Patient Label

KAISER PERMANENTE®

Well-Care Questionnaire

for teens aged 13 to 17

TO BE COMPLETED BY TEEN: This worksheet can give your health care team information to help you take better care of yourself. You don't have to answer any questions you don't want to. **Kaiser Permanente values your privacy. Your answers will be kept confidential. If we are concerned about your health or safety, we will talk with you about how to involve your parent/guardian.**

1. General Information	
a. Preferred name (or nickname):_____ b. Pronouns:_____	
c. Your phone number:_____ d. Is it okay to leave a message: ☐ Yes ☐ No	
e. How would you describe your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
f. Have you seen a dentist in the last year?	☐ Yes ☐ No
2. Friends and Hobbies	
a. Are you happy with the way things are at home?	☐ Yes ☐ No
b. Do you have at least one good friend? ☐ Yes ☐ No	
c. Do you prefer spending time with others who are – pick one: ☐ Your age ☐ Older ☐ Younger	
d. What activities or hobbies do you enjoy?	
3. School History	
a. Did you move to a new school in the last year? ☐ Yes ☐ No	
b. Do you like school? ☐ Yes ☐ No	
c. Optional: If you're interested in sharing, please tell us what you like most or least about school: _____	
d. Do you attend school most days? ☐ Yes ☐ No	
4. Nutrition	
a. Do you eat breakfast?	☐ Yes ☐ No
b. Do you drink soda or juice more than once a day?	☐ Yes ☐ No
c. How many caffeinated drinks do you drink per day: ☐ 0 ☐ 1 ☐ 2 or more	
d. Are you a vegetarian or vegan?	☐ Yes ☐ No
e. Are you taking any multi-vitamins or supplements?	☐ Yes ☐ No
5. Physical Activity	
a. How many days most weeks do you exercise (enough to make you sweat) for 30 minutes or more? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or	
b. What type of exercise do you do regularly?	
While exercising or playing sports, have you ever: Your responses to the following 6 questions will be shared with your parent/guardian.	
c. Passed out or nearly passed out while exercising?	☐ Yes ☐ No
d. Had a concussion?	☐ Yes ☐ No
e. Had discomfort, pain, tightness, or pressure in chest while exercising?	☐ Yes ☐ No
f. Had your heart skip beats or feel abnormal in another way while exercising?	☐ Yes ☐ No
g. Felt lightheaded while exercising?	☐ Yes ☐ No
h. Been more tired or short of breath than your friends while exercising?	☐ Yes ☐ No
i. Broken a bone, or had a dislocation or other significant sports injury?	☐ Yes ☐ No
j. Have you had COVID-19? ☐ No ☐ Yes – when did you have it: _____	

6. Safety

a. Do you always wear a helmet when you ride on a four-wheeler, bicycle, skateboard, snowboard, or ski? ☐ Yes ☐ No

b. Do you always use your seat belt when in a car? ☐ Yes ☐ No

c. Are there guns in your home? ☐ Yes ☐ No ☐ Unsure

If yes, are they stored unloaded and locked? ☐ Yes ☐ No ☐ I don't know

d. Please check any of the items below that you have ever experienced or have concerns about. Check all that apply.

- ☐ Alcohol, cannabis, tobacco, or other drug use by a friend or family member
- ☐ Being arrested or been in other trouble with the law
- ☐ Being (or seeing someone else being) hit, kicked, shoved, or yelled at in an abusive manner
- ☐ Being touched in a way that made you uncomfortable or afraid, being abused
- ☐ Eating in secret or feeling guilty about eating
- ☐ Feeling like running away now or having run away in the past
- ☐ Feeling lonely or isolated
- ☐ Gangs (belonging to a gang, being afraid you will be hurt by or recruited to join a gang)
- ☐ Not being able to walk away from fights
- ☐ Poor grades or a drop in grades

7. Gender – Check all that apply.

a. What is your gender:

☐ Female ☐ Male ☐ Transgender female, male-to-female ☐ Transgender male, female-to-male ☐ Non-binary ☐ Questioning
☐ Genderfluid ☐ Other: _____ ☐ Choose not to answer

8. For females and/or if you have a uterus and ovaries:

a. Have your periods started? ☐ Yes ☐ No - skip to next section.

b. If **Yes**: How old were you when they started? _____

c. Are they regular (meaning they come about once a month, almost every month)? ☐ Yes ☐ No

d. Do you have any questions or concerns about your periods? ☐ Yes ☐ No

9. Sexual Health

a. Are you romantically and/or sexually attracted to (check all that apply):

☐ Males ☐ Females ☐ People who are non-binary ☐ No one ☐ Unsure ☐ Other: _____

b. Have you ever had any kind of sex? ☐ No – skip remaining questions ☐ Yes – please answer remaining questions

c. Do, or did, your sexual partners have (check all that apply): ☐ A penis ☐ A vagina ☐ Both

d. When you have sex, how often do you use a male condom? ☐ Always ☐ Sometimes ☐ Never ☐ Doesn't apply to me

e. When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom?

☐ Always ☐ Sometimes ☐ Never ☐ Doesn't apply to me

f. If you use or your partner uses protection, please list:

g. Have you ever been pregnant or made someone else pregnant? ☐ Yes ☐ No