

CONFIDENTIAL HEALTH PROFILE - YOUNG ADOLESCENTS

Name: _____ Date: _____

Age: _____ Sex: M F Name of school & grade: _____

Do you have any concerns, questions, or problems that you would like to discuss today?		
What changes or challenges have there been at home since last year?		
Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	NO	YES
Do you have any concerns or questions about the size or shape of your body, or physical appearance?	YES	NO
In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	YES	NO
Are you going to school?	NO	YES
Are you in any special classes in school (for example, advanced placement classes, honor classes, resource room, special education classes)?	YES	NO
Are you having any problems in school? <i>Circle all that apply:</i> grades worse than last year failing class homework suspended from school during past year fighting missing school	YES	NO
Do you always wear a seat belt when riding in a car, truck, or van?	NO	YES
Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	NO	YES
Do you have a person you can call for a ride if you're feeling unsafe with someone?	NO	YES
Have you ever been in trouble with the law?	YES	NO
Do you worry a lot or feel overly stressed out?	YES	NO
When you are angry, do you do violent things?	YES	NO
Do you have trouble sleeping?	YES	NO
During the past few weeks have you felt sad or down, felt irritable, or felt as though you had nothing to look forward to?	YES	NO
Have you ever felt that life was not worth living?	YES	NO
Have you ever had sex (including intercourse or oral sex)?	YES	NO
Have you ever drank beer, wine, or other alcoholic beverages?	YES	NO
Have you ever used marijuana?	YES	NO
Have you ever used any drugs other than marijuana?	YES	NO
Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? <i>(These drugs can be bought at a store without a prescription.)</i>	YES	NO
FOR FEMALES ONLY		
Have you gotten your period?	YES	NO
If yes, are you having any problems with or do you have any questions about your period?	YES	NO

(Continued on the back of this page)

I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Please list below all the people that live with you.

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptoms put an “X” in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
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?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thought that you would be better off dead, or of hurting yourself in some way?				

10. In the <i>past year</i> have you felt depressed or sad most days, even if you felt okay sometimes? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. If you are experiencing any of the problems on this form, 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? <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you <i>ever</i> , in your <i>whole life</i> , tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of health care provider

Date

(This form was adapted from Bright Futures & includes the PHQ-9 Modified for Teens)