

Name: _____ DOB: _____ Date: _____

Please circle your answer to each of the following questions:

1. How often do you use a helmet when you rollerblade, skateboard, bicycle, or ride a motorcycle, minibike or ATV?

Always

Sometimes

Rarely or Never

2. How often do you wear a seat belt when you ride in a car, truck or van?

Always

Sometimes

Rarely or Never

3. Are you having any problems in school?

Rarely or Never

Sometimes

Always

Circle all that apply. . . grades, fighting, missing school

4. Have you ever felt you had a problem with your weight?
(underweight, overweight, anorexia, bulimia)

Rarely or Never

Sometimes

Always

5. Did you ever smoke cigarettes (even if you did not inhale), vape or chew tobacco?

Never

Once or Twice

3 or more times

6. Did you ever drink any alcohol? (beer, wine, liquor, other)

Never

Once or Twice

3 or more times

7. Did you ever use drugs?

Never

Once or Twice

3 or more times

Circle all that apply. . . marijuana, cocaine, crack, heroin, acid, speed, ecstasy, roofies, sniffed inhalants, steroids, hormones, prescriptions drugs not ordered for you, or others

8. Have you ever ridden in a vehicle when the driver is under the influence of alcohol or drugs?
(This includes when you were the driver as well as other people.)

Never

Once or Twice

3 or more times

9. Have you ever done something violent because you were angry?

Never

Once or Twice

3 or more times

10. Have you ever had someone at home, school or anywhere else, who made you feel afraid, threatened you or hurt you?

Never

Once or Twice

3 or more times

Continued on back...

Please circle your answer to each of the following questions:

11. Have you had sex?

No

Yes

Circle all that apply. . .vaginal sex anal sex oral sex

12. If you have had sex, how often do you use condoms (rubbers)?

Never had sex

Always

Sometimes

Rarely or never

13. Were you ever forced to have sex you did not want, or has someone touched you in a way that made you feel uncomfortable? (touching of breasts, buttocks or genitals)

Never

Not Sure

Yes

14. Have you ever thought about killing yourself or made a plan to kill yourself?

Never

Once or Twice

3 or more times

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15. In the past two weeks have you had no interest or pleasure in doing things that you typically like to do?

Yes

No

16. In the past two weeks have you been feeling down, depressed or hopeless?

Yes

No

DO YOU HAVE ANY QUESTIONS ABOUT ANY OF THESE TOPICS?

There may be subjects that you would like to know more about. You may have friends or know people who are making these choices, or you may want more information to help you make choices in the future. **CIRCLE** any subjects you would like more information about and add any subjects that are not listed below.

- | | | |
|------------------------------------|------------------------------------------|------------------------|
| Tobacco | abstinence (saying no) | depression |
| Quitting smoking | safer sex | suicide |
| Alcohol | birth control | abuse |
| Drugs | homosexuality (gay/lesbian) | weight problem |
| Steroids (bulking up) | HIV / AIDS | diet pills / laxatives |
| Sniffing (glue, aerosol) | sexual diseases (STDs) | exercise / fitness |
| Sharing needles / works | gender issues (transgender / transsexual | |
| Body piercing / tattoos / branding | other _____ | |

Name: _____ Age: _____

I have reviewed the above information with my patient.

Date: ____/____/____ Initials: _____