11-14 Year Questionnaire

History

Do you, your parents, or anyone else have any concerns about your health or well-being?

Yes No

Does you have any special health care needs?

Yes No

Have you seen another doctor are been in the hospital, emergency room or urgent care since your last visit?

Yes No

Do you receive care from anyone besides a medical doctor? For example, acupuncturist, herbalist or other healer.

Yes No

Have you had any procedures or tests done since your last visit?

Yes No

Household

How many people do you live with? _____

Do you live with both of your biological parents?

Yes No

If you are not living with both biological parents, what is living situation?

_____

Social History

Have there been any major changes for you or your family lately?

Yes No

Do you live with anyone who smokes or do you spend time in any places where people smoke?

_____

Does anyone smoke in the car you travel in?

Yes No

Anemia Risk Assessment

Has you ever been diagnosed with iron deficiency anemia?

Yes No

Are you on a strict vegetarian diet?

Yes No

Does your diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

Yes No

FEMALES: When you get your period, are they heavy or last more than 5 days?

_____

Tuberculosis Risk Assessment

Have you been exposed to someone with tuberculosis?
Yes No
Has a family member or contact had a positive tuberculin skin test?
Yes No
Were you born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?
Yes No
Have you traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?
Yes No
Are you infected with HIV?
Yes No

Dyslipidemia Risk Assessment

Do your parents or grandparents had a stroke or heart problem before the age of 55?
Yes No
Do you have a parent or sibling that has high cholesterol (total cholesterol of 240 or higher) or taking cholesterol medication?
Yes No

Family and Home Life

How is everything at home?_____

Do you get along with everyone in your family?
Yes No
Do you eat meals with your family?
Yes No
Do you have a family member or an adult who you can turn to for help?
Yes No
Are you permitted to make your own decisions?
Yes No
Do you discuss your family rules and how you should act with your parents?
Yes No

Education

Where do you go to school?_____

How are you doing in school?_____

Are there any concerns about your behavior or your attention?
Yes No
Are there concerns about your attention?
Yes No
Do you have any problems completing your homework?
Yes No

Are you having any problems at school?
Yes No
Has anyone teased or picked on you or made you feel bad about yourself?_____
Do you have adult supervision after school?
Yes No

Nutrition

How many meals do you eat a day? _____

How many cups of water do you drink a day?_____

How many cups of juice, soda, sports drinks, Kool-Aid or other drink mixes do you drink per day (total)?_____

How would you describe your intake of dairy products like milk, cheese and yogurt?
_____

How would you describe your intake of vegetables?
_____

How would you describe your intake of fruits?
_____

How would you describe your intake of protein like meat and eggs?
_____

How would you describe your intake of carbohydrates like grains, breads, cereals and pastas?
_____

How would you describe your intake of junk food like chips, candy, cookies, or cakes?
_____

Do you take vitamins or supplements?
Yes No

Body Image

Are you satisfied with the way your body looks?
Yes No
Are you satisfied with your weight?
Yes No
Do you have any questions or concerns about your body or the changes your body is going through?
Yes No
Are you comfortable asking your parent questions about your body?
Yes No

Oral Health

Do you see the dentist at least every 6 months?_____

How often do you brush your teeth? _____

Do you drink water from a public water system that is fluoridated?
Yes No

Physical Activity

Do you participate in exercise or physical activity?
Yes No
On average, how long do you exercise for?_____

How much time do you spend watching TV, computer or other electronic device screen like a tablet or game console?_____

Interests and Activities

Do you have friends that are your age?
Yes No
Does your parent know who your friends and their families are?
Yes No
Do you regularly participate in activities outside of the home?
Yes No
What are your hobbies?_____

Substance Use

Have you ever smoked cigarettes or cigars, or chewed tobacco?
Yes No
Does your parent talk to you about cigarettes and other tobacco products and the importance of not using it?
Yes No
Have you ever drank alcohol, like beer, wine, wine cooler, liquor or used alcohol soaked products?
Yes No
Does your parent talk to you about alcohol and the importance of not using it?
Yes No
Have you ever used any drugs such as marijuana, cocaine, crack, heroin, or ecstasy?
Yes No
Have you ever taken prescription medications that are not prescribed to you?
Yes No
Does your parent talk to you about street drugs and medications not prescribed to you and the importance of not using them?
Yes No

Have you ever participated in recreational activities with the goal of getting high such as huffing, bath salts or the choking game?
Yes No
Does your parent talk to you about recreational activities with the goal of getting high such as huffing, bath salts or the choking game and the importance of not doing it?
Yes No

Safety

Have you ever been the passenger in a car after the driver had used alcohol or drugs?
Yes No
How often do you wear a seatbelt when riding in the car?
_____
Do you wear a helmet when riding a bike, skateboard, ATV, or motorcycle?
_____
Do you use protective sports gear (helmets, wrist guards, knee pads etc.)?
_____
Do you use life vests aboard watercrafts?_____
Do you use ear protection around loud noises?_____

Do you use sunscreen or sun-protective garments/eyewear?_____

Do you have working smoke detectors at home?_____

Do you know it is never ok for an adult to tell you to keep secrets from your parents?
Yes No
Are there safety filters installed on all the computers and computer devices that you use?
Yes No
Does your parent regularly check your internet usage history?
Yes No
Is the computer that you use in a place your parent can easily see?
Yes No
Have you ever been upset over an experience you had while using the internet?
Yes No

Violence

Do you feel safe in your home, school, neighborhood or other places you spend time at?
Yes No
Have you ever been slapped, kicked, or physically hurt by someone?
Yes No
Do you know how or where to get help if you don't feel safe in your home?
Yes No
Do you have access to guns or other weapons at home?
Yes No
Have you ever carried a gun, knife, or weapon?
Yes No
Are you in a gang?

Yes No
Have you been in a fight in the last year?
Yes No

Reproductive Health

What gender do you feel most sexually attracted to?_____

Have you ever had sex?
Yes No

Have you ever had oral sex?
Yes No
Do you or your partner use condoms when having sex?_____
Have you ever had sex, including oral sex, without using a condom?
Yes No
Have you ever been tested for sexually transmitted diseases?
Yes No
Have you ever been forced to have sex when you did not want to or were touched you in a way that made you feel uncomfortable?
Yes No
Does your parent answer your questions about sex?
Yes No
Does your parent discuss with you the importance of waiting to have sex?
Yes No
FEMALES: Have you had your first period?
Yes No
FEMALES: If you have started getting your period, how often does it come?
_____
FEMALES: If you have started getting your period, how many days do they last for?
_____

Mental Health

How do you cope with stress?_____

Do you feel good about yourself?
Yes No
On average, how many hours of sleep do you get on a night?_____

Are you having problems with sleep?
Yes No
When you get angry, do you do violent things?
Yes No
Do you feel overly stressed out or worry a lot?
Yes No

Do you often feel sad, down, or hopeless?
Yes No
Have you ever thought about hurting or killing yourself?
Yes No