

14 Year

TEEN'S

Forms

Patient Name: _____



Bright Futures Previsit Questionnaire Older Child/Younger Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	<input type="checkbox"/> Teeth <input type="checkbox"/> Appearance or body image <input type="checkbox"/> How you feel about yourself <input type="checkbox"/> Healthy eating <input type="checkbox"/> Good ways to be active <input type="checkbox"/> How your body is changing <input type="checkbox"/> Your weight
School and Friends	<input type="checkbox"/> Your relationship with your family <input type="checkbox"/> Your friends <input type="checkbox"/> How you are doing in school <input type="checkbox"/> Girlfriend or boyfriend <input type="checkbox"/> Organizing your time to get things done
How You Are Feeling	<input type="checkbox"/> Dealing with stress <input type="checkbox"/> Keeping under control <input type="checkbox"/> Sexuality <input type="checkbox"/> Feeling sad <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Feeling irritable
Healthy Behavior Choices	<input type="checkbox"/> Smoking cigarettes <input type="checkbox"/> Drinking alcohol <input type="checkbox"/> Using drugs <input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted infections (STIs) <input type="checkbox"/> Decisions about sex and drugs
Violence and Injuries	<input type="checkbox"/> Car safety <input type="checkbox"/> Using a helmet or protective gear <input type="checkbox"/> Keeping yourself safe in a risky situation <input type="checkbox"/> Gun safety <input type="checkbox"/> Bullying or trouble with other kids <input type="checkbox"/> Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have you ever used marijuana or any other drug to get high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Have you ever been diagnosed with iron deficiency anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your period last more than 5 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- I feel like I have at least one friend or a group of friends with whom I am comfortable.
- I help others on my own or by working with a group in school, a faith-based organization, or the community.
- I am able to bounce back from life's disappointments.
- I have a sense of hopefulness and self-confidence.
- I have become more independent and made more of my own decisions as I have become older.
- I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Teen's Cell # _____



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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The CRAFFT Screening Interview

We're going to ask you to answer a few questions that we ask all our patients. Please be honest. We will keep your answers confidential.

Part A

During the PAST 12 MONTHS, did you: No Yes

1. Drink any alcohol (more than a few sips)?
(Do not count sips of alcohol taken during family or religious events.)

2. Smoke any marijuana or hashish?

3. Use anything else to get high?
("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

Did you answer "yes" to any questions in Part A?

No

Yes

Answer CAR question only, then

Answer all 6 CRAFFT questions

stop **Part B** 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?

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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Adapted from the Center for Adolescent Substance Abuse Research, CeASAR, Children's Hospital Boston (www.ceasar.org)