

You are here for your **ADOLESCENT EXAMINATION**. The following questions will help us discuss any concerns that you may have today. The information on this page is **CONFIDENTIAL** and will not be shared with anyone. This paper will be shredded at the end of the visit if that is your desire. Please be as honest as possible.

PLEASE LIST AND SPECIFIC CONCERNS YOU WOULD LIKE TO DISCUSS TODAY.

Do you think you are a generally happy person? YES _____ NO _____

Are you doing OK in school? What type of grades do you get? _____

What do you plan to do after high school? _____

Do you have a job? YES _____ NO _____

What do you like to do for fun? _____

Is your family under any stress like illness in a parent, divorce, death, economic hardship, moving?
Yes _____ NO _____

Does anyone in your household or close to you suffer from substance abuse, domestic violence or mental illness? YES _____ NO _____

Do you think your parents listen to you? YES _____ NO _____

Do you fight with your parents a lot? YES _____ NO _____

Do you drive yet? YES _____ NO _____

Do you wear a seat belt in the car at all times? YES _____ NO _____

On average, how many hours a day are you on the computer, texting, & playing video games? _____

How do you protect yourself online? _____

Do you ever use drugs? YES _____ NO _____ Alcohol? YES _____ NO _____

Do you smoke or chew tobacco? YES _____ NO _____ How much? _____

Do you engage in oral sex? YES _____ NO _____ Vaginal sex? YES _____ NO _____ Anal sex? YES _____ NO _____

If yes, what do you use to protect against sexually transmitted diseases? _____

Would you like to be tested for sexually transmitted diseases today? YES _____ NO _____

Are you interested sexually in guys? _____ Girls? _____ Both? _____ Not sure? _____

Have you ever had someone at home, school, or elsewhere, make you feel afraid, threatened, or hurt you either physically or sexually? YES _____ NO _____

Have you ever been bullied? YES _____ NO _____

Have you ever felt sad or down for more than two (2) weeks? YES _____ NO _____

Have you ever felt like hurting yourself? YES _____ NO _____

Do you frequently feel lonely or misunderstood? YES _____ NO _____

How many hours of sleep per night do you usually get? _____