



Adolescent Health Screening

NAME:
DOB:

Date:	Time:
THE ANSWERS ON THIS FORM ARE COMPLETELY PRIVATE	
School/Work	
What school do you attend? What grade are you in?	
Are you getting any failing grades this year?	
Have you ever been bullied at school or elsewhere?	Have you ever bullied another person?
What sports/clubs/activities are you involved in?	
Do you have a job?	
Family and Friends	
Who do you live with?	
Do you get along with your parents/family?	
Are there any problems at home?	
Do you have at least one close friend?	
Have you begun dating?	
Have you ever had sex in any way?	Have you used protection (and what type?)
Would you like to be tested for HIV or other STDs?	
Safety, Mood, Behavior	
Do you wear a seatbelt while driving or riding in a car?	
Do you wear a helmet when riding a bike, skating/skateboarding, or riding an ATV?	
Do you have guns, rifles or other firearms in your home? Are they securely locked?	
Do you ever drink alcohol, or get high on marijuana, meth, heroin, cocaine or any other substances?	
Do you smoke cigarettes or chew tobacco?	
Do you take any supplements to improve sports performance or change weight?	
Do you often feel sad or down or as though you have nothing to look forward to?	
Have you ever seriously thought about killing yourself or actually tried to kill yourself?	
Do you find yourself worrying excessively about things or getting violent when angry?	
Are there any other questions, concerns or issues that you want to talk to me about?	