700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
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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 If yes, who are you seeing?______________________
5. 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 been suspended? ❑ Yes ❑ No
5. What do you do after school?______________________
6. Do you work? ❑ Yes ❑ No
7. Have you experienced any 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:
   a. Seatbelts? ❑ Yes ❑ No b. Helmets? ❑ Yes ❑ No c. Sunscreen? ❑ Yes ❑ No

Personal Concerns (Check any items below which concern or trouble you)

❑ Stress at home ❑ Anger or temper ❑ Muscle or joint pain ❑ Making friends ❑ Skin problems or acne
❑ Being tired all the time ❑ Anxiety or nervousness ❑ Diarrhea or constipation ❑ Stomach ache ❑ Sleeping problems
❑ Headache or migraine ❑ Dizzy spells or fainting ❑ Boyfriend or girlfriend ❑ Other______________________

Sexual Health

1. Are you attracted to: ❑ Males ❑ Females ❑ Both ❑ Not sure
2. Do you identify as: ❑ Male ❑ Female ❑ Other:______________________
3. Have you ever had sexual experiences? ❑ Yes ❑ No
   If "No", go to the next section
   If yes, what? ❑ Kissing ❑ Touching private parts ❑ Oral sex ❑ Sexual intercourse ❑ Other:__________
4. How many sexual partners have you had?______________________

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Sexual Health (continued)

5. Are you or your partner using a method to prevent pregnancy? ☐ Yes ☐ No
   If yes, what kind of birth control?________________________________
6. Do you and your partner(s) always use condoms when you have oral sex and/or intercourse? ☐ Yes ☐ No
7. Have you ever had a sexually transmitted infection or disease (Herpes, Chlamydia, Gonorrhea, Genital warts)? ☐ Yes ☐ No
8. Have you been pregnant or gotten someone pregnant? ☐ Yes ☐ No

For Females

1. Have you started your menstrual periods? ☐ Yes ☐ No If yes, what age?________________________
2. Do you have a period every month? ☐ Yes ☐ No
3. Any problems with your periods? ☐ Yes ☐ No If yes, what and when?________________________
4. Are you worried you might be pregnant? ☐ Yes ☐ No

For Males

1. Have you been taught to do a testicular self-exam? ☐ Yes ☐ No
2. Have you noticed any change in the size or shape of your testicles? ☐ Yes ☐ No