Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

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.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
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	Nutrition
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	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
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	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
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	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	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.					
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date: