Pediatric Health Maintenance: 13-21 Years

Well Visit CONFIDENTIAL Questionnaire

To be completed by PATIENT only. Please complete BOTH sides

Virginia Mason Franciscan Health™

What would you like to talk about with your physician or nurse practitioner today?					
Are you taking any medication(s), vitamin(s), or supplements? Please list them.					
About You					
Preferred First Name/Last Name					
Personal cell phone, if available: *(for follow-up of any personal matters)*					
Who do you live with?					
Where do you attend school? Grade/Year					
Are you happy with your school performance? Days of school missed					
Which gender pronouns do you prefer?					
I identify as	MALE	FEMALE	TRANS	NON-BINARY	UNSURE
I am interested in/attracted to:	BOYS	GIRLS	BOTH	NEITHER	UNSURE
General Health					
How often do you usually exercise/get physical activity? Days/week Minutes/day					
How many hours of sleep do you usually get most nights?					
Do you feel tired/fatigued during the daytime? ☐ NO ☐ YES					
Do you eat healthy food most of the time ☐ NO ☐ YES					
Do you have concerns about your weight and/or height? ☐ NO ☐ YES					
Are you trying to change your weight ☐ NO ☐ YES If so, how?					
Behavioral Health					
What substances have you experimented with or used: ☐ None ☐ Alcohol ☐ Marijuana ☐ Nicotine Other (including other people's meds):					
Who do you share your concerns with?					
Are you seeing a counselor, mental health therapist, or psychiatrist?					
Do you have any questions about dating, sex, birth control, sexually transmitted diseases, or pregnancy? ☐ NO ☐ YES					
Menstruation (if applicable)					
Have you started having menstrual periods? ☐ NO ☐ YES If so, when					
If your periods have started, answer the following questions:					
What's the longest time you've gone between periods?					
Are you concerned about cramps, heavy, or irregular periods?					
Are you using hormonal contraceptives (birth control pills, patch, "Depo" shots, NuvaRing, IUD, Nexplanon) ☐ NO ☐ YES					
If so, which:					
Have you ever been pregnant? ☐ NO ☐ YES					

Please continue to next page

PATIENT NAME & ID#

8602041913

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Emotional Health – Section 1				
Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks?**	Not at all	Several days	More than half of days	Nearly every day
1. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
If you selected **a score of 2 or 3 on either of the above 2 questions, or have a history of DEPRESSION**, please continue on; otherwise, you can skip to the next section.				
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
In the **<u>past year</u>** have you felt depressed or sad most days, even if you felt OK sometimes?	YES		NO	
If you are experiencing any of the problems above, 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?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

Emotional Health – Section 2				
Instructions: How often have you been bothered by each of the following symptoms during the past **<u>two weeks</u>**?	Not at all	Several days	More than half of days	Nearly every day
1. Feeling nervous, anxious or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
*If you selected a **score of 2 or 3 on either of the above 2 questions, or have history of ANXIETY**, please continue with question 3-9; otherwise you can skip to the next section.*				
3. Not being able to stop or control worrying?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3
If you are experiencing any of the problems above, 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?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**

Completed by: _____ Date _____

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