Well Child Visit -- 11-12y Patient Form

Name **DATE**

DOB

SAFETY

Do you always wear a seatbelt when you ride in a car?	Yes ☐	☐ No
Do you always ride in the backseat?	No ☐	☐ Yes
Do you always wear a helmet when rollerblading, skateboarding, and riding a bike, scooter, ATV or snowmobile?	Yes ☐	☐ No
Do you feel safe at school and at home?	Yes ☐	☐ No
Do you own a gun or have access to one?	No ☐	☐ Yes
Have you used a tanning bed?	No ☐	☐ Yes

PHQ-9

Over the last two weeks, how often have you been bothered by the following problems? (Mark the best answer)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
1. Feeling down, depressed, irritable or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself - or feeling that you are a failure, have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Office Use Only
Total Score: _____ 10

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?	Yes ☐	☐ No
Has there been a time in the past month when you have had serious thoughts about ending your life	Yes ☐	☐ No
Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?	Yes ☐	☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Emotional Health (SCARED)

Choose the answer that seems to describe you for the last 3 months.

	Not True	Somewhat True	Very True
1. I get really frightened for no reason at all.			
2. I am afraid to be alone in the house.			
3. People tell me that I worry too much.			
4. I am scared to go to school.			
5. I am shy.			

Office Use Only
Total Score: _____ 3

OPTIONAL

SEXUALITY

How do you identify yourself? ☐ Male ☐ Female ☐ Transgender ☐ Other

Are you attracted to? ☐ Opposite Sex ☐ Same Sex ☐ Both ☐ Neither

Do you have questions about sex? No ☐ ☐ Yes

ALCOHOL/TOBACCO/DRUGS

Have you smoked cigarettes, chewed tobacco or vaped?	**No** ☐	☐ **Yes**
Are you exposed to second hand smoke?	**No** ☐	☐ **Yes**
Are you worried about any friends or family members and how much they drink or use drugs?	**No** ☐	☐ **Yes**
During the past year, have you drunk any alcohol?	**No** ☐	☐ **Yes**
Have you used marijuana or any other drugs to get high?	**No** ☐	☐ **Yes**
Are you happy with your body?	**Yes** ☐	☐ **No**
Do you ever fast, vomit or take laxatives or diet pills to control your weight?	**No** ☐	☐ **Yes**

EMOTIONAL HEAL TH

Have you been in trouble at school or with the law?	**No** ☐	☐ **Yes**