Early Adolescent Health Survey

Welcome to Park View Pediatrics. We want to be your partner is staying happy and healthy. We would appreciate you answering the following questions honestly and we will go over the answers during your visit.

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

Are there any guns in your home?	Yes	No

How many hours of screen time do you get a day (TV, 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

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

-Over-

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