15 - 17 Year Physical For parent to fill out: **Male**

Name of Child: _____

Is your teenager's general health OK?	Yes	No _____
Has your teen had any recent illnesses or injuries?	No	Yes _____
Please list any allergies your teen has: _____		
Please list all of your teen's medications: _____		
Does your teen exercise regularly?	Yes	No _____
Do you have any concerns about teen's eating habits?	No	Yes_____
Does your teen have a job?	Yes	No _____
Does your teen have their driver's license?	Yes	No _____
Does your teen have any ideas about their future plans?	Yes	No _____
Have their been any family changes?	No	Yes _____
Do you have any concerns about your relationship with your child?	No	Yes _____
May the Dr., NP or PA interview your teen privately?	Yes	No _____

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

_____

_____

15 - 17 Year Physical Form For youth to fill out: **Male**

Name: _____

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

What is your average letter grade?_____

What do you do for fun? . . . . . Sports Exercise Shopping Other_____

Do you have times when you feel down or depressed? No Yes _____

Who do you confide in with your feelings? . . . . . Family Friends Other_____

Have any of your friends or relatives tried suicide? No Yes

Do you have thoughts of hurting yourself? No Yes

How do you feel about your appearance? . . . . . Good Bad_____Other_____

Do you smoke, drink or use drugs? No Yes

Are there any unsecured firearms in your home? No Yes

Is schoolwork difficult for you? No Yes

How often are you absent from school? . . . . . A lot Sometimes Never_____

Are you dating? Yes No

Do you have a steady relationship with one person? Yes No

Do you have any questions or worries about sex? Yes No

Have you started having sex? No Yes

If you are having sex, what kind of birth control do you use? . . . . . Condoms BCP's Other_____

Is there anything you would like to talk about that you don't want to write down? 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? _____

_____

_____