

# Adolescent and Young Adult Health Questionnaire (11-20 Years)

We ask every patient these questions about things that can affect their health and well-being. Some of the questions might not fit you. It is okay to leave some questions blank. Please answer these questions on your own and be as honest as possible. Your answers are private.

Your name: \_\_\_\_\_ What you like to be called: \_\_\_\_\_

Your gender identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Your sex assigned at birth (as on your original birth certificate): \_\_\_\_\_

Questions	Please circle your answer	Want more info?
1. In general, are you happy with the way things are going for you?	Yes Sometimes No	<input type="checkbox"/>
2. Do you wear a seat belt in a car/truck?	Yes Sometimes No	<input type="checkbox"/>
3. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile, or ATV?	Yes Sometimes No	<input type="checkbox"/>
4. Do you get along with your family?	Yes Unsure No	<input type="checkbox"/>
5. Do you have at least one adult you can really talk to?	Yes Unsure No	<input type="checkbox"/>
6. Do you feel safe at home, at school, and in your community?	Yes Unsure No	<input type="checkbox"/>
7. Do you get 60 minutes of physical activity most days of the week?	Yes Unsure No	<input type="checkbox"/>
8. Do you have any concerns about your height or weight?	Yes Unsure No	<input type="checkbox"/>
9. Do you ever skip meals, use laxatives or diet pills, or throw up on purpose to lose weight or to control your weight?	Yes Sometimes No	<input type="checkbox"/>
10. Have you missed more than 7 days of school in the last year?	Yes Unsure No	<input type="checkbox"/>
11. Are you facing difficulties in school?	Yes Unsure No	<input type="checkbox"/>
12. Have you had any stressful or scary events that still bother you?	Yes Unsure No	<input type="checkbox"/>
13. Do you worry about money, a place to live, food or clothing?	Yes Unsure No	<input type="checkbox"/>
14. Do you or anyone you live with have a gun or carry around a gun?	Yes Unsure No	<input type="checkbox"/>
15. Have you ever run away from home?	Yes Unsure No	<input type="checkbox"/>
16. Do you or the people who care about you worry about your online activities, social media, video and online games, app or screen time use?	Yes Unsure No	<input type="checkbox"/>

ADOLESCENT AND YOUNG ADULT HEALTH QUESTIONNAIRE

Your answers to the questions on this page are confidential between you and your health care provider. Your health care provider will only talk to your parent/guardian about this information if they have a serious concern about your health and safety. Before they talk to your parent/guardian, they will talk about it with you.

Confidential questions	Please circle your answer	Want more info?
17. Have you ever been involved in gang-related activities (now or in the past)?	Yes    Unsure    No	<input type="checkbox"/>
18. Have you ever hurt or cut yourself on purpose?	Yes    Unsure    No	<input type="checkbox"/>
19. Have you ever texted/sent or received a sexual message or picture?	Yes    Unsure    No	<input type="checkbox"/>
20. Have you ever had any kind of sex?	Yes    Unsure    No	<input type="checkbox"/>
21. Have you ever had an infection that is spread by having sex? (such as herpes, gonorrhea, chlamydia, genital warts, pelvic inflammatory disease, HIV, syphilis)	Yes    Unsure    No	<input type="checkbox"/>
22. Have you ever traded sex or sexual activity for money, food, a place to live, or anything else?	Yes    Unsure    No	<input type="checkbox"/>
23. Are you, or do you ever wonder if you are gay, lesbian, bisexual, pansexual, asexual, or queer?	Yes    Unsure    No	<input type="checkbox"/>
24. Are you, or do wonder if you are transgender, genderqueer, genderfluid, nonbinary, or a gender that is different from what you were called (boy or girl) at birth?	Yes    Unsure    No	<input type="checkbox"/>
25. Have you ever been physically, sexually, or emotionally abused or hurt by anyone? (such as kicked, hit, forced or tricked into having sex, touched in a way that made you feel uncomfortable, called worthless)	Yes    Unsure    No	<input type="checkbox"/>
26. Have you ever tried to kill yourself?	Yes    Unsure    No	<input type="checkbox"/>

If you could change one thing about your life or yourself, what would it be?

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What four words best describe you? \_\_\_\_\_

What do you want to get out of today's visit? \_\_\_\_\_

## Questions about tobacco, alcohol, marijuana, other drugs

In the PAST YEAR, how many times have you used:	Never	Once or twice	Monthly	Weekly
Tobacco: cigarettes, cigars, chew, or e-cigarettes or vapes, such as JUUL, suorin, blu, VUSE, or logic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you tried any other drugs for fun, curiosity or coping, such as prescription pills, drugs that you sniff or huff, salvia, K2, or other illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## You are done! Thank you!

For office use:

An option is to offer the complete [S2BI \(nida.nih.gov/s2bi\)](https://nida.nih.gov/s2bi) for validated substance use screening and recommendations based on results. These screening questions correspond to the brief office-based intervention algorithm for young people 9-18 years of age: [Alcohol Screening and Brief Intervention for Youth \(www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide\)](https://www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide).

NOTE: Standardized mental health screening is required for C&TC visits at 12-20 years of age. Refer to the [Mental Health Screening \(6-20 Years\) C&TC Fact Sheet \(www.health.state.mn.us/docs/people/childreneyouth/ctc/mentalhealth.pdf\)](https://www.health.state.mn.us/docs/people/childreneyouth/ctc/mentalhealth.pdf) for instrument and referral recommendations.

Form made available by:

Minnesota Department of Health  
 Child and Teen Checkups  
 651-201-3650  
[health.childteencheckups@state.mn.us](mailto:health.childteencheckups@state.mn.us)  
[www.health.state.mn.us](http://www.health.state.mn.us)

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To obtain this information in a different format, call: 651-201-3650.