



Adolescent Health Questionnaire (Ages 11)

Confidentiality Statement: This form is **confidential**. What you share here is private. We won't share this with your parents or guardians unless we believe you are in immediate danger to yourself or others.

Name: _____ Date of Birth: _____

Home and School

- School and Current Grade (or grade starting in fall): _____
- Activities: What do you like to do for fun? _____
- Who do you live with? _____
- Do you feel unsafe at home or in your neighborhood? ☐ Yes ☐ No
- Do you feel unsafe at school? ☐ Yes ☐ No
- Are you struggling with your schoolwork/grades this year? ☐ Yes ☐ No
- Do you worry about your family having enough food, housing, or electricity? ☐ Yes ☐ No

Nutrition and Body Image

- Are you unhappy with how your body looks or your weight? ☐ Yes ☐ No
- Have you ever skipped meals or tried to lose weight on purpose? ☐ Yes ☐ No
- Do you have questions about your gender identity or your body? ☐ Yes ☐ No

Safety and Social Media

- Do you ever ride in a vehicle without wearing your seat belt? ☐ Yes ☐ No
- Do you ever ride a bicycle, scooter, skateboard, ATV, etc. without a helmet? ☐ Yes ☐ No
- Do you feel like you spend too much time on your phone, screens, or social media? ☐ Yes ☐ No
- Have you viewed or come across inappropriate or 'grown-up' pictures or videos? ☐ Yes ☐ No

Have you ever tried or used:

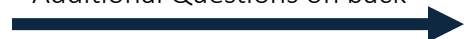
- Tobacco, vapes, or e-cigarettes? ☐ Yes ☐ No
- Alcohol? ☐ Yes ☐ No
- Marijuana (pot, weed, edibles) or anything else to get high? ☐ Yes ☐ No
- Have your friends done any of the above? ☐ Yes ☐ No
- Has a driver ever been drunk or high while you were in the car? ☐ Yes ☐ No

Relationship Safety

- Has anyone ever touched you in a way that felt wrong or uncomfortable? ☐ Yes ☐ No
- Have you been hurt, hit, bullied, or treated badly by someone? ☐ Yes ☐ No

Something I want to talk to my doctor about today is:

Additional Questions on back



Name: _____ Date of Birth: _____

PHQ-9

Not at all	Some days	More than half the days	Nearly every day	Over the last 2 weeks, how often have you been bothered by any of the following problems?
☐ 0	☐ 1	☐ 2	☐ 3	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're a failure or let yourself or you 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've been moving around more than usual.
☐ 0	☐ 1	☐ 2	☐ 3	9. Thought that you would be better off dead or of hurting yourself in some way

Total Score =

- Not difficult at all ☐
 Somewhat difficult ☐
 Very difficult ☐
 Extremely difficult ☐

If you checked off any problems, 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?

GAD-7

Not at all	Some days	More than half the days	Nearly every day	Over the last 2 weeks, how often have you been bothered by any of the following problems?
☐ 0	☐ 1	☐ 2	☐ 3	1. Feeling nervous, anxious or on edge
☐ 0	☐ 1	☐ 2	☐ 3	2. Not being able to stop or control worrying
☐ 0	☐ 1	☐ 2	☐ 3	3. Worrying too much about different things
☐ 0	☐ 1	☐ 2	☐ 3	4. Trouble relaxing
☐ 0	☐ 1	☐ 2	☐ 3	5. Being so restless that it is hard to sit still
☐ 0	☐ 1	☐ 2	☐ 3	6. Becoming easily annoyed or irritable
☐ 0	☐ 1	☐ 2	☐ 3	7. Feeling afraid as if something awful might happen

Total Score =

- Not difficult at all ☐
 Somewhat difficult ☐
 Very difficult ☐
 Extremely difficult ☐

If you checked off any problems, 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?