



Guidelines for Adolescent Preventive Services

Middle-Older Adolescent Questionnaire

Confidential

(Your answers will not be given out.)

Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School _____ Year in college _____ Sex: Male Female Age _____

Address _____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number _____

What languages are spoken where you live? _____ Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Do you have any health problems? Yes No Problem(s) _____
3. Did you have any health problems in the past 12 months? Yes No Problem(s) _____
4. Are you taking any medicine now? Yes No Name of medicine _____

For Girls

5. Date when last period started _____ Are your periods regular (monthly)? No Yes
Month Date
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? Yes No

Specific Health Issues

7. Please check whether you have questions or are worried about any of the following:

<input type="checkbox"/> Height/weight	<input type="checkbox"/> Mouth/teeth/breath	<input type="checkbox"/> Frequent or painful urination	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Neck/back	<input type="checkbox"/> Discharge from penis or vagina	<input type="checkbox"/> Feeling tired a lot
<input type="checkbox"/> Diet/food/appetite	<input type="checkbox"/> Chest pain/trouble breathing	<input type="checkbox"/> Wetting the bed	<input type="checkbox"/> Cancer
<input type="checkbox"/> Future plans/job	<input type="checkbox"/> Coughing/wheezing	<input type="checkbox"/> Sexual organs/genitals	<input type="checkbox"/> Dying
<input type="checkbox"/> Skin (rash, acne)	<input type="checkbox"/> Breasts	<input type="checkbox"/> Menstruation/periods	<input type="checkbox"/> Sad or crying a lot
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Heart	<input type="checkbox"/> Wet dreams	<input type="checkbox"/> Stress
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Stomach ache	<input type="checkbox"/> Physical or sexual abuse	<input type="checkbox"/> Anger/temper
<input type="checkbox"/> Eyes/vision	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Masturbation	<input type="checkbox"/> Violence/personal safety
<input type="checkbox"/> Ears/hearing/ear aches	<input type="checkbox"/> Diarrhea/constipation	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> Nose	<input type="checkbox"/> Muscle or joint pain in arms/legs		_____
<input type="checkbox"/> Lots of colds			_____

Health Profile

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.

Eating/Weight

8. Are you satisfied with your eating habits? No Yes
9. Do you ever eat in secret? Yes No
10. Do you spend a lot of time thinking about ways to be thin? Yes No
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? Yes No
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? No Yes

School

13. Are your grades this year worse than last year? Yes No Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? Yes No
15. Have you been suspended from school this year? Yes No Not in school

Friends & Family

16. Do you have at least one friend who you really like and feel you can talk to? No Yes
17. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? No Yes
18. Have you ever thought seriously about running away from home? Yes No Not sure

Turn page

Weapons/Violence/Safety

- 19. Do you or anyone you live with have a gun, rifle, or other firearm? Yes No Not sure
- 20. In the past year, have you carried a gun, knife, club, or other weapon for protection? Yes No
- 21. Have you been in a physical fight during the *past 3 months*? Yes No
- 22. Have you ever been in trouble with the law? Yes No
- 23. Are you worried about violence or your safety? Yes No Not sure
- 24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? No Yes
- 25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? No Yes

Tobacco

- 26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? Yes No
- 26. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? Yes No
- 28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? Yes No

Alcohol

- 29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? Yes No
- 30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? Yes No
- 31. Have you ever been criticized or gotten into trouble because of drinking? Yes No Not sure
- 32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? Yes No Does not apply
- 33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? Yes No
- 34. Does anyone in your family drink or take drugs so much that it worries you? Yes No

Drugs

- 35. Do you ever use marijuana or other drugs, or sniff inhalants? Yes No Not sure
- 36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? Yes No Not sure
- 37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) Yes No
- 38. Have you ever used steroid pills or shots without a doctor telling you to? Yes No Not sure

Development

- 39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? Yes No Not sure
- 40. Do you think you may be gay, lesbian, or bisexual? Yes No Not sure
- 41. Have you ever had sexual intercourse? (How old were you the first time? _____) Yes No Not sure
- 42. Are you using a method to prevent pregnancy? (Which: _____) No Yes Not active
- 43. Do you and your partner(s) *always* use condoms when you have sex? No Yes Not active
- 44. Have any of your close friends ever had sexual intercourse? Yes No Not sure
- 45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? Yes No Not sure
- 46. Have you ever been pregnant or gotten someone pregnant? Yes No Not sure
- 47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? Yes No Not sure
- 48. Would you like to know how to avoid getting HIV/AIDS? Yes No Not sure
- 49. Have you pierced your body (not including ears) or gotten a tattoo? Yes No Thinking about it

Emotions

- 50. Have you had fun during the past two weeks? No Yes
- 51. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? Yes No
- 52. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? Yes No
- 53. Have you ever been physically, sexually, or emotionally abused? Yes No Not sure
- 54. When you get angry, do you do violent things? Yes No
- 55. Would you like to get counseling about something you have on your mind? Yes No Not sure

Special Circumstances

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

Self

- 59. What four words best describe you? _____
- 60. If you could change one thing about your life or yourself, what would it be? _____
- 61. What do you want to talk about today? _____

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?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing illness?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?
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?
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?
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)?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a rash or hives develop during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever passed out during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been dizzy during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had chest pain during or after exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get tires more quickly than your friends do during exercise?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had high blood pressure or high cholesterol?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been told you have a heart murmur?
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?
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?
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?
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)?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious or lost your memory?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure?
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: _____		
FEMALES ONLY – Optional –		
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