



700 SW Ramsey Ave. Suite 204  
Grants Pass, OR 97527  
Phone (541) 955-5683  
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## Tips for Teens:

- Learn about your medical problems.
- Follow the treatment plan.
- Be honest with your physician.
- Be on time for your appointment.

## What should I talk to the doctor or nurse about?

You can talk to your doctor or nurse about anything! Fill your doctor or nurse in if you...

- Need information about alcohol, tobacco, or any drug use.
- Want to talk about personal, school, or family issues.

## What will my doctor or nurse tell my parents?

It is our practice to ask all parents and guardians to wait outside the exam room for part of your visit. This gives you and your provider a chance to discuss anything you may feel uncomfortable talking about in front of others.

**Your safety is most important to us.** Know that if you are doing anything to hurt yourself, or others, or if someone is hurting you, we may have to tell someone. We will always encourage you to talk to your parents or guardians about your health. We can help start the conversation.

## However,

Some things cannot remain confidential. Your health care provider will need to contact someone else to help if you say...

- You are being abused.
- You are going to hurt yourself or someone else.



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## Adolescent Questionnaire – Ages 11 & 12

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ 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
5. Are you in counseling now?  Yes  No If yes, who are you seeing? \_\_\_\_\_
6. 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 suspended?  Yes  No
5. What do you do after school? \_\_\_\_\_
6. Are you currently experiencing 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: Seatbelts?  Yes  No Helmets?  Yes  No Sunscreen?  Yes  No
8. Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise?  Yes  No

### For Females

1. Have you started your menstrual period?  Yes  No  
If yes, at what age? \_\_\_\_\_
2. Do you have a period every month?  Yes  No
3. Any problems with your period?  Yes  No  
If yes, what, and when \_\_\_\_\_

## Adolescent annual questionnaire

We ask all our adolescent patients to complete this form at least once a year, because substance use and mood can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

### S2BI questions

In the <b>PAST YEAR</b> , how many times have you used:	<b>Never</b>	<b>Once or twice</b>	<b>Monthly</b>	<b>Weekly</b>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “Never” to all three questions above, please skip to **CRAFFT q**

## Mood (PHQ-9 Modified for Teens):

How often have you been bothered by each of the following symptoms during the past <b>TWO WEEKS</b> ?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “Not at all” to both questions above, you are finished answering questions. Otherwise, please continue answering all the questions below.

3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired, or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite, weight loss, or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things like school work, reading, or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3

In the <b>PAST YEAR</b> , have you felt depressed or sad most days, even if you felt okay sometimes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are experiencing any of the problems on this form, 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?		
<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult		
Has there been a time in the past month when you have had serious thoughts about ending your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you <b>EVER</b> , in your <b>WHOLE LIFE</b> , tried to kill yourself or made a suicide attempt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Office Use Only:    Severity Score - \_\_\_\_\_