

12-14 Year Physical

For parent to fill out:

Female

Name of Child: _____

Is your child's general health OK? Yes No _____

Has your child had any recent illnesses or injuries? No Yes _____

Please list any allergies your child has: _____

Please list all of your child's medications: _____

Does your child exercise regularly? Yes No _____

Is your child involved in sports or other extra-curricular activities? Yes No _____

Do you have any concerns about your child's eating habits? No Yes _____

Does your child have at least 3 dairy servings per day? Yes No _____

Any concerns with your daughters periods? Yes No _____

Is there a family history of sudden death? No Yes _____

Is there a family history of depression? No Yes _____

Do you have any concerns about your relationship with your child? No Yes _____

May the Dr., NP or PA interview your child alone? Yes No _____

Do you have any concerns with your child's sleeping? No Yes _____

Are you aware of & try to implement 5-3-2-1-0 in your family? Yes No _____

Does your child watch more than 2 hrs/day of screen time? No Yes _____

Do you have any other concerns? _____

12-14 Year Physical

For youth to fill out:

Female

Name: _____

What grade are you in? _____ What school do you attend? _____

What is your average letter grade? _____

Do you have a best friend?" Yes No _____

Do you have activities that you do for fun? Yes No _____

Do you have things you are good at? Yes No _____

Are there things that worry you? No Yes _____

Do you have times when you feel sad or alone? No Yes _____

Who do you live with? Mother Father Parents Other

Would you rate your family relationships as: Good Poor

Do you feel your family listens to you? Yes No Sometimes

How are you doing in school? Good Average Poor

How often are you absent from school? A lot Sometimes Never

How do you feel about your appearance? Good Bad

How much time do you spend watching TV, on the computer
or playing video games per week? 1 hr 5 hrs 10 hrs 15 hrs 20 hrs per week

Do you smoke cigarettes or marijuana? No Yes

Do you chew tobacco or smoke cigars? No Yes

Do you drink alcohol? No Yes

Do you take drugs? No Yes

Do you feel peer pressure to do things you know aren't good for you? No Yes

Have you started dating? No Yes

Do you have any problems with your periods? No Yes

Do you have any questions about sex? Yes No

Have you started having sex? No Yes

If you are having sex, do you use birth control or condoms? Yes No

On a 1 to 5 scale, how do you feel your life is going?
Terrible OK Great
1 2 3 4 5

Do you have any other concerns? _____