

# Patient Questionnaire (Younger Teen)

How many milk/dairy/calcium servings do you have per day (including calcium supplements)?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-4 or more	
How many servings of fruits/vegetables do you have most days?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> 6+
How many times per week do you have sugared drinks (soda, sports drinks, etc.)	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> 5+
How many times per week do you have caffeinated drinks	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> 5+
Do you ever use energy drinks/supplements?	<input type="radio"/> No	<input type="radio"/> Yes		
How often do you worry about your weight, size, or body shape?	<input type="radio"/> Never	<input type="radio"/> Sometimes	<input type="radio"/> Often	
How often do you worry about/feel bad about your eating habits?	<input type="radio"/> Never	<input type="radio"/> Sometimes	<input type="radio"/> Often	
Has anyone ever told you they have concerns about your weight/eating?	<input type="radio"/> No	<input type="radio"/> Yes		
What (if anything) have you done to try and change your weight?	<input type="radio"/> Strict Diet	<input type="radio"/> Be more active	<input type="radio"/> Limit portions	<input type="radio"/> Other
	<input type="radio"/> Nothing	<input type="radio"/> Eat more vegetables	<input type="radio"/> Decrease sodas	<input type="radio"/> _____

## Emotional, Support, and Stress Management

What do you typically do to relieve stress?				
Do you have at least one friend you can talk to?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
Do your Parent(s)/Guardian(s) like your friends?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
If we were only talking about your safety, would you say your friends are good for you?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
Do you think your Parent(s)/Guardian(s) usually listen to you and take your feelings seriously?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
How often do you get angry or irritable with family or close friends?	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often	
How often do you feel extremely worried	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often	
How often do you feel extremely sad or hopeless?	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often	
Are you thinking about running a way from home?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
Are you thinking about killing yourself?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
Have you ever been a victim of abuse (emotional, sexual, physical)?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
If so, please explain _____	<input type="radio"/> Emotional	<input type="radio"/> Physical	<input type="radio"/> Sexual	

## Safety and Risk Behaviors

How often do you wear your seatbelt?	<input type="radio"/> Always	<input type="radio"/> Sometimes	<input type="radio"/> Never	
IF YOU rollerblade, bike etc. how often do you wear a helmet?	<input type="radio"/> Always	<input type="radio"/> Sometimes	<input type="radio"/> Never	
How often are you around family/ friends who smoke?	<input type="radio"/> Often	<input type="radio"/> Sometimes	<input type="radio"/> Never	
How often are you around family/friends who drink alcohol?	<input type="radio"/> Often	<input type="radio"/> Sometimes	<input type="radio"/> Never	
How often are you around family/friends who use illegal drugs?	<input type="radio"/> Often	<input type="radio"/> Sometimes	<input type="radio"/> Never	
Does anyone in your family drink or use drugs so much it worries you?	<input type="radio"/> Yes	<input type="radio"/> No		
Have you ever been in trouble with the law?	<input type="radio"/> Yes	<input type="radio"/> No		
Are there any guns or firearms in your home?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure	
Is there anything else you want us to know about you?				
May we share this with your parents?	<input type="radio"/> Yes	<input type="radio"/> No		