

Milestone Pediatrics Adolescent Questionnaire 14+

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Today's Date: _____

Your Name:(Pronoun)_____ DOB: _____

Your Age: _____ Your Sex (circle one): Male Female Choice Not Listed Prefer Not To Answer

Your Grade In School: _____

1.	Who do you live with?			
2.	Do you get along with your family?	No	Sometimes	Yes
3.	Are you having any problems in school or work? Circle all that apply: Grades worse than last year Fighting Homework Suspension in the last year Missing School or Work Other: _____	No	Sometimes	Yes
4.	Do you have any concerns or questions about the size or shape of your body or your physical appearance?	No	Sometimes	Yes
5.	In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	No	Sometimes	Yes

6.	Have you ever:				
	Drank alcohol	No	Sometimes	Yes	
	Taken things to get high, stay awake, calm down, or go to sleep	No	Sometimes	Yes	
	Used marijuana	No	Sometimes	Yes	
	Taken prescription drugs to get high	No	Sometimes	Yes	
	Used steroids	No	Sometimes	Yes	
	Used drugs (cocaine, crack, heroin, ecstasy, meth, inhalants, or pills)	No	Sometimes	Yes	
	Used tobacco products (chew, cigarettes, pipes, cigars)	No	Sometimes	Yes	
	Used vape pens, hookah pens, or electronic cigarettes?	No	Sometimes	Yes	
7.	Do you or your family or friends ever tell you that you should cut down on your drinking or drug use?	No	Sometimes	Yes	
8.	Have you ever felt bad or guilty about your drinking?	No	Sometimes	Yes	
9.	Have you ever ridden in a car driven by someone (including yourself) that was high or had been using alcohol or drugs?	No	Sometimes	Yes	
10.	Have you ever pierced your body (not including ears) or gotten a tattoo?	No		Yes	
11.	Who do you find yourself attracted to? Circle all that apply:	Males	Females	Both	Don't know
12.	Are you going out with anyone?	No		Yes	
13.	Have you ever had sex (including intercourse or oral sex)?	No		Yes	
14.	Are you using a method to prevent pregnancy? If so, please circle all that apply: Which method: Birth Control Pills Condoms Withdrawal	No		Yes	
15.	Have you ever been pregnant or gotten someone pregnant?	No		Yes	
16.	Do you think you or your partner could have a sexually transmitted infection?	No		Yes	

****Please complete both sides****

PHQ-9		Not at All 0	Several days 1	More than half the days 2	Nearly every day 3
1.	Feeling down, depressed, irritable, or hopeless?				
2.	Little interest or pleasure in doing things?				
3.	Trouble falling asleep, staying asleep, or sleeping too much? (If so, how many hours _____)?				
4.	Poor appetite, weight loss, or overeating?				
5.	Feeling tired, or having little energy?				
6.	Feeling bad about yourself?				
7.	Trouble concentrating on things like school work, reading, or watching TV?				
8.	Thoughts that you would be better off dead, or of hurting yourself in some way?				
9.	Moving or speaking so slowly that people could have noticed? Or the opposite being so fidgety or restless that you were moving around more than usual?				
FOR PROVIDER ONLY Total Score: _____ 0-4 5-9 10-14 15-19 20-27		Minimal or none Mild Moderate Moderately severe Severe			

Reviewed by Provider: _____ Date: _____

****Please complete both sides****