

Name _____ Preferred Name _____ Age _____ Grade _____
 Sex you were born as: Male Female Gender identity: Male Female Gender non-conforming
 Preferred Pronoun _____ Date _____ School _____
Do you have any special learning needs? Yes No If yes, what? _____

PERSONAL HEALTH

1. Do you have allergies to Medicine Foods Other _____
 If yes, what are you allergic to? _____ What kind of reaction? _____
2. Are you taking any medicine now? Yes, name(s) _____ No
3. What clinic do you go to _____
4. Have you ever been in: Counseling Treatment Center Foster Home Homeless Shelter Group Home
 JC/JD (Juvenile Correction/Detention) None
5. Have you ever been in the hospital overnight? Yes, reason _____ No
6. Have you ever had an operation? Yes, reason _____ No
7. Have you ever had tuberculosis (TB) or a positive skin test for TB? Yes, when _____ No
8. When was your last dental visit? _____
9. Do you use a seat belt? Yes No
10. Do you wear a helmet on a bike, motorcycle, scooter or skateboard? Yes No
11. Are you self-conscious about your body? Yes No
12. Are you concerned about food, diet or weight? Yes No
13. Do you have problems with sleep? Yes No

FAMILY HEALTH HISTORY

14. Who do you live with? _____
15. How many brothers (full, step, 1/2, adopted)? _____ How many sisters (full, step, 1/2, adopted)? _____
16. Name other family members who don't live with you who are very important to you _____
17. How are things at home? (Great) 5 4 3 2 1 (Not great at all)

18. Check any of these health problems that affect you or your family (brothers, sisters, parents, grandparents, aunts, uncles)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Alcohol/drug problems | <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other serious illness _____ | | | |

19. What else should we know about your health or your family's health? _____

20. Is school a positive place for you? Yes No Why or why not? _____
21. How are your grades? A ___ B ___ C ___ D ___ F ___
22. Have you had testing for a learning disability or been in Special Ed? Yes No
23. How often are you absent from school? Often, # of days _____ Rarely
24. Do you have a job? Yes, where? _____ hours/week? _____ No
25. Have you ever been suspended from school? Yes, why? _____ No

26. How well do you like yourself? A lot Mostly Some Not much Not at all
27. Do you have a best friend or group of friends? Yes No
28. Who do you trust or talk to when things are not going well? _____
29. Are you concerned about how you get along with family, friends or other people? Yes No

30. Do you participate in cultural activities, groups, community activities, volunteer activities, religious/spiritual groups, sports or anything else? Yes, what? _____ No

31. List three words to describe your life right now _____

32. How safe do you feel, most of the time? Very safe Safe OK Unsafe In danger

33. Have you been involved in or witnessed any violence in the last year? Yes, where _____ No

34. Have you been diagnosed with depression or other mental illness? Yes No

35. Have you ever thought about or tried to hurt yourself? Yes No

36. Within the past year have you been hit, slapped, kicked or otherwise physically hurt by anyone? Yes No

37. Are you in a relationship with a person who bullies, threatens or physically/sexually hurts you? Yes No

38. Which of the following meals/snacks do you eat?

Breakfast Morning snack Lunch Afternoon snack Dinner Evening snack

39. Do you exercise?

Every day Often Sometimes Rarely Never

40. Who are you attracted to? Males Females Both Neither Unsure

41. Have you ever had sex? Yes, when _____ No

42. Who have you had sex with? Males Females Both

43. Have you ever wondered if you might be gay/lesbian/bisexual or trapped in the wrong body (transgender)? Yes No

44. Have you ever had sex when you didn't want to or been made to do things you didn't want to do? Yes No

45. Do you use condoms/dental dams? Always Usually Sometimes Almost Never Never

46. Do you use birth control? Yes, what _____ No

47. How many sexual partners have you had: in the last 3 months? _____ in the last year? _____ since you started? _____

48. Have you ever had a sexually transmitted disease/infection? Yes No

If yes, which one(s)? Chlamydia Gonorrhea Other (HIV, syphilis, herpes, warts, other _____)

Were you treated? Yes and I took all my medicine No Was your partner treated? Yes No

49. Have you ever been pregnant or gotten someone pregnant? Yes, what did you do? _____ No

50. Do have concerns about your genital area? Yes, what _____ No

51. Do you have testicle pain or swelling? Yes No I don't have testicles

FOR THOSE WHO MENSTRUATE

52. How old were you when you had your first period? _____ haven't had it yet

53. When was your last period? _____

54. Do you have a period every month? Yes No

55. Do you have bad menstrual cramps that interfere with school, work or activities? Yes No

56. Do you have heavy or long periods? Yes No

57. Which of the following have you **ever tried** or use regularly?

Alcohol PCP/Dust IV drugs Sniffing/Poppers/Amyl Nitrate
 Marijuana/Weed Crack/Coke Heroin Chewing tobacco or snuff
 Speed/Crank Acid/LSD Ice/Crystal meth Prescription drug use
 Cigarettes (how many per day? _____) Ecstasy Other highs _____
 Steroids Caffeine E-cig None

58. How old were you when you first tried or started to use? _____

59. Have you ever ridden in a car driven by someone (including yourself) who was drunk, or high or had been using alcohol or drugs? Yes No

60. Do you ever use alcohol or drugs to relax, feel better about yourself or fit in? Yes No

61. Do you ever use alcohol or drugs while you are by yourself? Yes No

62. Do you ever forget things you did while using alcohol or drugs? Yes No

63. Do your family or friends ever tell you that you should cut down on your drinking or drug use? Yes No

64. Have you gotten into trouble while you were using alcohol or drugs? Yes No

65. Do have friends who do not drink or use drugs? Yes No

66. When was the last time you drank or got high? _____