Family Health Care
Adolescent Initial History
(Ages 13 – 17)

Dear Parent/Guardian,

Behavioral and emotional health is important to a person's overall health. That's why we have a Behavioral Health Team at our clinic. To help us best assess this critically important part of your teen's health, please fill out the following forms. Your answers will help us best support your teen and your family.

- **Middle-Older Adolescent Questionnaire** (2 pages): We ask that your teenager complete this form. Feel free to offer them help if they need it. If your teen is not willing or able to complete it, please do so for them. It asks about your teen's main areas of concern and symptoms.

- **The Child/Adolescent Psychiatry Screen – CAPS** (2 pages): We ask that you as the Parent/Guardian complete this one. This form lists 85 problems or behaviors that kids may experience and you are asked to check the category that best describes what is true of your child for each one.

Please complete both of these forms as completely and accurately as you can. Your counselor will ask for them and go over them with you during your first appointment. We find them very helpful in understanding you/your child's situation more quickly so we can better know how to start helping things improve.

If you have any questions or concerns, please call us at the clinic you are visiting:

- Cadillac (231)-775-6521
- Baldwin (231) 231-745-4624
- Grant (231) 834-0444
- White Cloud (231)-689-5943

Thank you,

The Behavioral Health Team

Confidential (Your answers will not be given out.)

Guidelines for Adolescent Preventive Services

Middle-Older Adolescent Questionnaire

Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School_____ Year in college_____ Sex: Male Female Age _____

Address_____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number_____

What languages are spoken where you live? _____Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Do you have any health problems? ☐ Yes ☐ No Problem(s) _____
3. Did you have any health problems in the past 12 months? ☐ Yes ☐ No Problem(s) _____
4. Are you taking any medicine now? ☐ Yes ☐ No Name of medicine _____

For Girls

5. Date when last period started_____ Are your periods regular (monthly)? ..... ☐ No ☐ Yes
   Month Date
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? ..... ☐ Yes ☐ No

Specific Health Issues

7. Please check whether you have questions or are worried about any of the following:

- ☐ Height/weight
- ☐ Blood pressure
- ☐ Diet/food/appetite
- ☐ Future plans/job
- ☐ Skin (rash, acne)
- ☐ Headaches/migraines
- ☐ Dizziness/fainting
- ☐ Eyes/vision
- ☐ Ears/hearing/ear aches
- ☐ Nose
- ☐ Lots of colds
- ☐ Mouth/teeth/breath
- ☐ Neck/back
- ☐ Chest pain/trouble breathing
- ☐ Coughing/wheezing
- ☐ Breasts
- ☐ Heart
- ☐ Stomach ache
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Muscle or joint pain in arms/legs
- ☐ Frequent or painful urination
- ☐ Discharge from penis or vagina
- ☐ Wetting the bed
- ☐ Sexual organs/genitals
- ☐ Menstruation/periods
- ☐ Wet dreams
- ☐ Physical or sexual abuse
- ☐ Masturbation
- ☐ HIV/AIDS
- ☐ Trouble sleeping
- ☐ Feeling tired a lot
- ☐ Cancer
- ☐ Dying
- ☐ Sad or crying a lot
- ☐ Stress
- ☐ Anger/temper
- ☐ Violence/personal safety
- ☐ Other (explain)

_____

_____

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

8. Are you satisfied with your eating habits? ..... ☐ No ☐ Yes
9. Do you ever eat in secret? ..... ☐ Yes ☐ No
10. Do you spend a lot of time thinking about ways to be thin? ..... ☐ Yes ☐ No
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ..... ☐ Yes ☐ No
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? ..... ☐ No ☐ Yes

School

13. Are your grades this year worse than last year? ..... ☐ Yes ☐ No ☐ Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? ..... ☐ Yes ☐ No
15. Have you been suspended from school this year? ..... ☐ Yes ☐ No ☐ Not in school

Friends & Family

16. Do you have at least one friend who you really like and feel you can talk to? ..... ☐ No ☐ Yes
17. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ..... ☐ No ☐ Yes
18. Have you ever thought seriously about running away from home? ..... ☐ Yes ☐ No ☐ Not sure

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Weapons/Violence/Safety

19. Do you or anyone you live with have a gun, rifle, or other firearm? ☐ Yes ☐ No ☐ Not sure
20. In the past year, have you carried a gun, knife, club, or other weapon for protection? ☐ Yes ☐ No
21. Have you been in a physical fight during the *past 3 months*? ☐ Yes ☐ No
22. Have you ever been in trouble with the law? ☐ Yes ☐ No
23. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not sure
24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle , motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? ☐ No ☐ Yes
25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? ☐ No ☐ Yes

Tobacco

26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
26. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No

Alcohol

29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
31. Have you ever been criticized or gotten into trouble because of drinking? ☐ Yes ☐ No ☐ Not sure
32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? ☐ Yes ☐ No ☐ Does not apply
33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? ☐ Yes ☐ No
34. Does anyone in your family drink or take drugs so much that it worries you? ☐ Yes ☐ No

Drugs

35. Do you ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) ☐ Yes ☐ No
38. Have you ever used steroid pills or shots without a doctor telling you to? ☐ Yes ☐ No ☐ Not sure

Development

39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ☐ Yes ☐ No ☐ Not sure
40. Do you think you may be gay, lesbian, or bisexual? ☐ Yes ☐ No ☐ Not sure
41. Have you ever had sexual intercourse? (How old were you the first time?_____) ☐ Yes ☐ No ☐ Not sure
42. Are you using a method to prevent pregnancy? (Which:_____) ☐ No ☐ Yes ☐ Not active
43. Do you and your partner(s) *always* use condoms when you have sex? ☐ No ☐ Yes ☐ Not active
44. Have any of your close friends ever had sexual intercourse? ☐ Yes ☐ No ☐ Not sure
45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? ☐ Yes ☐ No ☐ Not sure
46. Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No ☐ Not sure
47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? ☐ Yes ☐ No ☐ Not sure
48. Would you like to know how to avoid getting HIV/AIDS? ☐ Yes ☐ No ☐ Not sure
49. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No ☐ Thinking about it

Emotions

50. Have you had fun during the past two weeks? ☐ No ☐ Yes
51. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? ☐ Yes ☐ No
52. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? ☐ Yes ☐ No
53. Have you ever been physically, sexually, or emotionally abused? ☐ Yes ☐ No ☐ Not sure
54. When you get angry, do you do violent things? ☐ Yes ☐ No
55. Would you like to get counseling about something you have on your mind? ☐ Yes ☐ No ☐ Not sure

Special Circumstances

56. In the past year, have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not sure
57. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
58. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

59. What four words best describe you? _____
60. If you could change one thing about your life or yourself, what would it be? _____

_____

61. What do you want to talk about today? _____

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