

# Teen Screen

Do Not Copy from Medical Record

place sticker

Health Ed.  
Given?

Want  
More  
Info?

- |                          |   |                              |                                    |                             |                          |
|--------------------------|---|------------------------------|------------------------------------|-----------------------------|--------------------------|
| <input type="checkbox"/> | 1. In general, are you happy with the way things are going for you?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 2. Do you get along with your family?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 3. Do you go to school regularly?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 4. Have your grades gotten worse than they used to be?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 5. Do you have at least one adult you can really talk to?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 6. Do you get some exercise at least 3 times a week?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 7. Do you feel you are about the right weight for your height?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 8. Do you ever use laxatives or throw up on purpose after eating?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 9. Do you wear a seat belt in a car/truck?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 10. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile, or use an ATV?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 11. Do you smoke cigarettes or chew tobacco?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 12. Do you drink alcohol?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 13. Have you tried any drugs (pot, crack, cocaine, heroin, acid, speed, etc.?)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No        |                             | <input type="checkbox"/> |
| <input type="checkbox"/> | 14. Do you – or does anyone you live with – have a gun or carry a gun around?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 15. Are you – or have you been – in a gang?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No        |                             | <input type="checkbox"/> |
| <input type="checkbox"/> | 16. Are you worried about money, a place to live, or having enough food to eat?   | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 17. Have you ever had sex (with women, men or both)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No        |                             | <input type="checkbox"/> |
| <input type="checkbox"/> | 18. Have you ever been tested for or diagnosed with a sexually transmitted disease (VD)? (herpes, gonorrhea, Chlamydia, genital warts, PID, syphilis) | <input type="checkbox"/> Yes | <input type="checkbox"/> No        |                             | <input type="checkbox"/> |
| <input type="checkbox"/> | 19. Are you – or do you ever wonder if you are – gay, lesbian, bisexual, or transgender?  | <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes | <input type="checkbox"/> No | <input type="checkbox"/> |

**Please re-read the italicized paragraph on the reverse side before answering the following questions.**

- |                          |   |                              |                             |                          |
|--------------------------|---|------------------------------|-----------------------------|--------------------------|
| <input type="checkbox"/> | 20. Have you ever had thoughts about killing yourself?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 21. Do you feel afraid in any of your relationships?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| <input type="checkbox"/> | 22. Have you ever been physically or sexually abused or mistreated by anyone (kicked, hit, pushed, forced or tricked into having sex, touched on your private parts)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |

**Provider:**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Confidentiality addressed?             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parent present when screen filled out? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parent present during exam?            |

Provider Signature: \_\_\_\_\_

In order to help you the best we can, we would like you to answer the questions on the reverse side. We ask all teenagers these questions because we feel they are things that affect your health and well-being. All of the questions may not fit you. You may leave those that do not apply blank. Please answer the questions alone, away from your parents or friends, so you can be as honest as possible.

*Your answers are a confidential/private part of your medical record. However, for your safety, we are required by law to share information involving physical/sexual abuse and suicide. Every situation is individual and our staff will always talk with you before sharing any of this information.*

*ANSWER QUESTIONS ON REVERSE SIDE*

|             |  |  |
|-------------|--|--|
| <b>Date</b> |  | <b>Teen Screen</b><br><br><b>Do Not Copy from<br/>Medical Record</b> |
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