# Staying Healthy Assessment

## 12 – 17 Years

<table>
<thead>
<tr>
<th>Name (first &amp; last)</th>
<th>Date of Birth</th>
<th>☐ Female ☐ Male</th>
<th>Today's Date</th>
<th>Grade in School:</th>
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</thead>
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**Person Completing Form**
- ☐ Parent
- ☐ Relative
- ☐ Friend
- ☐ Guardian
- ☐ Other (Specify)
- School Attendance Regular?
- ☐ Yes ☐ No

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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.

### Nutrition

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

### Physical Activity

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

### Safety

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

### Mental Health

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
Do you use medicines not prescribed for you?  
No  Yes  Skip

Do you drink alcohol once a week or more?  
No  Yes  Skip

If you drink alcohol, do you drink enough to get drunk or pass out?  
No  Yes  Skip

Do you have friends or family members who have a problem with drugs or alcohol?  
No  Yes  Skip

Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?  
No  Yes  Skip

Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.

Have you ever been forced or pressured to have sex?  
No  Yes  Skip

Have you ever had sex (oral, vaginal, or anal)?  If no, skip to question 35.  
No  Yes  Skip

Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?  
No  Yes  Skip

Have you or your partner(s) had sex with other people in the past year?  
No  Yes  Skip

Have you or your partner(s) had sex without using birth control in the past year?  
No  Yes  Skip

The last time you had sex, did you use birth control?  
Yes  No  Skip

Have you or your partner(s) had sex without a condom in the past year?  
No  Yes  Skip

Did you or your partner use a condom the last time you had sex?  
Yes  No  Skip

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)?  
No  Yes  Skip

Do you have any other questions or concerns about your health?  
No  Yes  Skip

If yes, please describe:

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<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counseled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
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<tbody>
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<td>Nutrition</td>
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<td>Alcohol, Tobacco, Drug Use</td>
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<td>Sexual Issues</td>
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Patient Declined the SHA

PCP’s Signature:  
Print Name:  
Date:

SHA ANNUAL REVIEW

PCP’s Signature:  
Print Name:  
Date:

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