Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
Fax (541) 955-0983

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
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. Do you work? ☐ Yes ☐ No
7. 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

Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
Fax (541) 955-0983

Sexual Health

1. Are you attracted to: ☐ Males ☐ Females ☐ Both ☐ Not sure
2. Do you identify yourself as: ☐ Male ☐ Female ☐ Other
   _____
3. Have you ever had sexual experiences? ☐ Yes ☐ No ***IF NO, GO TO NEXT SECTION***
   If yes, what? ☐ Touching private parts ☐ Oral sex ☐ Sexual intercourse ☐ Other_____
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 or 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. At what age did you start your menstrual period? _____
2. Do you have a period every month? ☐ Yes ☐ No
3. Any problems with your period? ☐ Yes ☐ No
   If yes, what, and when_____
4. Are you worried you might be pregnant? ☐ Yes ☐ No