

**PARENT ADOLESCENT QUESTIONNAIRE**  
(This information will be shared with your teenager)

1. What are your teenager's strengths (personality, sports or academics)?

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2. Are there any marital, financial or employment stresses in the home? Yes    No

3. Are you separated, divorced or in the process? Yes    No

4. How is your health? Good    Fair    Poor  
If fair or poor, why?

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5. How is your spouse/partners health? Good    Fair    Poor  
If fair or poor, why?

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6. Do you work outside the house? Yes    No  
If yes, what do you do? \_\_\_\_\_

7. Is anyone home when your teenager comes home from school? No    Yes

8. Does your teenager like school? No    Yes

9. Does your teenager have friends that he/she sees regularly? No    Yes

10. Are you concerned about your teenager eating habits? Yes    No  
If yes, please elaborate.

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11. Have you discussed drugs or alcohol with your teenager? No    Yes

12. Does anyone in the home have issues with drugs or alcohol? Yes    No

13. Have you or your spouse discussed sexual health with your teenager? No    Yes

14. Do you or your spouse have (circle one-optional)  
a. depression      b. bipolar disease      c. other \_\_\_\_\_

15. Does your teenager snore? Yes    No

16. Does your teenager have a good self-esteem? No    Yes

**PLEASE TURN PAGE OVER**      

15. Does your teenager snore? Yes No

16. Does your teenager have a good self-esteem? No Yes

17. Would you say your teenager is anxious? Yes No

18. Are you concerned your teenager is being bullied? Yes No

19. Are you concerned your teenager is depressed?  
If yes, please elaborate.

\_\_\_\_\_

\_\_\_\_\_

20. Has your teenager seen a mental health professional or school counselor at any time? Yes No

21. Has your child ever attempted suicide? Yes No

22. Has your teenager won any academic sports or other awards this past year? (including honor roll) Yes No

23. Where are the computers in your home? \_\_\_\_\_

24. Do you monitor the websites your teenager goes into? No Yes

25. Do you have any concerns about your teenager's academic performance? Yes No

26. Are there any subjects you would like our provider to discuss with your teenager? If yes, in what areas and what are the weaknesses:

\_\_\_\_\_

\_\_\_\_\_

27. Has your teen gotten a ticket while driving? Yes No

28. Has your teen gotten into an accident while driving? Yes No

29. What are your hopes for your teenager's future?

\_\_\_\_\_

\_\_\_\_\_

Patient: \_\_\_\_\_  
11/07

Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

D.O. B: \_\_\_\_\_

***Cholesterol Screening Risk Factor Assessment for ANNUAL WELL VISIT***

Well Visit Risk Factor Assessment Form

(**Parents:** answer all questions that apply below)

Nursing only:

BMI over 85% Y \_\_\_ N

\_\_\_\_\_ My child has Diabetes and/or High Blood Pressure

Only for  
children  
ages  
3, 5, 10,  
15 & 18

\_\_\_\_\_ There is a history of high Cholesterol or Heart Disease in my Family (ie. in you or your spouse's, your/spouse's parents, grandparents, etc.) Note: Heart Disease includes Diabetes, stroke, and high blood pressure

\_\_\_\_\_ My Family's Cholesterol and/or Heart history is unknown

If any of the above questions are checked and/or your child's BMI% is over 85% the new recommendations are to do a ***Random Cholesterol Level Test*** here in the office. Most insurance cover the test, depending on the type of insurance you have. If it is not covered, the cost of the test is \$15.00. High cholesterol puts a child at risk for significant future cardiac disease. This test will help your physician determine the best plan of action to decrease your child's future cardiac risks. The test involves a finger stick and you will have the result before you leave today with a plan from your provider.

\_\_\_\_\_ I agree to have my child's Cholesterol checked today.

\_\_\_\_\_ I decline testing today.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date