Pediatric Health Care Alliance, P.A.

Patient Information for Pediatric Visits for 12 -18 Year-Old Adolescents

Because of our respect for you, as a young adult, we would like to offer you time to discuss issues with your doctor without your parent's presence. Your parent/guardian has agreed to allow you this opportunity. We will make efforts as allowed by law to maintain the confidentiality of your information, but it is important for you to know that there are certain times when we may be required to share information contained in this form with others based on the laws that apply to us. In addition, if we become concerned that you are going to hurt yourself or someone else, these matters may be discussed with your parents/legal guardians. Let your doctor or nurse know if you have questions about the privacy of the information related to this form. We do encourage you to discuss most issues openly with your family and hope to help you think of ways to do this.

	Yes	No
1. Do you now, or have you in the past smoked cigarettes, cigars, pipes, e-cigarettes or chewed tobacco?	☐	☐
2. Do you now, or have you in the past used illegal drugs (including marijuana)?	☐	☐
3. Do you sniff anything to get "high"?	☐	☐
4. Do you drink alcohol?	☐	☐
5. Are you attracted to boys, girls, both, or neither?	☐	☐
6. Are you having sex now or have you in the past had sex with anyone? If so, was this with your consent, something you wanted? Are you using any kind of birth control (condoms, etc.)?	☐	☐
7. During the past month, have you... … been bothered by feeling down, depressed, or hopeless? *If yes, complete screening A on following page* …often been bothered by little interest or pleasure in doing things? *If yes, complete screening A on following page*	☐ ☐	☐ ☐
8. Do you ever have thoughts of suicide?		
Do you feel anxious? *If yes, complete screening B on following page*		
Is anyone harming you?		
Do you have any concerns about your current weight?		
Do you have any issues you would like to discuss confidentially with your doctor?		

Which of the above are your parents aware of? _____

Is there a private number where you can be reached? _____

Name three things you like about yourself: _____

_____

_____

Your Signature: Date:

Screening A

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom, circle the answer that best describes how you have been feeling.

	0 Not at all	I Several days	II More than half of days	III Nearly every day
1. Feeling down, depressed, irritable or hopeless?	0	I	II	III
2. Little interest or pleasure in doing things?	0	I	II	III
3. Trouble falling asleep, staying asleep or sleeping too much?	0	I	II	III
4. Poor appetite, weight loss or overeating?	0	I	II	III
5. Feeling tired or having little energy?	0	I	II	III
6. Feeling bad about yourself-or feeling that you are a failure or that you have let yourself or your family down?	0	I	II	III
7. Trouble concentrating on things like school work, reading or watching TV?	0	I	II	III
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you were moving around a lot more than usual?	0	I	II	III
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0	I	II	III

Screening B

Instructions: Over the last 2 weeks, how often have you been bothered by the following problems? For each symptom, circle the answer that best describes how you have been feeling.

	0 Not at all	I Several days	II Over half of days	III Nearly every day
1. Feeling nervous, anxious, or on edge	0	I	II	III
2. Not being able to stop or control worrying	0	I	II	III
3. Worrying too much about different things	0	I	II	III
4. Trouble relaxing	0	I	II	III
5. Being so restless that it's hard to sit still	0	I	II	III
6. Becoming easily annoyed or irritable	0	I	II	III
7. Feeling afraid as if something awful might happen	0	I	II	III

***If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult