11-17 Year Pre-Visit PATIENT Questionnaire

Today's Date: __________ Patient Name: ____________________________________________ Sex: M / F DOB: ____________

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? □ NO □ YES, Describe ________________________________

________________________________________

Have there been any changes or challenges at home since last year? □ NO □ YES, Describe ________________________________

________________________________________

Do you live with anyone who uses tobacco or spend time in any place where people smoke? □ NO □ YES, Describe ________________________________

Please check off any topics you would like to discuss today.

Your Growing and Changing Body:

□ appearance / body image □ how you feel about yourself □ healthy eating □ teeth
□ good ways to be active □ how your body is changing □ your weight/height

School / Friends:

□ your relationship with your family □ how you are doing in school □ your friends
□ organizing your time to get things done □ girlfriend /boyfriend

How You Are Feeling:

□ dealing with stress □ keeping under control □ sexuality
□ feeling irritable □ feeling anxious □ feeling sad

Questions

Dyslipidemia:
Do you smoke cigarettes? □ yes □ no □ unsure

Alcohol or Drug Use:
Have you ever had an alcoholic drink? □ yes □ no □ unsure
Have you ever used marijuana or any other drug to get high? □ yes □ no □ unsure

STI's:
Have you ever had sex (including intercourse or oral sex)? □ yes □ no □ unsure

Anemia:
Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals or beans? □ yes □ no □ unsure
Have you ever been diagnosed with iron-deficient anemia? □ yes □ no □ unsure

Growing and Developing

Check off all of the items that are true for you.

□ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active and keeping safe.
□ I feel I have at least one responsible adult in my life who cares about me and who I can go to for help.
□ I have at least one friend or a group of friends with whom I am comfortable.
□ I help others on my own or by working with a group in school, a faith-based organization, or the community.
□ I am able to bounce back from life's disappointments.
□ I have a sense of hopefulness and self-confidence.
□ I have become more independent and made more of my own decisions as I have become older.
□ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe. ________________________________

Reviewed by Physician: __________________________________________ Date: ______________
### PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Patient Name ___________________________ Date of Birth ___________________________

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