Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
Fax (541) 955-0983

Tips for Teens:

- Learn about your medical problems.
- Follow the treatment plan.
- Be honest with your physician.
- Be on time to your appointment.

What should I talk to the doctor or nurse about?
You can talk to your doctor or nurse about anything! Fill your doctor or nurse in if you…

- Think you might be pregnant.
- Need birth control.
- Think you have a sexually transmitted disease (STD).
- Need information about alcohol, tobacco, or any drug use.
- Want to talk about personal, school, family issues, or feelings about sex and sexuality.

What will my doctor or nurse tell my parents?
It is our practice to ask all parents and guardians to wait outside the exam room for part of your visit. This gives you and your provider a chance to discuss anything you may feel uncomfortable talking about in front of others.

Your safety is most important to us. Know that if you are doing anything to hurt yourself, or others, or if someone is hurting you, we may have to tell someone. We will always encourage you to talk to your parents or guardians about your health. We can help start the conversation.

However,
Some things cannot remain confidential. Your health care provider will need to contact someone else to help if you say…

- You are being abused, physically and/or sexually.
- You are going to hurt yourself or someone else.
- You are under 16 and having sex with someone 21 years or older.
- You are under 14 and having sex with someone 14 years or older.

You as a young person, after you turn age 14, can consent for care on your own for problems and concerns in the areas of sexuality, mental health, and substance abuse. You do not need your parent or guardian's consent for other health services such as physicals and care for colds, flu, and injuries after you turn 15 years old. It's a good idea to talk with them or another adult you trust about the medical care you need. We want you to be safe. If you have any questions about confidentiality, please ask us!

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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
5. Are you in counseling now? ☐ Yes ☐ No If yes, who are you seeing? _____
6. 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 suspended? ☐ Yes ☐ No
5. What do you do after school? _____
   _____
6. Do you work? ☐ Yes ☐ No
7. Are you currently experiencing 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: Seatbelts? ☐ Yes ☐ No
   Helmets? ☐ Yes ☐ No
   Sunscreen? ☐ Yes ☐ No
8. Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise? ☐ Yes ☐ No

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Sexual Health

1. Are you attracted to: ☐ Males ☐ Females ☐ Both ☐ Not sure
2. Do you identify yourself as: ☐ Male ☐ Female ☐ Other
   _____
3. Have you ever had sexual experiences? ☐ Yes ☐ No ***IF NO, GO TO NEXT SECTION***
   If yes, what? ☐ Touching private parts ☐ Oral sex ☐ Sexual intercourse ☐ Other_____
4. How many sexual partners have you had? _____
5. If you have ever had a sexual partner is your parent aware? ☐ Yes ☐ No
6. Are you or your partner using a method to prevent pregnancy? ☐ Yes ☐ No
   If yes, what kind of birth control? _____
7. Do you or your partner(s) always use condoms when you have oral sex and/or intercourse? ☐ Yes ☐ No
8. Have you ever had a sexually transmitted infection or disease (herpes, chlamydia, gonorrhea, genital warts)? ☐ Yes ☐ No
9. Have you been pregnant or gotten someone pregnant? ☐ Yes ☐ No

For Females

1. At what age did you start your menstrual period? _____
2. Do you have a period every month? ☐ Yes ☐ No
3. Any problems with your period? ☐ Yes ☐ No
   If yes, what, and when_____
4. Are you worried you might be pregnant? ☐ Yes ☐ No

Adolescent annual questionnaire

We ask all our adolescent patients to complete this form at least once a year, because substance use and mood can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

S2BI questions

In the **PAST YEAR**, how many times have you used:	**Never**	**Once or twice**	**Monthly**	**Weekly**
Tobacco:	☐	☐	☐	☐
Alcohol:	☐	☐	☐	☐
Marijuana:	☐	☐	☐	☐

If you answered "Never" to all three questions above, please skip to **CRAFFT question #1** and then turn the page. Otherwise, please continue answering all questions below.

Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)	☐	☐	☐	☐
Illegal Drugs: (such as cocaine or Ecstasy)	☐	☐	☐	☐
Inhalants: (such as nitrous oxide)	☐	☐	☐	☐
Herbs or synthetic drugs: (such as salvia, "K2", or Bath salts)	☐	☐	☐	☐

If you answered "Never" or "Once or twice" to all questions above, please answer only **CRAFFT question #1** below and then turn the page. Otherwise, please continue answering all questions below.

CRAFFT questions

	No	**Yes**
1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	☐	☐
4. Do you ever forget things you did while using alcohol or drugs?	☐	☐
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into trouble while you were using alcohol or drugs?	☐	☐

Please turn page

Mood (PHQ-9 Modified for Teens):

How often have you been bothered by each of the following symptoms during the past **TWO WEEKS?**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐

If you answered "Not at all" to both questions above, you are finished answering questions.
Otherwise, please continue answering all the questions below.

3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired, or having little energy?	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
	0	1	2	3

In the **PAST YEAR,** have you felt depressed or sad most days, even if you felt okay sometimes?	☐ Yes	☐ No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult		
Has there been a time in the past month when you have had serious thoughts about ending your life?	☐ Yes	☐ No
Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?	☐ Yes	☐ No

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Office Use Only: Severity Score - _____