ADOLESCENT (11-12 year) QUESTIONNARIE FOR THE **PAST ONE YEAR** DATE _____ PCC# _____

Name _____The preadolescent is to complete this and **NOT** THE PARENT and some questions are either yes or no. If your preadolescent is unable to complete, return form to the front desk or nursing staff. This is confidential and please let your preadolescent complete this by themselves.

EATING/WEIGHT/BODY:

1. Any concerns about your body appearance (ht/wt)? _____
2. Do you spend a lot to time thinking about your weight? _____

SCHOOL

1. What School do you attend _____Grade_____
2. Is doing well in school important to you? _____
3. What are your grades like? _____and if poor why? _____
4. Are you attending school regularly? _____
5. What school activities/clubs do you participate in? _____
6. Have you ever been suspended or in ISS this school year and why? _____

HOME/ACTIVITIES

1. How are things at home? _____
2. Do you think your parent(s) or guardian usually listen to you? _____
3. Have you ever seen a violent act take place in your home? _____
4. Are you concerned about being hurt by a parent or anyone else in the home? _____
5. Any concerns with alcohol or drug abuse by people who live in your home? _____
6. Do you have a least one friend or adult that you feel you can talk to? _____
7. Any concerns of bullying or being a bully? _____
8. Do you have chores that you do in the home? _____
9. Do you participate in any community activities/church or volunteer? _____

WEAPONS/VIOLENCE/SAFETY

1. Is there a firearm (gun/rifle) in the home and are they locked up? _____
2. Have you ever carried a weapon to school to protect yourself? _____
3. Have you been in a fight this past year where you or someone else got hurt? _____
4. Do you use a seatbelt at ALL times when driving or as a passenger? _____
5. Do you use a helmet **if** you ride a bicycle, motorcycle, skate/hoverboard, ATV? _____
6. Did you know it is a law in GA to wear one and a fine if caught without? _____

DRUGS

1. Have you ever used marijuana/spice/Molly/or other illegal drugs? _____
2. Have you ever used inhalants to get high (glue, lighter fluid, paint, etc)? _____
3. Do any of your **BEST** friends use drugs of any sort? _____
4. Do you ever use drugs you can buy over the counter to get to sleep on a regular basis, get high, stay awake or stay calm? _____
5. Have you ever used steroids or creatin or “muscle milk” for sports? _____
6. Have you ever tried alcohol/beer/illegal drugs or overused prescriptions meds? _____

Chart #_____

RELATIONSHIPS FOR THE ADOLESCENT TO ANSWER BY THEMSELVES!

1. When you think of yourself as a person, do you think of yourself as a male, female, somewhere in between, or another gender? _____
2. Do you have any questions about relationships with a person of the same sex? _____
3. Do you know how to avoid getting HIV and other STI's? You do not have to have sexual intercourse to get an STI or HIV! _____

EMOTIONS/SPECIAL CIRCUMSTANCES

1. Have you done something fun in the past few weeks? _____
2. During the past few weeks have you felt VERY sad or down as though you have nothing to look forward to? _____
3. Have you ever seriously thought about killing yourself or made a plan? _____
4. In the past year have you run away from home? _____
5. In the past year have you stayed in a homeless shelter? _____
6. In the past year have you been in a detention center or jail? _____

FOR CLINICIAN USE ONLY

RISK TAKING BEHAVIORS DISCUSSED AND DOCUMENTED EITHER ABOVE AND/OR IN EMR AND REFERENCES AS REQUESTED GIVEN

SMOKING/CRAFTT/PHQ9 IN EMR