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**Well-Child Questionnaire for teens: age 13 - 17**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by Teen - *You don’t have to answer any questions you don’t want to.***

 This questionnaire will give your physician information to help you take better care of yourself.

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| Do you have any questions or concerns about your eating habits? |  |  |
| Do you have any concerns about your body or weight? |  |  |
| Do you ever eat in secret or feel guilty about eating? |  |  |
| **During the past year:**Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor products?Did you drink any alcohol?Did you smoke any marijuana or hashish?Did you use anything else to get high? (this includes illegal drugs, over the counter prescription drugs, and things you sniff or ‘huff’) |  |  |
|  |  |
|  |  |
|  |  |
| Do you ever text while driving or ride with someone who text and drives? |  |  |
| When driving or riding with someone do you ever NOT wear your seatbelt? |  |  |
| Do you have any issues getting along with your family? |  |  |
| Are you having a hard time at home?  |  |  |
| Are you feeling pressure to do what others are doing? |  |  |
| Do you need a better support system (friends or family who you can talk to)? |  |  |
| Are you being bullied at home or school? |  |  |
| Has anyone ever hit or touched you in a way that made you uncomfortable or afraid? |  |  |
| Have you ever had sex? If yes, are you using protection against STD’s and pregnancy?  |  |  |
|  |  |
| For females:Have your periods started? |  |  |

See next page

Patient Health Questionnaire (PHQ-9)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the *last 2 weeks*, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 |  |  |  |  |
| 1. Feeling down, depressed, or hopeless
 |  |  |  |  |
| 1. Trouble falling/staying asleep, sleeping to much
 |  |  |  |  |
| 1. Feeling tired or having little energy
 |  |  |  |  |
| 1. Poor appetite or overeating
 |  |  |  |  |
| 1. Feeling bad about yourself or that you are a failure or have let yourself or your family down
 |  |  |  |  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching tv
 |  |  |  |  |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.
 |  |  |  |  |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way
 |  |  |  |  |
| If you checked off any problem on this questionnaire so far, how difficult have these problems made if 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 |

Please give this completed form to your nurse. (Rev. 11-2018)