

LAMPREY HEALTH CARE

Adolescent Questionnaire

Teenagers often face big choices and make difficult decisions. We would like to know about your issues so that we can better help you. This questionnaire is **confidential**.

We will not discuss your answers with anyone without your permission (unless someone's life is in danger).

FAMILY

- | | | |
|--|-----|----|
| 1. Would you like to have a better relationship with your parents, brothers and/or sisters? | Yes | No |
| 2. Do you think that your parents/guardian usually listen to you & take your feelings seriously? | Yes | No |
| 3. In your opinion, is there a lot of tension or conflict in your home? | Yes | No |

SCHOOL/PEERS

- | | | |
|---|-----|----|
| 4. Do you have at least one friend who you really like and can talk to? | Yes | No |
| 5. Are you currently enrolled in school? | Yes | No |
| 6. Are your grades this year worse than last year? | Yes | No |
| 7. Have you ever been suspended from or dropped out of school? | Yes | No |

SELF ESTEEM

- | | | |
|--|-----|----|
| 8. Have you had fun during the past 2 weeks? | Yes | No |
| 9. In general, are you happy with the way things are going for you right now? | Yes | No |
| 10. Do you ever feel "down in the dumps" or as if you have nothing to look forward to? | Yes | No |
| 11. Do you have activities that you enjoy or that you are good at outside of school? | Yes | No |
| 12. Have you ever thought about killing yourself, or have you actually tried to kill yourself? | Yes | No |

BODY IMAGE

- | | | |
|--|-----|----|
| 13. Do you have any concerns or questions about the size or shape of your body or your appearance? | Yes | No |
| 14. Have you ever tried to lose weight or control your weight by vomiting, taking diet pills or starving yourself? | Yes | No |
| 15. Do you ever eat in secret? | Yes | No |

WEAPONS

- | | | |
|--|-----|----|
| 16. Do you or anyone you live with have a gun, rifle or other firearm? | Yes | No |
| 17. Have you ever carried a gun, knife or other weapon? | Yes | No |

VIOLENCE

- | | | |
|--|-----|----|
| 18. Have you been in a physical fight during the psat 3 months? | Yes | No |
| 19. Are guns or violence a problem in your school or neighborhood? | Yes | No |

SAFETY

- | | | |
|---|-----|----|
| 20. Are you concerned about physically hurt by a parent or anyone in your home? | Yes | No |
| 21. Do you have any questions or concerns about being physically, sexually or emotionally abused? | Yes | No |
| 22. Have you ever been physically hurt in any way by a person you have gone out with? | Yes | No |

TOBACCO

- | | | |
|--|-----|----|
| 23. Do you ever smoke cigarettes or use chewing tobacco (snuff or chew)? | Yes | No |
|--|-----|----|

ALCOHOL

- | | | |
|--|--------------------------------------|----|
| 24. Do you drink beer, wine, wine coolers or hard alcohol? | Yes | No |
| 25. Do any of your friends drink beer, wine, wine coolers or hard alcohol? | Yes | No |
| 26. Have you ever used alcohol AND then done any of the following: | Yes | No |
| Driven in a car/truck/motorcycle? | Gone swimming or boating? | |
| Gotten into a fight? | Used tools or other Power Equipment? | |
| Done something you have regretted later? | | |

TURN OVER AND COMPLETE OTHER SIDE

ALCOHOL, continued

- 27. Have you ever been criticized or gotten into trouble because of drinking? Yes No
- 28. Have you ever ridden in a car driven by someone who had been drinking? Yes No

DRUGS

- 29. Do you ever use marijuana, cocaine, acid, other drugs, inhalants or steroids? Yes No
- 30. Do any of your friends use marijuana, cocaine, acid, other drugs, inhalants or steroids? Yes No
- 31. Some drugs & herbs can be bought at a store without a prescription – do you ever use non-prescription drugs/herbs to get to sleep, stay awake, calm down or get high? Yes No
- 32. Have you ever used your prescription drugs, or a family member's/friend's prescription drugs to get to sleep, stay awake, calm down or get high? Yes No

SAFE SEX & STDs/FAMILY PLANNING

- 33. Have you ever had sexual intercourse Yes No
- 34. If so, did you or your partner use a condom (rubber) the last time? Yes No
- 35. Do you feel pressured to have sex? Yes No
- 36. Do you know how to avoid getting HIV/AIDS/STDs? Yes No
- 37. Have you ever had an STD such as genital herpes, gonorrhea (drip), trichomonas (trick), hepatitis, genital warts, HIV or any other STD not mentioned? Yes No

PLEASE COMPLETE THIS SENTENCE BY CHOOSING FROM THE OPTIONS OR FILLING IN YOUR OWN STATEMENT:

In 5 years, I hope to:

- a. be working at a local job
- b. have finished high school
- c. be married
- d. be moved out and on my own
- e. go to college
- f. have a baby
- g. other: _____

What do you like most about yourself? _____

What do you do best? _____

If you could, what would you change about yourself or your life? _____

For Staff Use Only

For all patients seeking information or services related to SAFE SEX/FAMILY PLANNING/STD/HIV:

- Parental Involvement Encouraged Education on STD/HIV prevention Education on ECP
- Education on all methods of contraception, including ABSTINENCE