Staying Healthy Assessment

12 - 17 Years

Name (first & last)		Date of Birth		Today	Today's Date		Grade in School:	
			☐ Male					
Person Completing Form		Parent Relative Friend Guardian			School Attendance			
Other (Specify) Regular?								
Please answer all the questions on this form as best you can. Circle "Skip" if you do do not wish to answer. Be sure to talk to the doctor if you have questions about any							Need Interpreter?	
Your answers will be protected as part of your medical record.							Clinic Use Only:	
1	Do you drink or eat 3 servings of cal milk, cheese, yogurt, soy milk, or to	Yes	No	Skip	Nutrition			
2	Do you eat fruits and vegetables at le	Yes	No	Skip				
3	Do you eat high fat foods, such as fr pizza more than once per week?	No	Yes	Skip				
4	Do you drink more than 12 oz. (1 so sports drink, energy drink, or sweete	No	Yes	Skip				
5	Do you exercise or play sports most	days of the week?		Yes	No	Skip	Physical Activity	
6	Are you concerned about your weight?				Yes	Skip		
7	Do you watch TV or play video gam	Yes	No	Skip				
8	Does your home have a working smoke detector?				No	Skip	Safety	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?				No	Skip		
10	Do you always wear a seatbelt when riding in a car?				No	Skip		
11	Do you spend time in a home where a gun is kept?				Yes	Skip		
12	Do you spend time with anyone who carries a gun, knife, or other weapon?				Yes	Skip		
13	Do you always woor a halmat when riding a hike skataboard or				No	Skip		
14	Have you ever witnessed abuse or violence?				Yes	Skip		
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?				Yes	Skip		
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?				Yes	Skip		
17	Do you brush and floss your teeth daily?				No	Skip	Dental Health	
18	Do you often feel sad, down, or hopeless?				Yes	Skip	Mental Health	
19	Do you spend time with anyone who smokes?				Yes	Skip	Alcohol, Tobacco, Drug Use	
20	Do you smoke cigarettes or chew tobacco?				Yes	Skip	g	
21	Do you use or sniff any substance to cocaine, crack, Methamphetamine (r	No	Yes	Skip				

22	Do you use medicines not prescribed for you?		Yes	Skip			
23	Do you drink alcohol once a week or more?		Yes	Skip			
24	If you drink alcohol, do you drink enough to get drunk or pass out?		Yes	Skip			
25	Do you have friends or family members who have a problem with drugs or alcohol?		Yes	Skip			
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip			
Υc	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.						
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues		
28	Have you ever had sex (oral, vaginal, or anal)? If no, skip to question 35.	No	Yes	Skip			
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?		Yes	Skip			
30	Have you or your partner(s) had sex with other people in the past year?		Yes	Skip			
31	Have you or your partner(s) had sex without using birth control in the past year?		Yes	Skip			
32	The last time you had sex, did you use birth control?		No	Skip			
33	Have you or your partner(s) had sex without a condom in the past year?		Yes	Skip			
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip			
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip			
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions		

If yes, please describe:

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Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
□ Nutrition								
Physical activity								
Safety								
☐ Dental Health								
☐ Mental Health								
Alcohol, Tobacco, Drug Use								
☐ Sexual Issues					☐ Patient Declined the SHA			
PCP's Signature:		Print Name:			Date:			
SHA ANNUAL REVIEW								
PCP's Signature:	Print Name:			Date:				
PCP's Signature:		Print Name:			Date:			
DCD's Signature		Dwint Name.			Data			
PCP's Signature:		Print Name:			Date:			
PCP's Signature:	Print Name:			Date:				