Woodinville Pediatrics 15-21 years Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Home
Eats meals with family ___yes ___no
Has family member/adult to turn to for help ___yes ___no
Is permitted and is able to make independent decisions ___yes ___no

Eating
5 servings of fruit/vegetable ___yes ___no
Limited sweetened liquids ___yes ___no
Vitamins/Supplements _____
Diet Concerns ___yes ___no
Diet comments _____

Has concerns about body or appearance ___yes ___no

Education
Grade _____
Performance Concerns ___yes ___no
Behavior/Attention concerns ___yes ___no
Homework concerns ___yes ___no

Activities
Has friends ___yes ___no
At least 1 hour of physical activity/day ___yes ___no
Screen time (except for homework) <2 hours/day ___yes ___no
Interests/participates in community activities/volunteers ___yes ___no
Activities _____

Drugs
Uses tobacco/alcohol/drugs ___yes ___no
Uses e-cigs ___yes ___no

Safety
Home is free of violence ___yes ___no
Uses safety belts/safety equipment ___yes ___no
Has peer relationships free of violence ___yes ___no

Sex
Has had oral sex ___yes ___no
Has had sexual intercourse (vaginal, anal) ___yes ___no

Suicidality/Mental Health

Over the last 2 weeks, how often has patient been bothered by any of the following problems?

1. Little interest or pleasure in doing things	__Not at all __Several days __ More than half the days __Nearly every day
2. Feeling down, depressed, or hopeless	__Not at all __Several days __More than half the days __Nearly every day

If you checked off any problem on this questionnaire so far, 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

Are you seeing a counselor/psychiatrist/psychologist? ___yes ___no
If yes, the counselor/psychiatrist/psychologist name: _____

Has ways to cope with stress ___yes ___no
Displays self-confidence ___yes ___no
Has problems with sleep ___yes ___no
Gets depressed, anxious, or irritable/has mood swings ___yes ___no
Has thought about hurting self of considered suicide ___yes ___no

Additional comments: _____

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