## ADOLESCENT QUESTIONNAIRE

## **Reston Town Center Pediatrics**

## **CONFIDENTAL**

<u>Please circle "Yes "or "No" after each question and hand this paper directly to your doctor. This form</u> your official chart! It will be torn up during your visit.	does 1	<u>not go into</u>
What grade are you in? What school do you go to?		
What is your favorite subject in school?		
Do you have any difficulties in school?	No	Yes
Do you miss more than 2 days of school a month?	No	Yes
Have you smoked or chewed tobacco, vaped, or used Juules in the past year?	No	Yes
Have you smoked marijuana in the past year?	No	Yes
Have you used any other substances to get high in the last year (cough syrup, poppyseed tea, hash,		
heroin, etc.)?	No	Yes
Have you used other drugs, including prescription drugs (for example: ADHD medicines or pain killers)?		
not prescribed for you?	No	Yes
Do any of your friends drink alcohol?	No	Yes
Have you consumed alcohol with your friends in the past year?	No	Yes
Do you have a job?	No	Yes
If yes, where do you work?		
To whom are you attracted? Men, women, or		
Do you consider yourself straight, gay, bisexual, transgender, questioning, or other?		
Have you ever had sex?	No	Yes
If yes, oral, vaginal, or anal? (Please circle which)		
If yes, do you or your partner use a condom?	Yes	No
Do you or your partner use any other form of birth control?	Yes	No
Has anyone approached you or touched you in any manner that either hurt or made you uncomfortable?	No	Yes
Do you have a driver's license?	No	Yes
Have you ever had your driver's license suspended or revoked?	No	Yes
Do you text or use a cell phone while driving?	No	Yes
Do you always wear a seatbelt when riding or driving in a motor vehicle?	Yes	No
Is there anything you would like to change about yourself?	. No	Yes
Do you get along with family members?	Yes	No
Do you worry about other family members getting along?	No	Yes
Do you have any career or job plans?	.No	Yes

Do you take part in after school activities/hobbies/clubs?	No
Do you exercise regularly? (60 min 3 times a week on average)	No
Do you like to play sports?	No
Do you use nutritional supplements, steroids, pre-workout drinks, herbal supplements, or energy drinks? No	Yes
Do you have questions about over the counter medications, nutritional supplements, or steroids? No	Yes
Are there any guns or weapons in your house?	Yes
Do you have trouble getting to or staying asleep? No	Yes
Do you have friends you can talk to?	No
Do you find it hard to make friends? No	Yes
Is life in general going OK for you?	No
Do you often feel down, depressed, or hopeless? No	Yes
Do you find yourself crying more than usual? No	Yes
Do you have little interest or pleasure in doing things? Sometimes Often Never	
Have you thought a lot about hurting yourself or someone else?	Yes
<u>For females:</u>	
Do you have menstrual periods? Yes	No
If yes, when was the first period you ever had?	
If yes, when was your last period?	
If yes, how often are your periods?	
Do you have any questions about your period?	
Have you ever been pregnant? No	Yes
Do you have any questions about your body or development? No	Yes
For males:	
Do you know how to check your testicles for lumps?	No
Do you have questions about your body or development?	Yes
Please circle below if you wish to discuss any of the following:	
Growth & Development Nutrition Bullying Weight Concerns Peer Pressure Family Pregnancy Alcohol Career Planning Drugs Sexually Transmitted Infections (	y Conflicts STIs)
Masturbation Contraception Other:	

How did you feel about filling out this form? Please check ALL that apply:

\_\_\_\_I'm not sure I answered all the questions correctly

\_\_\_\_No problem

\_\_Made me feel uncomfortable

If you have any questions after completing this form, please do not hesitate to ask you provider.