Lockport Pediatrics Adolescent Questionnaire

Name: _____Date:_____Date of Birth: _____

******PATIENT CELL PHONE******: _____

Please answer the following questions honestly by checking the appropriate column. This information is confidential.				
GENERAL			YES	NO
Do you feel down, depressed, or hopeless?				
Have you lost interest or pleasure in things that you previously enjoyed doing?				
Is it easy to talk with your parents?				
Do you feel comfortable talking with anyone other than your parents?				
Do members of your family like you?				
Do you have any pets?				
Do either of your parents or siblings have a serious illness?				
Do you feel safe at home?				
Have you ever been physically abused?				
Is there a gun or firearm in your house?				
Do you drive?				
Do you wear your seatbelt?				
EDUCATION & CAREER			YES	NO
Do you like school?				
Do you feel safe at school?				
Do you plan to finish high school?				
Do you worry about failing school?				
Do you plan to continue your education after high school?				
What grades did you earn last year?	90s	80s	70s	Less
What grades are you earning this year?	90s	80s	70s	Less
Do you worry about the future?				
Do you work?				
If yes, do you like your job?				
LIFESTYLE & DIET			YES	NO
Do you frequently use the internet?				
Do you frequently use social media networks? (such as Facebook/Twitter/SnapChat/Instagram)				
Do you think you are too fat?				
Do you think you are too thin?				
Would you like to lose weight?				
Would you like to gain weight?				
Do you think about dieting?				
Do you have trouble sleeping at night?				
Do you consider yourself a happy person?				
Do you think about dying?				
Do you ever think about killing yourself?				
Have you ever tried to kill yourself?				
SOCIAL & EXPERIENCES			YES	NO
Do you consider yourself a leader or follower?	Leader		Follower	
Do you feel pressure to go along with what your friends do?				
Do you have friends of the opposite sex?				
Does anyone at home smoke cigarettes?				
How many times have you smoked cigarettes in the past month?	0	1	5	10+
Does anyone at home get drunk or have a problem with alcohol?				
Do your friends drink?				
How often have you used alcohol in the last month?	0	1	3	5+
How often have you been drunk in the last month?	0	1	3	5+
Do you drink and drive or drive with someone who has been drinking?				
Do you use any other drugs?				
Have you ever had sex?				
If yes, do you use protection?				
Do you think you might be gay or lesbian?				
Have you ever been pregnant? (females only)				
Are you worried about being pregnant? (females only)				
Do you want information about protection from pregnancy, STD's or AIDS?				
Do you think you need to be tested for AIDS or another sexually transmitted disease?				
Have you ever been sexually abused or raped?				