

Teen Screen – 10 questions

Please Read Me!

We want to help you be healthy. Please answer these questions. We ask all teenagers these questions. Your answers are private and confidential. Your doctor will explain what this means. If you are worried about who will see your answers, please talk to us.

Ten Question Teen Screen

Clinic Name _____ Name: _____
Birthdate: _____

Adolescent Health Screen

	Yes	No
1. Do you wear a seat belt all the time?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been immunized for Hepatitis B and cervical cancer?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you drink alcohol (beer, wine, or hard alcohol)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you tried drugs (marijuana, speed, cocaine/crack, or acid)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had sex (intercourse, “done it”)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had an infection from sex (STD or VD)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever thought of suicide?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has anyone ever hurt you physically or sexually?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you having problems getting along with your family?	<input type="checkbox"/>	<input type="checkbox"/>

Signature

For Physician Use Only

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Do Not Copy From Chart

List all concerns identified and/or dealt with.

Date	