? .....  Yes  No  Not Sure
58. Would you like to receive information on abstinence (“how to say no to sex”)? .....  Yes  No  Not Sure
59. Would you like to know how to avoid getting pregnant, getting HIV/AIDS, or getting sexually transmitted diseases? .....  Yes  No  Not Sure

**Emotions**

60. Have you done something fun during the past two weeks? .....  No  Yes
61. When you get angry, do you do violent things? .....  Yes  No
62. During the past few weeks, have you felt very sad or down as though you have nothing to look forward to? .....  Yes  No
63. Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself? .....  Yes  No
64. Is there something you often worry about or fear? .....  Yes  No
65. Have you ever been physically, emotionally, or sexually abused? .....  Yes  No  Not Sure
66. Would you like to get counseling about something that is bothering you? .....  Yes  No  Not Sure

**Special Circumstances**

67. In the past year have you been around someone with tuberculosis (TB)? .....  Yes  No  Not Sure
68. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? .....  Yes  No
69. Have you ever lived in foster care or a group home? .....  Yes  No

**Self**

70. What two words best describe you?  
 1) \_\_\_\_\_ 2) \_\_\_\_\_
71. What would you like to be when you grow up?  
 \_\_\_\_\_
72. If you could have three wishes come true, what would they be?  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

Nataloni Pediatrics, P.C.  
**Pre-Participation Physical Evaluation**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

The following questions should be completed by student or parent. Please explain "yes" answers where indicated. Circle questions you don't know answers to.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical?<br>If yes, please explain: _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing illness?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills, or using an inhaler?<br>If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your Performance?<br>If yes, please explain: _____                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies (for example: to pollen, medicine, food or stinging insects)?<br>If yes, please explain: _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a rash or hives develop during or after exercise?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever passed out during or after exercise?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been dizzy during or after exercise?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had chest pain during or after exercise?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get tires more quickly than your friends do during exercise?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had high blood pressure or high cholesterol?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been told you have a heart murmur?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has any family member or relative died of heart problems or sudden death before age 50?<br>If yes, please explain: _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?<br>If yes, please explain: _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems?<br>If yes, please explain: _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?<br>If yes, please explain: _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious or lost your memory?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure?<br>If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
23. Do you have frequent or severe headaches? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever had a stinger, burner or pinched nerve? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever become ill from exercising in the heat? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you cough, wheeze or have trouble breathing during or after activity? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have asthma? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have seasonal allergies that require medical treatment? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position, (for example, knee brace, special neck roll, foot orthotics, retainer for your teeth, hearing aid)? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had any problems with your eyes or vision? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you wear glasses, contacts or protective eyewear? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you ever had a sprain, strain or swelling after injury? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you broken or fractured any bones or dislocated any joints? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check appropriate blank and explain in the space provided: ___Head ___Elbow ___Hip ___Neck ___Forearm ___Thigh ___Back ___Wrist ___Knee ___Chest ___Hand ___Shin/Calf ___Shoulder ___Finger ___Ankle ___Upper Arm ___Foot If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you want to weigh more or less than you do now? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you lose weight regularly to meet weight requirements for your sport? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
38. Do you feel stressed out? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
39. Record the dates of your most recent immunizations (shots) for: Tetanus: _____ Measles: _____ Hepatitis B: _____ Chickenpox: _____		
<b>FEMALES ONLY - Optional -</b>		
40. When was your first menstrual period? _____		
41. When was your most recent menstrual period? _____		
42. How much time do you usually have from the start of one period to the start of another? _____		
43. How many periods have you had in the last year? _____		
44. What was the longest time between periods in the last year? _____		

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## A Survey From Your Healthcare Provider

Name	Date	ID	
Please mark under the heading that best fits you or circle yes or no	Never 0	Sometimes 1	Often 2
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			
36. During the past three months, have you thought of killing yourself?		Yes	No
37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

Cutoff Scores for Interpretation:

I ≥ 5

E ≥ 7

A ≥ 7

TS \_\_\_\_\_

Q 36 or Q 37=Y    TS ≥ 30

Plan for follow-up

Annual Screening  
  Return visit w/ PCP  
  Referred to counselor  
  Parent declined  
  Already in treatment  
  Referred to other professional

Source: Pediatric Symptom Checklist – Youth Report (psc-y)

---

ADOLESCENT CONFIDENTIALITY STATEMENT

***Parent Information for Pediatric Visits  
Ages 12-21 years***

As children and adolescents mature and become more independent, both physiologically and socially, their physical health may be jeopardized. Risk-taking behaviors are increasingly observed in this age group.

