Adolescent Health Survey

Welcome to Park View Pediatrics.

We care about you and want to be your partner in a healthy and happy life. It is our promise to work with you to provide a safe place to receive information, support, and health care. The best way we can do this is by creating a partnership of communication and trust. You can tell us anything, ask us anything, and rely on us to give you honest answers and never judge you or any questions you have.

In Colorado, minors of any age, without their parent's knowledge, may get evaluated and treated for pregnancy, sexually transmitted diseases, family planning and contraception, and drug and alcohol use. Those 15 and over can also be treated for mental health problems. Providers cannot discuss or disclose any information about these confidential visits to parents or legal guardians without minors' express written consent. The only exception is if the minor's situation poses a substantial threat to the life or physical well-being of themselves or another person.

We at Park View Pediatrics honor these laws. We encourage patients to discuss these sensitive subjects in an open and forthright manner with their parents or guardians if at all possible. By working together, we can help you be the healthiest that you can be.

We appreciate your honesty in filling out this questionnaire.

NUTRITION

Calcium is important for bone health. How do you fit calcium into your diet? Cow's milk Other dairy products Nut milks Leafy Greens Supplements

How often do you eat restaurant or fast food? Please circle: 1-2 times/week 2-5 times/week daily

Do you eat breakfast before school?	Yes	No
Do you eat 5 servings of fruits and vegetables daily?	Yes	No
Are you happy with your weight and height?	Yes	No

SAFETY

Do you wear a helmet when you bike, scooter, skateboard, ski, etc.?	Yes	No
Do you wear a seatbelt?	Yes	No
Do you wear sunscreen?	Yes	No

Do you floss your teeth? Please circle: Daily Once a week Rarely Never

Have you travelled outside of our country in the past 5 years?	Yes	No
Have you visited jails, migrant farm workers, homeless shelter, people with HIV/AIDS or do you have contact with anyone known to have Tuberculosis?	Yes	No
Are there any guns in your home?	Yes	No

How many hours of screen time do you get a day (phone, computer games, etc.)?

Please circle: 0-1 1-2 2-4 4-6 hours More

Do you have a TV in your bedroom?	Yes	No
Does anyone in your house smoke?	Yes	No
Do you smoke cigarettes or use chewing tobacco?	Yes	No
Do you drink alcohol?	Yes	No
Do you use marijuana or other drugs to get high?	Yes	No
Have you ever ridden in a car with someone who was high or drunk?	Yes	No
Have alcohol or drugs caused problems for you or someone you know?	Yes	No
Are you now or have you ever been sexually active?	Yes	No
Have you ever been sexually involved when you didn't want to be?	Yes	No
Are you questioning if you might be gay/lesbian/bi/transgender?	Yes	No

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DEPRESSION SCREEN

How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed, irritable, or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling asleep, staying asleep, or sleeping too much?				
Poor appetite, weight loss, or overeating?				
Feeling tired or having little energy?				
Trouble concentrating on things like school work, reading, or watching TV?				
Moving or speaking so slowly that other people could have noticed? Or the opposite- being fidgety or restless that you were moving around a lot more than usual?				
Thought that you would be better off dead, or of hurting yourself in some way?				

In the **past year**, have you felt depressed or sad **most** days, even if you felt OK sometimes? Yes No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?
Not difficult at all Somewhat difficult Very difficult Extremely difficult
Has there been a time in the past month when you have had serious thought about ending your life? Yes No
Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

EXERCISE

What is your favorite way to stay active? _____

Any fainting, dizziness, or passing out with exercise?	Yes	No
Any chest pain, funny or skipped heart beats with exercise?	Yes	No
Any family members died of heart problem /sudden death before the age of 50?	Yes	No
Any shortness of breath, coughing, wheezing, or asthma with exercise?	Yes	No
Ever had any sport related injuries, fractures, sprains, or joint problems?	Yes	No
Ever had a head injury or concussion?	Yes	No

FAMILY AND COMMUNITY

Do you get along well with your parents/stepparents?	Yes	No
Do you feel you have friends you can count on?	Yes	No
Are you doing OK in school?	Yes	No
Do you have a job?	Yes	No