



Adolescent Health Questionnaire (Age 14 and older)

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: _____

Cell Phone Number: _____ Can we text/voicemail? ☐ Yes ☐ No

Home and School

- School and Current Grade (or grade starting in fall): _____
- Activities/Hobbies/Job: _____
- 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 tried to lose weight by skipping meals, excessive exercise, or pills? ☐ Yes ☐ No
- Do you have concerns about your eating, sleep, or exercise habits? ☐ Yes ☐ No
- Do you have questions about your gender identity or body? ☐ Yes ☐ No

Safety and Social Media

- Do you ever ride in a vehicle without wearing your seat belt? ☐ Yes ☐ No
- Do you ever look at your phone while you are driving? ☐ Yes ☐ No
- Do you feel you spend too much time on your phone, screens, or social media? ☐ Yes ☐ No
- Do you view pornographic content? ☐ Yes ☐ No
- Have you had a private photo shared without your consent? ☐ Yes ☐ No
- Have you saved private photos on your phone or computer? ☐ Yes ☐ No
- Have you been hurt, bullied, or treated badly by someone? ☐ Yes ☐ No

Have you ever tried or used:

- Tobacco, vapes, or e-cigarettes? ☐ Yes ☐ No
- Alcohol? ☐ Yes ☐ No
- Marijuana (pot, weed, edibles)? ☐ Yes ☐ No
- Anything else to get high (prescription or IV drugs)? ☐ 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

Sexual Health

- Have you ever had sexual intercourse (oral, vaginal, or anal)? ☐ Yes ☐ No
- Has someone ever touched you in a way that made you feel uncomfortable? ☐ Yes ☐ No
- Do you have questions about pregnancy or sexually transmitted infections? ☐ Yes ☐ No

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

Name: _____ Date of Birth: _____

GPA Form (GAD, PHQ,ASQ)

GAD-7

Not at all	Some days	More than half the days	Nearly every day	
☐ 0	☐ 1	☐ 2	☐ 3	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?

7.21

PHQ-9

Not at all	Some days	More than half the days	Nearly every day	
☐ 0	☐ 1	☐ 2	☐ 3	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?

ASQ

Yes	No	
☐	☐	In the past few weeks, have you wished you were dead?
☐	☐	In the past few weeks, have you felt that you or your family would be better off if you were dead?
☐	☐	In the past week, have you been having thoughts about killing yourself?
☐	☐	Have you ever tried to kill yourself?
		If yes, when was the most recent attempt? _____ ☐ Within last 12 months ☐ Over 1 year ago
If you answered YES to any of questions #1 through #4, answer the following question		
☐ YES	☐ NO	Are you having thoughts of killing yourself right now?
If yes, describe briefly:		