Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

Teen (14 Years+) Observations

Please have teen fill out, if possible:

Are there any concerns you would like to discuss today?_____

_____

Activities/interests:

How active are you? ☐ very active ☐ fairly active ☐ occasionally active ☐ little/none

List any extracurricular activities (i.e. a sport, dance): _____

List any interests (i.e. instrument, art, playing outside): _____

How much screen time (TV/tablet/phone/video games) do you have per day? _____

Do your parents monitor your electronic use and social media? Yes No

Diet/Physical Development/Sleep:

Does you eat a well-balanced diet (includes vegetables, fruits, proteins)? Yes No

Do you eat at least 3 servings of calcium (i.e. milk, cheese, yogurt)? Yes No

What do you usually drink? ☐ water ☐ milk ☐ juice ☐ soda/caffeinated drinks

Do you have any concerns about puberty or your sexuality? Yes No

Do you have any concerns about your appearance or figure? Yes No

FEMALES: Started your period? Yes No If yes, any problems? Yes No

Does you have any problems with sleep? Yes No

On average, how many hours of sleep do you get a night? _____

School:

What school do you child attend?_____ Grade _____

What grades do you usually get? _____ Any honors/AP classes? Yes No

What do you want to do after high school/college? _____

Do you have any problems with bullying/cyberbullying? Yes No

Social/Behavior:

Are there any family or home issues we should discuss? Yes No

Do you have any problems getting along with your parents and/or siblings? Yes No

Do you have any concerns about depression, anxiety or mood swings? Yes No

Do you feel you handle stress well? Yes No

Do you have close friends? Yes No

Are you exposed to: ☐ smoking ☐ alcohol ☐ drugs Do you use any? Yes No

Safety/Preventative Health:

Does your always buckle your seatbelt? Yes No

If you have your license, do you ever use your phone while driving? Yes No

Does you always wear a helmet when riding bike/skiing/etc? Yes No

Have you gone to the dentist in the past 6 months? Yes No

Do you own a gun? Yes No If yes, is it stored safely (i.e. locked case)? Yes No

Are your immunizations up to date? Yes No

Does you have any allergies (that you know of)? Yes No

Please list any medications or supplements you took this week: _____

_____