12-14 Year Physical For parent to fill out: **Male**

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 _____
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: **Male**

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
Have you started having wet dreams?	Yes	No
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? _____

_____