

Health Information Update (15 Years Old)

INTAKE

How many ounces of milk do you drink/day? _____ Ounces What kind? _____

How many meals per day do you eat? _____ How many snacks per day? _____

How many servings/**DAY** do you have of: _____ Fruits _____ Veggies _____ Whole Grains

How many servings/**DAY** do you have of: _____ Cheese/yogurt

How many servings/**WEEK** do you have of: _____ Meat _____ Beans _____ Nuts _____ Eggs _____ Fish

How many ounces/**DAY** do you have of: _____ Juice _____ Pop

How often do you eat sweets? 15 or more x/wk 8-14x/wk <8x/wk

OUTPUT

How many stools do you have per week? _____ What is the consistency? _____

Do you see any blood in the stool? Yes No

SLEEP

Is there a TV or computer in your room? Yes No

Do you watch TV or play on a computer or smartphone before or at bedtime? Yes No

Do you read at night? Yes No

Weekday : Bedtime _____ pm Wake time _____ am

Weekend: Bedtime _____ pm Wake time _____ am

Any sleep problems? Yes No Explain: _____

SAFETY

Do you use a seat belt? Yes No

Wear a helmet? Yes No

SCHOOL

Who are you with at home after school? Mom Dad Family member Self

Name of school: _____ What grade? _____

How are grades? _____ Concerns: _____

What do you want to be when you grow up? _____

BEHAVIOR/DEVELOPMENT

Describe your temperament (happy, irritable, stressed, moody, calm, etc.) _____

What happens when you get in trouble? _____

OTHER

How many hours of screen time do you watch/day? School day _____ hrs Non-school day _____ hrs

How many minutes/ day do you get of physical activity? 0-15min 15-30 min 30-60 min

What activities/hobbies do you participate in? _____

How many times per day do you brush your teeth? _____ Flosses? _____ per week

When was your last visit to the dentist? _____ Any cavities? Yes No

List any medications or vitamins/supplements you take: _____

Do you need any medication refills? _____

Concerns? _____

Pediatric Symptom Checklist – Parent

Please mark under the heading that best fits your child:

Never Sometimes Often

- | | | | |
|--|-------|-------|-------|
| 1. Fidgety, unable to sit still..... | _____ | _____ | _____ |
| 2. Feels sad, unhappy..... | _____ | _____ | _____ |
| 3. Daydreams too much..... | _____ | _____ | _____ |
| 4. Refuses to share..... | _____ | _____ | _____ |
| 5. Does not understand others people's feelings..... | _____ | _____ | _____ |
| 6. Feels hopeless..... | _____ | _____ | _____ |
| 7. Has trouble concentrating..... | _____ | _____ | _____ |
| 8. Fights with other children..... | _____ | _____ | _____ |
| 9. Is down on him or herself..... | _____ | _____ | _____ |
| 10. Blames others for his or her troubles..... | _____ | _____ | _____ |
| 11. Seems to have less fun..... | _____ | _____ | _____ |
| 12. Does not listen to rules..... | _____ | _____ | _____ |
| 13. Acts as if driven by a motor..... | _____ | _____ | _____ |
| 14. Teases others..... | _____ | _____ | _____ |
| 15. Worries a lot..... | _____ | _____ | _____ |
| 16. Takes things that do not belong to him or her..... | _____ | _____ | _____ |
| 17. Distracted easily..... | _____ | _____ | _____ |

Pediatric Symptom Checklist – Youth

Please mark under the heading that best fits you:

