

Follow-Up Patient Questionnaire (Younger Teen)

Name (Full): _____

Today's Date: _____

Sex: _____

What is the Main Reason for Your Appointment today? (Bubble in)

- General Check-Up
- Specific Question/Concern (If so describe in the lines below)

Update

Major changes in your life since your last visit?

Social History

Who do you live with most of the time? (circle one)

Mother Father Step-parent Other _____

Do you live in more than one home?

Yes (Circle Primary Custodian: mother father shared)

Recent Changes/Stressors such as

- Move to a new home / school
- Parent loss of job
- Parent Separation or Divorce
- Change in living situation
- Major illness / death in the family or friend
- Other _____

Academic/Work History

Current School / Grade _____

What Grades Do you Get?

A's B's C's D F

Are you comfortable with how you do in school?

Yes No

Activity, Nutrition, and Body Image

How many days per week do you participate in physical play or exercise or sports?

0 1-2 3-4 5+

How many hours of TV, movies and computer/video games do you watch daily (combined)?

Week day 0 <1 1-2 2+

Week end 0 <1 1-2 2+

How many times a week does your family eat dinner together?

0 1-2 3-4 5+

How many hours of sleep do you get every

Weekday <6 0-8 8-10 >10

Weekend <6 0-8 8-10 >10

How many times a week do you eat fast food?

0 1-3 4-7 >7

How many times per week do you have sugared drinks (soda, sports drinks, etc.)

0 1-2 3-5 5+

Has anyone ever told you they have concerns about your weight / eating

No Yes

In the last year...

How often do you feel extremely worried

Rarely Sometimes Often

How often do you feel extremely sad or hopeless?

Rarely Sometimes Often

Are you thinking about running a way from home?

Yes No Not Sure

Are you thinking about killing yourself?

Yes No Not Sure

Have you ever been a victim of abuse (emotional, sexual, physical)?

Yes No Not Sure

If so, please explain _____

Emotional Physical Sexual

May we share these answers with your parents (circle)? Yes No