Four Seasons Pediatrics – Young Adult Questionnaire

Patient Name: _____ Birth Date: _____ Age: _____ Years

This information will not be shared with anyone (including your parents) without your permission.
Please complete this form on your own. Today's provider will go over the answers with you.
The questionnaire is to be used during your visit. Please carefully answer each question "Yes" or "No"

YES NO 1. Do you get along well with your parents?
YES NO 2. Do you get along well with your brothers and sisters?
YES NO 3. Do you have chores at home?
YES NO 4. Do you have a part time job?
YES NO 5. Are you satisfied with your personal relationships, daily activities and social interactions with others your age?
YES NO 6. Do you have a close friend?
YES NO 7. Are you doing OK in school? What is your average grade? ____
YES NO 8. Is life going OK for you?
YES NO 9. Do you feel your parents are fair about discipline?
YES NO 10. Do your parents get along well with each other?
YES NO 11. Are you involved or participate in church or other religious observance?
YES NO 12. Do you like to have friends visit your home?
YES NO 13. Do you do any volunteer or community service?
YES NO 14. Do you have someone you can talk over problems or frustrations with?
YES NO 15. Do you wear a seat belt?
YES NO 16. Would you wear a bike helmet if you got on a bike?
NO YES 17. Do you feel nervous, anxious or on edge?
NO YES 18. Do you feel that you have a hard time stopping or controlling worry?
NO YES 19. Do you feel down, depressed or hopeless?
NO YES 20. Do you find you have little interest or pleasure in things you do?
NO YES 21. Have you recently felt like doing harm to yourself or ever contemplated suicide?
NO YES 22. Are you sexually active or have questions about sex that you would like to ask about?
NO YES 23. Do you miss more than 2 days of school each month?
NO YES 24. Are you thinking about dropping out of school?
NO YES 25. Have you recently been in trouble with the law?
NO YES 26. Is your family under any serious stress?
NO YES 27. Is there any possibility of recent separation or divorce in your family?
NO YES 28. Do you have any concerns about your weight, nutrition, or oral health/dental care ?
NO YES 29. Do you smoke or are you exposed to second hand smoke? (circle which one if positive)
NO YES 30. Do you consume any alcoholic beverages, drugs or use anything else to get high?
NO YES 31. I would like to be tested for STDs, such as Chlamydia or GC?

32. Some things that my parents do that upset me are: _____

_____

33. When my parents are upset with me they: _____

_____

34. Things that I like to do in my free time: _____

35. What sports do you participate in? _____

36. List any concerns that you would like to discuss during your appointment: _____

_____