RISK QUESTIONNAIRE 13-20 YEARS OLD

NAME_____DATE OF BIRTH_____ COMPLETED BY_____-

MENTAL HEALTH QUESTIONNAIRE

Check all answers that may apply:

Do you have trouble paying attention? ☐ Yes ☐ No

Do you often:

Feel distrustful of others …… ☐ Yes ☐ No

Have strange thoughts …… ☐ Yes ☐

Hear voices …… ☐ Yes ☐ No

Have to do things the same way or keep repeating them ……☐ Yes ☐ No

Do you have problems at school with:

Behavior ……☐ Yes ☐ No

Grades …… ☐ Yes ☐ No

Skipping classes …… ☐ Yes ☐ No

Do you worry about your:

Eating …… ☐ Yes ☐ No

Sleep …… ☐ Yes ☐ No

Weight ……☐ Yes ☐ No

Do you have trouble making or keeping friends? …… ☐ Yes ☐ No

Do you often feel:

Sad …… ☐ Yes ☐ No

Angry …… ☐ Yes ☐ No

Nervous or afraid …… ☐ Yes ☐ No

Have you thought about or done any of the following:

Destroy property ……☐ Yes ☐ No

Hurt animals …… ☐ Yes ☐ No

Set fire …… ☐ Yes ☐ No

Listen to music with violent message …… ☐ Yes ☐ No

Use alcohol ……☐ Yes ☐ No

Use drugs …… ☐ Yes ☐ No

Smoke cigarettes …… ☐ Yes ☐ No

Sex without protection…… ☐ Yes ☐ No

Suicide attempt …… ☐ Yes ☐ No

Is there a history of injuries, accidents? …… ☐ Yes ☐ No

If yes, please specify:

_____

Is there any history of maltreatment or abuse? … ☐ Yes ☐ No

If yes, please specify: _____

Is there a recent stress on the family or child such as :

Birth of a child …… ☐ Yes ☐ No

Moving …… ☐ Yes ☐ No

Divorce or separation …… ☐ Yes ☐ No

Death of a close relative …… ☐ Yes ☐ No

Fired or laid off …… ☐ Yes ☐ No

Legal problems …… ☐ Yes ☐ No

Others (Please specify): _____

Do you have other parenting concerns? ……☐ Yes ☐ No

Please specify:

_____

Provider: Give details of all **Positive** findings.

STD/HIV ASSESSMENT

Check all answers that may apply:

(12 years through 20 years)

1. ***Have you had a blood transfusion or are you a Hemophiliac? YES NO***
2. ***Have you ever been sexually molested or physically attacked? YES NO***
3. ***Have you ever been diagnosed with any sexually transmitted diseases? YES NO***
4. ***Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy? YES NO***
5. ***If sexually active, have you had unprotected sex, with opposite/same sex? YES NO***
6. ***If sexually active, have you had more than one partner? YES NO***
7. ***Any body tattoos or body piercing of ears, navel, etc, including any performed by friends? YES NO***

(A "yes" response to any question indicates a positive risk)

TUBERCULOSIS RISK ASSESSMENT

Starting at 1 year of age and annually thereafter

1. Has your child been exposed to anyone with a case of TB? YES NO
2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)? YES NO
3. Has your child, or a household member, lived more than a year in an area where TB is common? YES NO
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? YES NO
5. Does your child have HIV infection? YES NO

(A "yes" response to any question indicates a positive risk)

Heart Disease/Cholesterol Risk Assessment:

(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death? YES NO
2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher) YES NO

(**A "yes" response to <u>either</u> question 1 or 2 indicates a positive risk.)**

YES NO

3. Is the child/adolescent overweight? YES NO
4. And is there also a personal history of:
   - Smoking? YES NO
   - Lack of physical activity? YES NO
   - High blood pressure? YES NO
   - High cholesterol? YES NO
   - Diabetes mellitus? YES NO

(A "yes" response to <u>both</u> questions 3 and 4 indicates a positive risk)

Provider Signature_____ Date_____

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