New Patient History Questionnaire, Adolescent Supplement

Name_____ Current Date_____

Date of Birth _____

Welcome to our office. This questionnaire has been designed so that we can both review your medical history and factors in your life that affect health. We have asked you and/or your parents to fill out a questionnaire on child health, but we would like to know if you have any concerns of your own that may not have been addressed there.

We encourage teens to talk with their parents about everything going on in their lives, but there are also some topics that teens may want to keep confidential, including items relating to mental health and/or sexual activity or birth control. State law says we can keep these items confidential even from your parents if you are 12 or older. Mark the items you want kept confidential with an asterisk (*).

Be warned that by law we must report any concerns for physical or sexual abuse if there is an ongoing risk to you or anyone else.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

Medical issues or symptoms you want to be sure are addressed today:

_____

_____

_____

Current medications(in addition to those mentioned on the other questionnaire – i.e. anything your parents may not realize you are using/you do not want them to know you are using, including birth control) _____

Allergies to any Medication or Food: (list substance and reaction): _____

_____

Do you follow any special eating plan for yourself? ❒ no ❒ yes What?_____

Have you done anything to try to gain or lose weight? ❒ no ❒ yes What?_____

Do you feel out of control about your eating or food? ❒ no ❒ yes How?_____

Social Support and Stress: (Please write details of any positive answers on the other side)

Do you feel stress is a problem in your life?..... ❒ yes ❒ no
Do you have problems with getting angry frequently or at little things?..... ❒ yes ❒ no
Are you afraid of your own temper or that of anyone else in your family?..... ❒ yes ❒ no
Do you sometimes feel out of control? ..... ❒ yes ❒ no
Do you sometimes feel you are no good or you can't do anything right? ..... ❒ yes ❒ no
Have you ever thought about or tried to commit suicide? ..... ❒ yes ❒ no
Have you or anyone on your block or in your class been shot or mugged in the last year?..... ❒ yes ❒ no
Is there any history of violence in your family? ..... ❒ yes ❒ no
Has anyone close to you ever physically hit you or hurt you?..... ❒ yes ❒ no
Do you feel unsafe in your home, at school, or in your current relationship?..... ❒ yes ❒ no
Is there a partner from a previous relationship who is making you feel unsafe now?..... ❒ yes ❒ no
Do you frequently feel isolated or alone?..... ❒ yes ❒ no
Do you feel people take advantage of you or try to control you?..... ❒ yes ❒ no
Do you feel threatened or bullied by anyone in your life?❒ yes ❒ no

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things ❒ not at all ❒ several days ❒ more than half the days ❒ nearly every day

Feeling down, depressed, or hopeless ❒ not at all ❒ several days ❒ more than half the days ❒ nearly every day

Who provides you with emotional support(family, close friend, teacher, religious advisor, other)? _____

_____

Sexual History:

Have you ever had sex with another person? (Including using hands, mouths, genitals, anus)..... ❒ yes ❒ no
If so, have you had sex in the last month? ..... ❒ yes ❒ no
3 months? ..... ❒ yes ❒ no
1 year?..... ❒ yes ❒ no
Do you have or have you ever had sex with:.....❒ males ❒ females ❒ both
How many people have you had sex with in the last year?.....❒ 1 ❒ 2-3 ❒ more than 3
What do you use for birth control/safe(r) sex? _____
Do you want to discuss safe sex, AIDS, or other sexual issues with the provider? ..... ❒ yes ❒ no
Has anyone ever sexually abused or raped you, or has anyone ever pressured you into being sexual when you did not want to?..... ❒ yes ❒ no
If so, are you willing to discuss the event(s) to your provider?..... ❒ yes ❒ no
Have you had some counseling or other help with this? ..... ❒ yes ❒ no
Do you feel this still affects you? ..... ❒ yes ❒ no

During the PAST 12 MONTHS, did you:

Drink any alcohol? ..... ❒ yes ❒ no
Smoke any marijuana or hashish?..... ❒ yes ❒ no
Use anything else to get high?..... ❒ yes ❒ no
("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.")

Have you ever:

Ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol/drugs? ❒ yes ❒ no
Used alcohol or drugs to relax, feel better about yourself, or fit in? ..... ❒ yes ❒ no
Used alcohol or drugs while you were by yourself or alone?..... ❒ yes ❒ no
Forgotten things you did while using alcohol or drugs? ..... ❒ yes ❒ no
Gotten into trouble while you were using alcohol or drugs?..... ❒ yes ❒ no
Do your family or friends ever tell you that you should cut down on your drinking or drug use? ..... ❒ yes ❒ no

Please list any other concerns and any details for your answers on this form: