wasatch pediatrics | ST. MARK'S

PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

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 electronics use and social media? .....YES NO

Diet/Physical development/Sleep:

Do 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

Do 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 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 today? .....YES NO

Do you have 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:

Do you always buckle your seatbelt? .....YES NO

If you have your license, do you ever use your phone while driving? .....YES NO

Do you always wear a helmet when riding a 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

Do you have any allergies (that you know of)? .....YES NO

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

*Have you wished you were dead or wished you could go to sleep and not wake up? .....YES NO

*Have you had any actual thoughts of killing yourself? .....YES NO

If you answered "YES" to the last 2 questions, please see more questions on back of page

Have you been thinking about how you might do this? ……..YES NO
e.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it"

Have you had these thoughts and had some intention of acting on them? ……YES NO
as opposed to "I have the thoughts but I definitely will not do anything about them"

Have you started to work out or worked out the details of how to kill yourself? ……YES NO
Do you intend to carry out this plan? ……..YES NO

Have you ever done anything, started to do anything, or prepared to do anything to end your life? ……..YES NO
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took the pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If YES: Was this within the past 3 months? ……YES NO