18-20 Year Physical **Name: _____** **Female**

Is your general health OK? **Yes** **No** _____

Have you had any recent physical problems? No Yes _____

Please circle any problems you have from the list on the back of this form.

Please list any allergies you have: _____

Please list all medications you take: _____

List any past surgeries, hospitalizations or chronic medical problems: _____

Have any family members developed any significant illnesses? No Yes_____

Do you exercise regularly? Yes No _____

Are you still in school? Yes No _____

Do you have a job? Yes No _____

Do you have any problems with your periods? No Yes _____

Have there been any changes in your family that concern you? No Yes _____

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

Do you have thoughts of hurting yourself? No Yes

What worries you? Or makes you angry? _____

Do you feel you will be successful? Yes No

How do you feel about how you are doing in school? . . . . . .Good Bad_____Other_____

Do you own a gun? **No** **Yes**

Has anyone ever tried to hurt you? **No** **Yes**

Are you sexually active? No Yes

If you are sexually active, do you use birth control? . . . . . Yes No Sometime

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

Have you ever contracted an STD such as Chlamydia or herpes? No Yes

What does your family do together? Eat together Activities Recreation

Are you living away from home? Yes No

Are you satisfied with your job/school? Yes No

Do you have any concerns with your sleeping habits? No Yes _____

Are you aware of and try to implement 5-3-2-1-0? Yes No _____

Do you spend more than 2 hrs/day of screen time? No Yes _____

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? _____