RAPID ASSESSMENT FOR ADOLESCENT PREVENTIVE SERVICES

CONFIDENTIAL - ADOLESCENT HEALTH

Name:_____ **Sex:** _____ **Insurance:**_____

Birthdate: _____ **Ethnicity/Race:**_____ **Reg #:**_____

Health Risk Profile: Confidential ***Your answers will only be seen by the center staff***

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1. **In the past 12 months,** have you tried to **lose weight** by taking diet pills or laxatives, making yourself vomit (throw up) after eating, or starving yourself? ☐ No ☐ Yes
2. Do you eat some fruits and vegetables every day? ☐ Yes ☐ No
3. Do you exercise (run, dance, swim, bike, play basketball, etc) for at least **60 mins, 3 or more days a week**? ☐ Yes ☐ No
4. Do you **always** wear a lap/seat belt when driving or riding in a car, truck, or van? ☐ Yes ☐ No
5. Do you **always** wear a helmet when rollerblading,biking,or skateboarding? ☐ Yes ☐ No
6. **During the past month,** have you been threatened, teased, or hurt by someone (on the web, by text, or in person) or has anyone made you feel sad, unsafe, or afraid? ☐ No ☐ Yes
7. Has anyone **ever abused** you physically (hit, slapped, kicked), emotionally (threatened or made you feel afraid) or **forced you** to have sex or be involved in sexual activities when you didn't want to? ☐ No ☐ Yes
8. Have you **ever** carried a weapon (gun, knife, club, etc.) to protect yourself? ☐ No ☐ Yes
9. **In the past 3 months,** have you smoked cigarettes or any other form of tobacco (black and mild, hookah, etc) or chewed/used smokeless tobacco? ☐ No ☐ Yes
10. **In the past 12 months,** have you driven a car drunk, high, or while texting or ridden in a car with a driver who was? ☐ No ☐ Yes
11. **In the past 3 months,** have you drunk any alcohol (beer, wine coolers, liquor, etc) other than a few sips? ☐ No ☐ Yes
12. **In the past 12 months,** have you smoked marijuana, used other street drugs, steroids, or sniffed inhalants ("huffed" household products)? ☐ No ☐ Yes
13. **In the past 12 months,** have you used someone else's prescription (from a doctor or other health care provider) or nonprescription (from a store) drugs to sleep, stay awake, calm down or get high? ☐ No ☐ Yes
14. Have you **ever** had any type of sex (vaginal, anal or oral sex)? ☐ No ☐ Yes
15. Have you **ever** been attracted to the same sex (girl to girl / guy to guy) or do you feel that you are gay, lesbian, or bisexual? ☐ No ☐ Yes
16. If you have had sex, do you **always** use a method to prevent sexually transmitted infections and pregnancy (condoms, female barriers, etc)? ☐ Yes ☐ No
17. Do you have questions about abstinence (saying no to sex), condoms, birth control, HIV/AIDS, or sexually transmitted infections (STI)? ☐ No ☐ Yes
18. **During the past month,** did you often feel very sad or down as though you had nothing to look forward to? ☐ No ☐ Yes
19. Do you have any serious problems or worries at home or at school? ☐ No ☐ Yes
20. **In the past 12 months,** have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself? ☐ No ☐ Yes
21. Do you have at least one adult in your life that you can talk to about any problems or worries? ☐ Yes ☐ No

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Evaluation: _____ at risk counseled _____ at risk needs f/u _____ no current risk **Referred to:** _____

Provider Signature: _____ **Date:** _____

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