Staying Healthy Assessment (12-17 Years)

Question #	Question Text	Yes	No	Skip
1	Do you drink or eat 3 servings of calcium rich foods daily such as formula, breastmilk, cheese, yogurt, soy milk or tofu?	☐	☐	☐
2	Do you eat fruits and vegetables at least two times per day?	☐	☐	☐
3	Do you eat high fat foods, such as fried foods, chips, ice cream or pizza more than once a week?	☐	☐	☐
4	Do you drink more than 12oz of soda, juice drinks, sports drinks, energy drink or other sweetened drinks per day?	☐	☐	☐
5	Do you exercise or play sports actively most days of the week?	☐	☐	☐
6	Are you concerned about your weight?	☐	☐	☐
7	Do your child watch any tv or play video games less than 2 hours per day?	☐	☐	☐
8	Does your home have a working smoke detector?	☐	☐	☐
9	Does your home have the phone number of Poison Control Center (800-222-1222) posted by your phone?	☐	☐	☐
10	Do you always wear a seatbelt when riding in a car?	☐	☐	☐
11	Do you child spend time in a home where a gun is kept?	☐	☐	☐
12	Do you spend time with anyone who carries a gun, knife or other weapon?	☐	☐	☐
13	Do you always wear a helmet when riding a bike, skateboard or scooter?	☐	☐	☐
14	Have you ever witnessed or been a victim of abuse or violence??	☐	☐	☐
15	Have you been hit, slapped or physically hurt by someone in the past year?	☐	☐	☐

16	Have you been bullied or felt unsafe at school or in your neighborhood?	☐	☐	☐
17	Do you help brush and floss your teeth daily?	☐	☐	☐
18	Do you often feel sad or depressed?	☐	☐	☐
19	Do you spend time with anyone who smokes?	☐	☐	☐
20	Do you smoke cigarettes or chewed tobacco?	☐	☐	☐
21	Do you use or sniff substances to get high such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	☐	☐	☐
22	Do you use medicines not prescribed to you?	☐	☐	☐
23	Do you drink alcohol once a week or more?	☐	☐	☐
24	If you drink alcohol, do you drink enough to get drunk or pass out?	☐	☐	☐
25	Do your child have friends or family members who have a problem with drugs or alcohol?	☐	☐	☐
26	Do you drive a car after drinking or ride in a car driven by someone who has been drinking or using drugs?	☐	☐	☐
27	Have you ever been forced or pressured to have sex?	☐	☐	☐
28	Have you ever had sex (oral, vaginal or anal)? If no skip to question 35.	☐	☐	☐
29	Do you think you or your partner could have a sexually transmitted infection (STI) such as Chlamydia, Gonorrhea genital warts, etc…?	☐	☐	☐
30	Have you or your partner(s) had sex with other people in the past year?	☐	☐	☐
31	Have you or your partner(s) had sex without using birth control in the past year?	☐	☐	☐
32	The last time you had sex, did you use birth control?	☐	☐	☐

33	Have you or your partner(s) had sex without a condom in the past year?	☐	☐	☐
34	Did you or your partner use a condom the last time you had sex?	☐	☐	☐
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl or other gender)?	☐	☐	☐
36	Do you have any other questions or concerns about your health?	☐	☐	☐

If yes, please describe: _____

Is an interpreter needed today? Yes / No

School Attendance regular? Yes / No