Name:
ID#:

HOW AM I DOING?
ADOLESCENTS 11 YEARS THROUGH 20 YEARS
RISK ASSESSMENT

If you have any questions or concerns about yourself, please share these with your health - care provider. We want to assist you with your needs anyway possible.

YES	NO	
☐	☐	1. Have you had contact with a person with confirmed or suspected infectious tuberculosis? **(Family member or associate in jail or prison)**
☐	☐	2. Have you had an x-ray or examination that may suggest tuberculosis?
☐	☐	3. Have you emigrated from a foreign country where there is a history of tuberculosis? **(Asia, Middle East, Africa, Latin America)**
☐	☐	4. Have you traveled to a foreign country or had contact with a native person from such a country where there is a history of tuberculosis?
☐	☐	5. Do you have HIV/AIDS?
☐	☐	6. Have you or do you live in a group home, foster care, or orphanage, or been incarcerated?
☐	☐	7. Are you physically active for a total of 30 minutes each day?
☐	☐	8. Do you have problems with activities of daily living, such as: making meals, shopping, bathing, or moving around?
☐	☐	9. Have you ever experienced feeling really down or depressed for more than a week at a time?
☐	☐	10. Have you ever had thoughts about harming yourself?
☐	☐	11. Are you concerned that someone will harm you (or your child), or worry that you will harm someone?
☐	☐	12. Has your partner or someone important to you ever physically, verbally, or sexually abused you?
☐	☐	13. Do you smoke cigarettes, use smokeless tobacco, or use other tobacco products?
☐	☐	14. Do you or have you ever used **(Circle all that apply)**: Alcohol: Beer, Wine, Liquor Drugs: Prescription (nerve, sleeping, or pain medicines) Street Drugs (marijuana, cocaine, crack, or others)
☐	☐	15. Have you ever felt you should cut-down on your drinking or drug use?
☐	☐	16. Do you examine your breasts (or testicles) monthly?
☐	☐	17. Do you have questions or concerns about sex or sexual orientation?
☐	☐	18. Are you planning on becoming sexually active, have you been sexually active, or are you now sexually active? **(If NO skip to question 25.)**
☐	☐	19. Since beginning sexual relations have you had more than 1 partner? If yes, total number of partners _____.
☐	☐	20. Have you ever had a sexually transmitted infection? **(Circle all that apply):** Gonorrhea Chlamydia Herpes HIV/AIDS Genital Warts or HPV Syphilis
☐	☐	21. Do you (or your partner) use condoms to protect against sexually transmitted infections?
☐	☐	22. Do you use any kind of birth control?

YES NO

☐ ☐ 23. Have you ever been pregnant (or gotten someone pregnant)?

24. What type of water do you drink daily? **(circle all that apply 11 years. – 16 years only):**
City Well Cistern Bottled Water

CIRCLE ALL THAT APPLY OF THE FOLLOWING:

25. Are you experiencing or have you been experiencing any of the following **(circle all that apply to you)**:

11 Yrs. - 15 Yrs.
Having Dramatic Physical Changes
Demand and Seek Privacy
Preoccupied with Appearance
Anxious about Number of Changes in Life

15 Yrs. – 18 Yrs
Wonder About Who You Are
Friends Assume Great Importance
Sensitivity to Fads & Peers' Social Norms
Question Rules & Authority
Becoming Future Oriented in Thinking

18 Yrs. - 20 Yrs.
Making Decisions about College, Work, or Military
Focus on Achieving Greater Autonomy
Seeking Mature Emotional Intimacy
Development of Mature Sexual Identity

☐ ☐ 26. Do you have concerns about your weight or eating habits?

☐ ☐ 27. Do you follow a special diet or are on a prescribed medication?

☐ ☐ 28. Do you eat or drink every day: **(circle all that apply)**
Fried Foods Lunch Meats Soft Drinks Cake Cookies Chips

☐ ☐ 29. Do you eat 6 servings of any of the following daily: bread, cereal, rice, or pasta?

☐ ☐ 30. Do you eat 3 servings of vegetables each day?

☐ ☐ 31. Do you eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?

☐ ☐ 32. Do you eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup, beans, eggs or peanut butter?

☐ ☐ 33. Do you eat or drink 3 servings daily of any of the following: milk, cheese or yogurt?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

_____

_____

_____

ENTIRE FORM HAS BEEN REVIEWED AND UPDATED WITH PATIENT ON FOLLOWING DATES: (SIGNATURE AND DATE REQUIRED)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reference: Maternal and Child Health Bureau, *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, National Center for Education in Maternal and Child Health, 1994, Arlington, VA.