Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
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Phone (541) 955-5683
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Adolescent Questionnaire - Ages 13 & Up

Name:_____ Date of Birth:_____

Your Cell Phone # (if you have one):_____ Today's Date:_____

1. Do you have any concerns to discuss with the doctor today?_____
   _____
2. Who lives in your home?_____
3. Who do you talk to when things aren't going well?_____
4. Have you ever been to counseling? ❑ Yes ❑ No If yes, who are you seeing?_____
5. Is there anything about yourself or your life you would like to be different?_____

School

1. Are you in school? ❑ Yes ❑ No If yes, what school?_____ What grade?_____
2. What do you like most about school?_____
3. Compared to last year, are your grades ❑ The same ❑ Better ❑ Worse
4. Have you ever cut classes, skipped school, been expelled or been suspended? ❑ Yes ❑ No
5. What do you do after school?_____
6. Do you work? ❑ Yes ❑ No
7. Have you experienced any bullying or cyber bullying? ❑ Yes ❑ No

Health Habits

1. Have you seen a dentist in the last year? ❑ Yes ❑ No
2. How many times a week do you exercise?_____ For how long?_____
3. What do you do for exercise?_____
4. Are you satisfied with the size or shape of your body and your physical appearance? ❑ Yes ❑ No
5. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills, laxatives or starving yourself? ❑ Yes ❑ No
6. Does anyone in your family drink alcohol or take drugs so much that it worries you? ❑ Yes ❑ No
7. Do you regularly use:
   a. Seatbelts? ❑ Yes ❑ No b. Helmets? ❑ Yes ❑ No c. Sunscreen? ❑ Yes ❑ No

Personal Concerns (Check any items below which concern or trouble you)

❑ Stress at home	❑ Anger or temper	❑ Muscle or joint pain	❑ Making friends	❑ Skin problems or acne
❑ Being tired all the time	❑ Anxiety or nervousness	❑ Diarrhea or constipation	❑ Stomach ache	❑ Sleeping problems
❑ Headache or migraine	❑ Dizzy spells or fainting	❑ Boyfriend or girlfriend	❑ Other_____	

Sexual Health

1. Are you attracted to: ❑ Males ❑ Females ❑ Both ❑ Not sure
2. Do you identify as: ❑ Male ❑ Female ❑ Other:_____
3. Have you ever had sexual experiences? ❑ Yes ❑ No

   If "No", go to the next section

   If yes, what? ❑ Kissing ❑ Touching private parts ❑ Oral sex ❑ Sexual intercourse ❑ Other:_____

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Sexual Health (continued)

4. How many sexual partners have you had?_____
5. If you have ever had a sexual partner is your parent aware? ❑ Yes ❑ No
6. Are you or your partner using a method to prevent pregnancy? ❑ Yes ❑ No
   If yes, what kind of birth control?_____
7. Do you and your partner(s) always use condoms when you have oral sex and/or intercourse? ❑ Yes ❑ No
8. Have you ever had a sexually transmitted infection or disease (Herpes, Chlamydia, Gonorrhea, Genital warts)? ❑ Yes ❑ No
9. Have you been pregnant or gotten someone pregnant? ❑ Yes ❑ No

For Females

1. Have you started your menstrual periods? ❑ Yes ❑ No If yes, what age?_____
2. Do you have a period every month? ❑ Yes ❑ No
3. Any problems with your periods? ❑ Yes ❑ No If yes, what and when?_____
4. Are you worried you might be pregnant? ❑ Yes ❑ No

For Males

1. Have you been taught to do a testicular self-exam? ❑ Yes ❑ No
2. Have you noticed any change in the size or shape of your testicles? ❑ Yes ❑ No