Never Sometimes Often

- | | | | |
|--|-------|-------|-------|
| 1. Fidgety, unable to sit still..... | _____ | _____ | _____ |
| 2. Feels sad, unhappy..... | _____ | _____ | _____ |
| 3. Daydreams too much..... | _____ | _____ | _____ |
| 4. Refuses to share..... | _____ | _____ | _____ |
| 5. Does not understand others people's feelings..... | _____ | _____ | _____ |
| 6. Feels hopeless..... | _____ | _____ | _____ |
| 7. Has trouble concentrating..... | _____ | _____ | _____ |
| 8. Fights with other children..... | _____ | _____ | _____ |
| 9. Is down on him or herself..... | _____ | _____ | _____ |
| 10. Blames others for his or her troubles..... | _____ | _____ | _____ |
| 11. Seems to have less fun..... | _____ | _____ | _____ |
| 12. Does not listen to rules..... | _____ | _____ | _____ |
| 13. Acts as if driven by a motor..... | _____ | _____ | _____ |
| 14. Teases others..... | _____ | _____ | _____ |
| 15. Worries a lot..... | _____ | _____ | _____ |
| 16. Takes things that do not belong to him or her..... | _____ | _____ | _____ |
| 17. Distracted easily..... | _____ | _____ | _____ |

Adolescent Questionnaire – YOUTH

*(For adolescent to complete)

Please answer ALL the questions below.

- | | | | |
|--|-----|-----------|----|
| 1. In, general, are you happy with the way things are going for you? | Yes | Sometimes | No |
| 2. Do you get along with your family? | Yes | Sometimes | No |
| 3. Do you go to school regularly? | Yes | Sometimes | No |
| 4. Do you have at least one adult you can really talk to? | Yes | Sometimes | No |
| 5. Do you feel you are about the right weight for your height? | Yes | Sometimes | No |
| 6. Have you ever tried to lose weight by taking diet pills or laxatives, making yourself vomit (throw up) after eating or starving yourself? | Yes | Sometimes | No |
| 7. Do you smoke cigarettes or chew tobacco? | Yes | Sometimes | No |
| 8. Do you drink alcohol? | Yes | Sometimes | No |
| 9. Have you ever driven a car drunk, high or while texting or ridden in a car with a driver who was? | Yes | Sometimes | No |
| 10. Have you tried any drugs (pot, crack, cocaine, heroin, speed, acid)? | Yes | Sometimes | No |
| 11. Have you ever used someone else's prescription (from a doctor or other health care provider) or non-prescription (from a store) drugs to sleep, stay awake, calm down or get high? | Yes | Sometimes | No |
| 12. Do you – or does anyone you live with – have a gun or carry a gun? | Yes | Sometimes | No |
| 13. Are you – or have you been - in a gang? | Yes | Sometimes | No |
| 14. Are you worried about money, a place to live, or having enough food to eat? | Yes | Sometimes | No |
| 15. Have you ever had any type of sex (vaginal, anal or oral sex)? | Yes | Sometimes | No |
| 16. Have you ever been attracted to the same sex (girl to girl/guy to guy) or do you feel that you are gay, lesbian or bisexual? | Yes | Sometimes | No |
| 17. Have you ever been tested for or diagnosed with a sexually transmitted disease (herpes, gonorrhea, chlamydia, genital warts, etc.)? | Yes | Sometimes | No |
| 18. Do you often feel very sad or down as though you had nothing to look forward to? | Yes | Sometimes | No |
| 19. Do you have serious problems or worries at home or school? | Yes | Sometimes | No |
| 20. Have you ever had thoughts about killing yourself? | Yes | Sometimes | No |
| 21. Do you feel afraid in any of your relationships? | Yes | Sometimes | No |
| 22. Have you been threatened, teased or hurt by someone (on the web, by text, or in person) or has anyone make you feel sad, unsafe, or afraid? | Yes | Sometimes | No |
| 23. Have you ever been physically or sexually abused or mistreated by anyone (kicked, hit, pushed, forced or tricked into having sex, touched on you private parts)? | Yes | Sometimes | No |

Menses Questionnaire

***(For females to complete if they have started menstruation)**

When did you start your period for the 1st time? _____ years/old

When was your last period? _____

How often do you get your period? Every _____ days

How many days does your period last? _____ days

How is the flow? (Heavy, moderate, light) _____

Do you get cramps? ___ Always ___ Sometimes ___ Never

Are your cramps severe? ___ Yes ___ No

What do you do to help your cramps? (Take medicine, heating pad, etc.)

What do you use? ___ Tampons ___ Pads ___ Both

Do you know what Toxic Shock Syndrome is and its cause? ___ Yes ___ No