hutchinson CLINIC
Setting a gold standard

Well-Care Questionnaire – Page 1 of 2
for teens aged 13-17

WORKSHEET TO BE COMPLETED BY TEEN – this worksheet can give your health care team information to help you take better care of yourself. Your answers will be kept confidential.

Name	Chart#	D.O.B.	Date

Confidential Phone #: Is it ok to leave a message? ☐ Yes ☐ **No**

What is your **MAIN** reason for today's visit? ☐ Physical ☐ Sport's exam ☐Camp exam
☐ Other concern (please list):

Who are the people who live with you (names, ages, relationship)

Are you in school? ☐ Yes ☐ **No** If yes – what grade are you in? _____ Which school? _____
Are you having a hard time in school? ☐ No ☐ **Yes**
In a typical month, how often do you:
MISS a class or day of school (# of days)?_____ **SKIP** a class or day of school? _____

What activities or sports do you enjoy? _____
Do you have a job outside of school? ☐ **Yes** ☐ No
If YES, what: _____
In this job, do you work more than 20 hours per week? ☐ No ☐ **Yes**

MEDICATIONS – what medicine are you taking, including prescription, herbal, and over-the-counter?

MEDICAL HISTORY: check box if you have, or ever had, any of the following:

☐ Asthma	☐ Diabetes	☐ Mental health problem
☐ Allergies	☐ Heart problems	☐ Seizure / epilepsy
☐ Depression/Anxiety	☐ Learning disability / ADD	☐ Sexually transmitted disease (STD)

List other major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):

FAMILY HISTORY ☐ check here if you know you were adopted

☐ Alcohol/Drug problem _____
☐ Asthma/Allergies _____
☐ Cancer _____
☐ Depression/Suicide _____
☐ Diabetes _____
☐ Other illnesses/conditions

SPORTS – have you ever:		
Passed out while exercising?	☐ **Yes**	☐ No
Gotten dizzy or had headaches while exercising?	☐ **Yes**	☐ No
Been knocked out?	☐ **Yes**	☐ No
Had a significant joint or bone problem?	☐ **Yes**	☐ No
Had a serious injury?	☐ **Yes**	☐ No
Can you run twice around a ¼ mile track without stopping?	☐ Yes	☐ **No**
Do you have a family member with heart disease?	☐ **Yes**	☐ No
Do you have a family member who died suddenly before age 50?	☐ **Yes**	☐ No

NUTRITION		
Do you eat fruits and vegetables every day?	☐ Yes	☐ **No**
Do you eat or drink dairy products?	☐ Yes	☐ **No**

Are you a vegetarian?	☐ **Yes** ☐ No	
Do you have any questions or concerns about your eating habits?	☐ **Yes** ☐ No	
SAFETY		
If you ride motorcycle/bike/ATV, do you always wear a helmet?	☐ Yes ☐ **No**	
Do you always wear seatbelt when in car or truck?	☐ Yes ☐ **No**	
Do you text while driving? ☐ I don't drive	☐ **Yes** ☐ **No**	
Do you ever drive, or ride with a driver, under influence of alcohol or drugs?	☐ **Yes** ☐ No	
Has anyone ever touched you in a way that made you uncomfortable or afraid?	☐ **Yes** ☐ No	
FAMILY and PEERS		
Do you get along with your family?	☐ Yes ☐ **No**	
Are you having a hard time at home?	☐ **Yes** ☐ No	
Do you have a friend you can talk to about problems you have?	☐ Yes ☐ **No**	
Are you having a hard time with friends - including boyfriend/girlfriend?	☐ **Yes** ☐ No	
Are you having trouble with fighting or bullying?	☐ **Yes** ☐ No	
Are you feeling pressure to do what others are doing?	☐ **Yes** ☐ No	
STRESS and DEPRESSION		
During the past 2 years, have you or anyone in your family had any major good or bad changes?	☐ **Yes** ☐ No	
Do you have any concerns about your body or weight?	☐ **Yes** ☐ No	
Do you ever eat in secret or feel guilty about eating?	☐ **Yes** ☐ No	
Do you ever make yourself throw up?	☐ **Yes** ☐ No	
Have you recently lost interest or pleasure in doing things?	☐ **Yes** ☐ No	PHQ-9 Adolescents for YES
Have you been feeling down, depressed, irritable, or hopeless?	☐ **Yes** ☐ No	
Tobacco, Nicotine & Vapor		
Have you ever used tobacco (smoke, chew, e-cigs) or other vapor product?	☐ **Yes** ☐ No	
Alcohol, Marijuana, and Other Drugs – during the past 12 months:		
Do you drink alcohol (more than a few sips) – not counting sips taken during family or religious events?	☐ **Yes** ☐ No	
Do you smoke marijuana or hashish?	☐ **Yes** ☐ No	
Do you do anything else to get high (this includes illegal drugs, over the counter and prescription drugs, and things you sniff or huff)	☐ **Yes** ☐ No	
SEXUALITY		
Are you attracted to: ☐ Males ☐ Females ☐ Both ☐ Unsure		
Have you ever had sex: ☐ **Yes** ☐ No		
If YES, are, or were, your sexual partners: ☐ Males ☐ Females ☐ Both		
When you have sex, how often do you use a condom? ☐ Always ☐ Sometimes ☐ Never		
When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom? ☐ Always ☐ Sometimes ☐ Never		
If you use or your partner uses protection, what kind do you or your partner use?		
Have you ever been pregnant or made someone else pregnant? ☐ **Yes** ☐ No		
For Females		
Have your periods started?	☐ **Yes** ☐ No	
If YES, how old were you when they started? _____	Are they regular? ☐ Yes ☐ **No**	
Do menstrual cramps keep you from doing your normal activities?	☐ **Yes** ☐ No	

Person Completing Form: _____

Signature: _____ Date: _____