We plan to discuss these issues with your child and offer non-judgmental support and advice. Confidentiality is promised to the adolescents as part of our working relationship. We do, however, strongly encourage them to discuss these issues openly with their families, and we will inform you if your adolescent poses a serious risk to him/herself or others.

Please advise us of any specific concerns you have regarding risk-taking behaviors or the emotional health of your adolescent.

Please sign indicating your understanding of the (above) information.

Adolescent's Name

Your relationship to above

Signature: \_\_\_\_\_

Date:





# Guidelines for Adolescent Preventive Services Parent/Guardian Questionnaire

**Confidential**

(Your answers will not be given out.)

Date \_\_\_\_\_

Adolescent's name \_\_\_\_\_ Adolescent's birthday \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Relationship to adolescent \_\_\_\_\_

Your phone number: Home \_\_\_\_\_ Work \_\_\_\_\_

## Adolescent Health History

1. Is your adolescent allergic to any medicines?  
 Yes  No If yes, what medicines? \_\_\_\_\_

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?  
 Yes  No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?  
 Yes  No If yes, please explain. \_\_\_\_\_

5. Have there been any changes in your adolescent's health during the past 12 months?  
 Yes  No If yes, please explain. \_\_\_\_\_

6. Please check (✓) whether your adolescent ever had any of the following health problems:  
If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?  
 Yes  No  Not sure

## Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seiures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Stepmother            | <input type="checkbox"/> Sister(s)/ages _____ |
| <input type="checkbox"/> Mother                         | <input type="checkbox"/> Stepfather            | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Father                         | <input type="checkbox"/> Guardian              | <input type="checkbox"/> Alone                |
| <input type="checkbox"/> Other adult relative           | <input type="checkbox"/> Brother(s)/ages _____ |   |

10. In the past year, have there been any changes in your family? (Check all that apply.)

- |                                     |   |  |                                      |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Marriage   | <input type="checkbox"/> Loss of job                | <input type="checkbox"/> Births          | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to a new neighborhood | <input type="checkbox"/> Serious illness |                                      |
| <input type="checkbox"/> Divorce    | <input type="checkbox"/> A new school or college    | <input type="checkbox"/> Deaths          |                                      |

**Parental/Guardian Concerns**

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems .....	<input type="checkbox"/>	Guns/weapons .....	<input type="checkbox"/>
Physical development .....	<input type="checkbox"/>	School grades/absences/dropout .....	<input type="checkbox"/>
Weight .....	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco .....	<input type="checkbox"/>
Change of appetite .....	<input type="checkbox"/>	Drug use .....	<input type="checkbox"/>
Sleep patterns .....	<input type="checkbox"/>	Alcohol use .....	<input type="checkbox"/>
Diet/nutrition .....	<input type="checkbox"/>	Dating/parties .....	<input type="checkbox"/>
Amount of physical activity .....	<input type="checkbox"/>	Sexual behavior .....	<input type="checkbox"/>
Emotional development .....	<input type="checkbox"/>	Unprotected sex .....	<input type="checkbox"/>
Relationships with parents and family .....	<input type="checkbox"/>	HIV/AIDS .....	<input type="checkbox"/>
Choice of friends .....	<input type="checkbox"/>	Sexual transmitted diseases (STDs) .....	<input type="checkbox"/>
Self image or self worth .....	<input type="checkbox"/>	Pregnancy .....	<input type="checkbox"/>
Excessive moodiness or rebellion .....	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual) .....	<input type="checkbox"/>
Depression .....	<input type="checkbox"/>	Work or job .....	<input type="checkbox"/>
Lying, stealing, or vandalism .....	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs .....	<input type="checkbox"/>		

12. What seems to be the greatest challenge for your teen? \_\_\_\_\_

13. What is it about your teen that makes you proud of him or her? \_\_\_\_\_

14. Is there something on your mind that you would like to talk about today?  
 What is it? \_\_\_\_\_

15. Can we share your answers to Question 13 with your teen?  Yes  No