13-14 Year Pre-Visit Questionnaire

***Instructions:** Please answer the questions below by circling or putting an X on the correct choice. These questions help us assess your health, development, and safety.*

General Health

1	Do you have any concerns about your health today?	NO	YES
2	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

3	Do you eat 5 or more helpings of fruits/vegetables each day?	YES	NO
4	When you eat grains (cereal, bread, pasta, crackers, waffles, rice, etc.), are they mostly whole grains?	YES	NO
5	Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
6	Do you eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 times per week?	NO	YES
7	Do you snack more than 1-2 times a day on food other than fruits and vegetables?	NO	YES
8	Do you drink soda, juice or other sweetened drinks more than once or twice per week?	NO	YES
9	Do you eat meals together as a family?	YES	NO
10	Do you have any concerns or questions about the size or shape of your body?	NO	YES
11	In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	NO	YES
12	Are you taking any vitamins or supplements?	NO	YES

Oral Health

13	Do you see a dentist at least twice a year?	YES	NO

Activity

14	Do you play any competitive sports?	NO	YES
15	Is there any family history of heart problems or sudden death?	NO	YES
16	Are you active (exercising/heart rate elevated) for at least 1 hour every day?	YES	NO

17 Do you watch TV, play video games, or spend time on the computer more than 2 hours per day (not including screen time for homework)?	NO	YES
a. Do you have screen time (TV, video games, computer, tablet, smart phone) in your bedroom?	NO	YES
18 Do you have a hard time falling asleep or staying asleep at night?	NO	YES
19 Are you sleeping 8-10 hours at night?	YES	NO

School

20 Are you having problems in school?	NO	YES
21 Are your grades worse than last year?	NO	YES
22 Do you have trouble concentrating?	NO	YES
23 Have you been getting into fights?	NO	YES
24 Do you have problems doing your homework?	NO	YES
25 Have you been suspended in the past year?	NO	YES
26 Have you missed more than a few days of school in the last year?	NO	YES
27 Do you have an IEP or other learning plan?	NO	YES

Injury Prevention

28 Do you always wear a seat belt when you are in a car?	YES	NO	
29 Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	YES	NO	
30 Do you ever carry a gun?	NO	YES	
31 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY

Tuberculosis

32 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
33 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
34 Were you born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
35 Have you traveled to a high-risk country for more than a month?	NO	YES

Emotional Wellbeing

36 Do you feel stressed out, anxious, moody or overly worried?	NO	YES
37 Does your nervousness/worrying make it hard for you to do well in school/at home/or with your other activities?	NO	YES
38 When you are angry, do you do violent things?	NO	YES
39 Have you ever seriously thought about hurting or killing yourself or someone else?	NO	YES
40 Do you get along with your family and follow their rules?	YES	NO
41 Have you experienced bullying or harassment on social media (Facebook, Snapchat, Intagram, etc?)	NO	YES
42 Is there someone you are dating or a person at home or at school that is hurting you?	NO	YES

Review of Systems

43 Do you have any concerns about eating habits, weight loss, or lack of energy?	NO	YES
44 Do you have any sleep problems, including a lot of snoring?	NO	YES
45 Do you have concerns about your eyes or vision?	NO	YES
46 Do you have concerns about recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
47 Have you had chest pain, shortness of breath, or irregular heartbeat?	NO	YES
48 Do you have concerns about frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
49 Do you have concerns about abdominal (stomach) pain, vomiting, diarrhea, constipation?	NO	YES
50 Do you have concerns about kidney or bladder problems, infections, or blood in your urine (pee)?	NO	YES
51 Do you have concerns about your skin, hair, or nails?	NO	YES
52 Do you have concerns about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
53 Do you have concerns about recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES

54 Do you have excessive thirst or increased urination?	NO	YES
55 Do you have concerns about paleness, anemia, easy bruising, swollen glands?	NO	YES
56 Do you have concerns about puberty?	NO	YES

For girls:

57 Have you gotten your period?	YES	NO
58 Do you have any problems or questions about menstruation (getting your period)?	NO	YES
59 Do you get your periods every 21-42 days?	YES	NO
60 When was your last period?		