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.**

Name:______________________________ Pronouns: ____________________

Confidential phone number:____________________ Is it okay to leave a message? ☐Yes ☐No

		Staff:
What is your gender? (choose as many as you'd like) ☐ Female ☐ Male ☐ Transfemale ☐ Transmale ☐ Non-binary ☐ Other: ☐ Choose not to answer	**Sex you were assigned at birth:** ☐ Female ☐ Male ☐ Choose not to answer	**Staff:** In note, use .genderhealth

What are your MAIN REASONS for today's visit?	**Chief Complaint**
☐ Physical exam ☐ Sports exam ☐ Camp exam ☐ Other:	
Family, School, and Other Activities	
Who are the people that live with you (include names, ages, relationships):	**History: Social Documentation**
Are you in school? ☐Yes ☐**No** If YES: What grade are you in? Which school do you go to?	**Flow Staff Note**
Are you having a hard time in school? ☐**Yes** ☐No	**Provider Note**
In a typical month, how often do you: **Miss** a class or day of school? ______ **Skip** a class or day of school? ______	
Do you have a job outside of school? ☐**Yes** ☐No If YES: Do you work at this job more than 20 hours a week? ☐**Yes** ☐No	**Flow Staff Note**
What sports, activities, and hobbies are you involved in?	**Flow Staff Note**
Medications	
What medicines are you taking, including prescription, herbal, and over-the-counter?	**Medications**

Medical History – check box if you have, or ever had, any of the following:

☐ Allergies	☐ Diabetes	☐ Seizure/epilepsy	**History: Medical/Surgical**
☐ Asthma	☐ Heart problems	☐ Sexually transmitted infection (STI)	
☐ Depression/anxiety	☐ Learning disability/ADHD	☐ Other mental health problem	
List major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):			

Family History

Check here if you know you were adopted ☐	**History: Family**
Please check boxes below if you have any family members who have had any of following:	
	Which family members?
☐ Alcohol/drug problems	____________________
☐ Asthma/allergies	____________________
☐ Cancer	____________________
☐ Depression/suicide	____________________
☐ Diabetes	____________________
☐ Other illnesses/conditions	____________________

Sports

Have you ever:		
Passed out or nearly passed out while exercising?	☐**Yes** ☐No	**Provider Note**
Had discomfort, pain, tightness or pressure in chest while exercising?	☐**Yes** ☐No	

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Question	Answer	
Had your heart race or skip beats while exercising?	☐**Yes** ☐No	
Felt lightheaded while exercising?	☐**Yes** ☐No	
Had an unexplained seizure?	☐**Yes** ☐No	
Been more tired or short of breath than your friends while exercising?	☐**Yes** ☐No	
Had heart problems?	☐**Yes** ☐No	
Been knocked out or had a concussion?	☐**Yes** ☐No	
Broken a bone, or had a dislocation or other significant sports injury?	☐**Yes** ☐No	
Do you have any of the following:		
Family member who died suddenly before the age of 50?	☐**Yes** ☐No	
Family history of heart problems?	☐**Yes** ☐No	
Family history of unexplained fainting, seizures, or near drowning?	☐**Yes** ☐No	

Nutrition		
Do you eat fruits and vegetables every day?	☐Yes ☐**No**	**Provider Note**
Do you eat or drink dairy products?	☐Yes ☐**No**	
Are you a vegetarian?	☐**Yes** ☐No	
Do you have any questions or concerns about your eating habits?	☐**Yes** ☐No	

Safety		
If you ride a motorcycle or bicycle, do you always use a helmet?	☐Yes ☐**No**	**Provider Note**
Do you always use your seat belt when in a car?	☐Yes ☐**No**	
Do you text while driving?	☐ I don't drive ☐**Yes** ☐No	
Do you ever drive, or ride with a driver who is, under the influence of alcohol or drugs?	☐**Yes** ☐No	
Do you or any of your friends have access to guns?	☐**Yes** ☐No	
If yes, are they stored unloaded and locked?	☐Yes ☐**No** ☐**Don't know**	
Has anyone ever hit or touched you in a way that made you uncomfortable or afraid?	☐**Yes** ☐No	

Family and Peers		
Do you get along with your family?	☐Yes ☐**No**	**Provider Note**
Are you having a hard time at home?	☐**Yes** ☐No	
Do you have a friend you can talk to about any problems you have?	☐Yes ☐**No**	
Are you having a hard time with friends including your boyfriend or girlfriend?	☐**Yes** ☐No	
Are you having trouble with fighting or bullying?	☐**Yes** ☐No	
Are you feeling pressure to do what others are doing?	☐**Yes** ☐No	

Stress and Depression		
During the past 2 years, have you or anyone in your family had any major good or bad changes?	☐**Yes** ☐No	**Provider Note**
Do you have any concerns about your body or weight?	☐**Yes** ☐No	
Do you ever eat in secret or feel guilty about eating?	☐**Yes** ☐No	
Do you ever make yourself throw up?	☐**Yes** ☐No	
In the past 2 weeks:		**PROVIDER:** If YES to either, complete PHQ-9 depression workflow
Have you recently lost interest or pleasure in doing things?	☐**Yes** ☐No	
Have you been feeling down, depressed, irritable, or hopeless?	☐**Yes** ☐No	

Tobacco, Nicotine, and Vapor		
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)?	☐**Yes** ☐No	**If YES:** Complete Tobacco History section

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Alcohol, Marijuana, and Other Drugs		
During the past 12 months:		**Social: Substance PROVIDER:** If YES to any question, complete CRAFFT
• Did you drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious events.	☐ **Yes** ☐ No	
• Use any marijuana (weed) or hashish?	☐ **Yes** ☐ No	
• Use anything else to get high? This includes illegal drugs, over the counter and prescription drugs, and things you sniff or huff.	☐ **Yes** ☐ No	
• Have you ever ridden in a car driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?	☐ **Yes** ☐ No	

Sexuality		
Are you attracted to (check all that apply): ☐ Men ☐ Women ☐ Both ☐ Non binary people ☐ Not sure ☐ No one ☐ Other		**Provider Note/ Social: Sexuality**
Have you ever had any kind of sex?	☐ No – skip to next section ☐ Yes - please answer the next 5 questions	
Do, or did, your sexual partners have (check all that apply): ☐ a penis ☐ a vagina ☐ both		
When you have sex, how often do you or your partner use a male condom?	☐ Always ☐ Sometimes ☐ Never ☐ Doesn't apply to me	
When you have sex, how often do you or your partner use protection from pregnancy other than a condom?	☐ Always ☐ Sometimes ☐ Never ☐ Doesn't apply to me	
If you or your partner use other protection from pregnancy, what do you use (please list):		
Many sexually transmitted infections (STIs) do not have symptoms you can see or feel. That's why it's important to get tested if you could be at risk. Places that could be infected by an STI include the genitals, anus, throat, and mouth. When we screen for STIs, we routinely test all sites that could be infected. Are there any sites you don't want me to check? ☐ No ☐ Yes		
Have you ever been pregnant or made someone pregnant?	☐ **Yes** ☐ No	

For females and/or you have a uterus and ovaries:		
Have your periods started?	☐ Yes ☐ **No**	**Provider Note**
If YES: How old were you when they started? Are they regular?	☐ Yes ☐ **No**	
Do menstrual cramps keep you from doing your normal activities?	☐ **Yes** ☐ No	

DO NOT FILE IN THE MEDICAL RECORD

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