Advanced Pediatric Associates LLP

Tween Questionnaire (11-12 years)

As part of your well care, we would like to know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger.
Thank you for your time.

Your Name _____ Today's Date _____

Your Age _____ Your Sex: M F Your Grade (in School) _____

Physical Growth and Development	1.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes	No
	2.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes	No
	3.	Do you eat more than 1 fast food meal per week?	No	Yes
	4.	Do you drink more than one soda or juice drink each day?	No	Yes
	5.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, at least 3 or 4 times per week?	Yes	No
	6.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No	Yes
	7.	Do you have a TV in your bedroom?	No	Yes
	8.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	No	Yes
	9.	Do you eat meals together as a family?	Yes	No
	10.	Are you on a diet to lose weight?	No	Yes
Social and Academic	11.	Are you having any problems in school? Circle all that apply: Grades worse than last year · Failing grade · Homework · Suspension this year Fighting · Bullying · Missing School · Other _____	No	Yes
	12.	Has anyone offered you or pressured you to try a cigarette, alcohol or drugs?	No	Yes
Violence & Injury Prevention	13.	Do you always wear a seatbelt when riding in a car, truck, or van?	Yes	No
	14.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	Yes	No
	15.	Do you ever carry a gun or other weapon (even to protect yourself) or have access to a gun at home or in places where you spend time?	No	Yes
	16.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No	Yes
Emotional Well-being	17.	Do you worry a lot or feel overly stressed out?	No	Yes
	18.	When you are angry, do you do violent things?	No	Yes
	19.	Do you continue to remember or think about an unpleasant experience that happened in the past?	No	Yes
	20.	During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you had nothing to look forward to?	No	Yes
	21.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	No	Yes