Adolescent and Young Adult Health Questionnaire (11-20 Years)

Your name/What you like to be called: _____ Your gender: _____

What four words best describe you? _____

What do you want to get out of today's visit? _____

We ask every patient these questions about things that can affect your health and well-being. Some of the questions might not fit you. It is okay to leave some questions blank. Please answer these questions on your own, without help from your parent or friends, and be as honest as possible. Your answers are private.	**PLEASE CIRCLE YOUR ANWER**	**WANT MORE INFO?**
1. In general, are you happy with the way things are going for you?	Yes Sometimes No	☐
2. Do you wear a seat belt in a car/truck?	Yes Sometimes No	☐
3. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile or ATV?	Yes Sometimes No	☐
4. Do you get along with your family?	Yes Sometimes No	☐
5. Do you have at least one adult you can really talk to?	Yes Sometimes No	☐
6. Do you feel safe at home, at school and in your community?	Yes Sometimes No	☐
7. Do you get 60 minutes of physical activity most days of the week?	Yes Sometimes No	☐
8. Do you think you are about the right weight and height?	Yes Sometimes No	☐
9. Do you ever skip meals, use laxatives or diet pills, or throw up on purpose to lose weight or to control your weight?	Yes Sometimes No	☐
10. Have you missed more than 7 days of school in the last year?	Yes Sometimes No	☐
11. Are your grades worse than they used to be?	Yes Sometimes No	☐
12. Do you or anyone you live with have a gun or carry around a gun?	Yes Sometimes No	☐
13. Do you worry about money, a place to live, food or clothing?	Yes Sometimes No	☐
14. Have you ever run away from home?	Yes Sometimes No	☐
15. Have you ever been in a gang (now or in the past)?	Yes Sometimes No	☐
Your answers are private between you and your health care provider. We will only talk to your parent/guardian about this information if we have a serious concern about your health and safety. Before we talk to a parent/guardian, we will talk about it with you.	**PLEASE CIRCLE YOUR ANSWER**	**WANT MORE INFO?**
16. Do you ever hurt or cut yourself on purpose?	Yes Sometimes No	☐
17. Have you ever texted/sent or received a sexual message or picture?	Yes Sometimes No	☐
18. Have you ever had any kind of sex (with anyone of any gender)?	Yes Sometimes No	☐
19. Have you ever had an infection that is spread by having sex? (like herpes, gonorrhea, chlamydia, genital warts, pelvic inflammatory disease, HIV, syphilis)	Yes Sometimes No	☐
20. Have you ever traded sex or sexual activity for money, food, a place to live, or anything else?	Yes Sometimes No	☐
21. Are you, or do you wonder if you are gay, lesbian, bisexual, pansexual, asexual, or other?	Yes Sometimes No	☐
22. Are you, or do wonder if you are transgender, gender diverse, or a gender that is different from what you were called (boy or girl) at birth?	Yes Sometimes No	☐
23. Have you ever been physically, sexually, or emotionally abused or hurt by anyone? (such as kicked, hit, forced or tricked into having sex, touched in a way that made you feel uncomfortable, called worthless)	Yes Sometimes No	☐
24. Have you ever, in your whole life, tried to kill yourself?	Yes Sometimes No	☐
25. Have you had any stressful or scary events that still bother you?	Yes Sometimes No	☐

If you could change one thing about your life or yourself, what would it be? _____

What is the most important thing you want us to focus on at today's clinic visit? _____

PLEASE TURN THE PAGE OVER →

Questions about tobacco, alcohol, marijuana, other drugs

In the PAST YEAR, how many times have you used:	Never	Once or twice	Monthly	Weekly
Tobacco, e-cigarettes or vapes, such as JUUL, suorin, blu, VUSE, or logic?	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Have you tried any other drugs for fun, curiosity or coping, such as prescription pills, drugs that you sniff or huff, salvia, K2, or other illegal drugs?	☐	☐	☐	☐

You are done! Thank you!

For office use:

An option is to offer the complete S2BI (www.drugabuse.gov) for validated substance use screening and recommendations based on results. These screening questions correspond to the brief office-based intervention algorithm for young people 9-18 years of age: Alcohol Screening and Brief Intervention for Youth (www.nih.gov).

NOTE: Standardized mental health screening is required for C&TC visits at 12-20 years of age. Refer to the Mental Health Screening (6-20 Years) C&TC Fact Sheet (www.health.state.mn.us/ctc) for instrument and referral recommendations.

To obtain this information in a different format, contact:

Minnesota Department of Health
Child and Teen Checkups Program
Phone: 651-201-3750
Email: health.childteencheckups@state.mn.us
Website: www.health.state.mn.us/ctc

DEPARTMENT OF HEALTH