KAISER PERMANENTE

Well-Care Questionnaire
for teens aged 13 to 17

WORKSHEET 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:

Confidential phone number: **Is it okay to leave a message?**

What are your MAIN REASONS for today's visit?	**For clinic use**
☐ Physical exam ☐ Sports exam ☐ Camp exam ☐ Other concerns, please list:	**Chief Complaint**
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, what: In this job, do you work 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 ☐ Mental health problem ☐ Asthma ☐ Heart problems ☐ Seizure/epilepsy ☐ Depression/anxiety ☐ Learning disability/ADHD ☐ Sexually transmitted disease (STD) List major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):	**History: Medical/Surgical**
Family History	
Check here if you know you were adopted ☐ 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 ________________	**History: Family**
Sports	
Have you ever:	
Passed out while exercising? ☐**Yes** ☐No Gotten dizzy or had headaches while exercising? ☐**Yes** ☐No Been knocked out? ☐**Yes** ☐No Had a significant joint or bone problem? ☐**Yes** ☐No Had a serious injury? ☐**Yes** ☐No Can you run twice around a ¼ mile track without stopping? ☐Yes ☐**No** Do you have a family member with heart disease? ☐**Yes** ☐No Do you have a family member who died suddenly before the age of 50? ☐**Yes** ☐No	**Provider Note**

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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?	☐**Yes** ☐No ☐ I don't drive	
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	
Have you recently lost interest or pleasure in doing things?	☐**Yes** ☐No	**PROVIDER: If YES to either, complete PHQ-9 depression workflow**
Have you been feeling down, depressed, irritable, or hopeless?	☐**Yes** ☐No	
Tobacco, Nicotine, and Vapor		
Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor product?	☐**Yes** ☐No	**If YES: Complete Tobacco History section**
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	
• Did you smoke any marijuana or hashish?	☐**Yes** ☐No	
• Did you 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	☐Males ☐Females ☐Both ☐Not sure	**Provider Note/ Social: Sexuality**
Have you ever had sex?	☐Yes ☐No	
If YES, are, or were, your sexual partners:	☐Male ☐Female ☐Both	
When you have sex, how often do you use a condom?	☐Always ☐Sometimes ☐Never	
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	
If you use or your partner uses protection, what kind do you or your partner use (please list):		
Have you ever been pregnant or made someone pregnant?	☐**Yes** ☐No	
For Females		
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	

NOT TO BE FILED IN THE MEDICAL RECORD

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