# Staying Healthy Assessment
## 12 – 17 Years

<table>
<thead>
<tr>
<th>Name (first &amp; last)</th>
<th>Date of Birth</th>
<th>Female ☐</th>
<th>Male ☐</th>
<th>Today's Date</th>
<th>Grade in School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Completing Form</td>
<td>☐ Parent</td>
<td>☐ Relative</td>
<td>☐ Friend</td>
<td>☐ Guardian</td>
<td>☐ Other (Specify)</td>
</tr>
</tbody>
</table>

**Please answer all the questions on this form as best you can. Circle “Skip” if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.**

1. **Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?**
   - Yes ☐
   - No ☐
   - Skip ☐

2. **Do you eat fruits and vegetables at least 2 times per day?**
   - Yes ☐
   - No ☐
   - Skip ☐

3. **Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?**
   - No ☐
   - Yes ☐
   - Skip ☐

4. **Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?**
   - No ☐
   - Yes ☐
   - Skip ☐

5. **Do you exercise or play sports most days of the week?**
   - Yes ☐
   - No ☐
   - Skip ☐

6. **Are you concerned about your weight?**
   - No ☐
   - Yes ☐
   - Skip ☐

7. **Do you watch TV or play video games less than 2 hours per day?**
   - Yes ☐
   - No ☐
   - Skip ☐

8. **Does your home have a working smoke detector?**
   - Yes ☐
   - No ☐
   - Skip ☐

9. **Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?**
   - Yes ☐
   - No ☐
   - Skip ☐

10. **Do you always wear a seatbelt when riding in a car?**
    - Yes ☐
    - No ☐
    - Skip ☐

11. **Do you spend time in a home where a gun is kept?**
    - No ☐
    - Yes ☐
    - Skip ☐

12. **Do you spend time with anyone who carries a gun, knife, or other weapon?**
    - No ☐
    - Yes ☐
    - Skip ☐

13. **Do you always wear a helmet when riding a bike, skateboard, or scooter?**
    - Yes ☐
    - No ☐
    - Skip ☐

14. **Have you ever witnessed abuse or violence?**
    - No ☐
    - Yes ☐
    - Skip ☐

15. **Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?**
    - No ☐
    - Yes ☐
    - Skip ☐

16. **Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?**
    - No ☐
    - Yes ☐
    - Skip ☐

17. **Do you brush and floss your teeth daily?**
    - Yes ☐
    - No ☐
    - Skip ☐

18. **Do you often feel sad, down, or hopeless?**
    - No ☐
    - Yes ☐
    - Skip ☐

19. **Do you spend time with anyone who smokes?**
    - No ☐
    - Yes ☐
    - Skip ☐

20. **Do you smoke cigarettes or chew tobacco?**
    - No ☐
    - Yes ☐
    - Skip ☐

21. **Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?**
    - No ☐
    - Yes ☐
    - Skip ☐
<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 Do you use medicines not prescribed for you?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>23 Do you drink alcohol once a week or more?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>24 If you drink alcohol, do you drink enough to get drunk or pass out?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>25 Do you have friends or family members who have a problem with drugs or alcohol?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>26 Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td><strong>Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.</strong></td>
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<tr>
<td>27 Have you ever been forced or pressured to have sex?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>28 Have you ever had sex (oral, vaginal, or anal)? <em>If no, skip to question 35.</em></td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>29 Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>30 Have you or your partner(s) had sex with other people in the past year?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>31 Have you or your partner(s) had sex without using birth control in the past year?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>32 The last time you had sex, did you use birth control?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
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<tr>
<td>33 Have you or your partner(s) had sex without a condom in the past year?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>34 Did you or your partner use a condom the last time you had sex?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
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<tr>
<td>35 Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<tr>
<td>36 Do you have any other questions or concerns about your health?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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*If yes, please describe:*

### Clinic Use Only

<table>
<thead>
<tr>
<th>Topic</th>
<th>Counseled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Nutrition</td>
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<td>Physical activity</td>
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<td>Safety</td>
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<td>Dental Health</td>
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<tr>
<td>Alcohol, Tobacco, Drug Use</td>
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<tr>
<td>Sexual Issues</td>
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**Patient Declined the SHA**

### SHA ANNUAL REVIEW

<table>
<thead>
<tr>
<th>PCP's Signature</th>
<th>Print Name</th>
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