10 Question Teen Screen

Name: _____ Birthdate: _____

Adolescent Health Screen
Please Answer Yes or No

1. Do you wear a seat belt and a bike helmet?	YES	NO
2. Have you had all recommended immunization?	YES	NO
3. Do you smoke or chew tobacco?	YES	NO
4. Do you drink alcohol (beer, wine, or hard alcohol)?	YES	NO
5. Have you tried drugs (marijuana, speed, cocaine/crack, or acid)?	YES	NO
6. Have you had sex (intercourse, "done it")?	YES	NO
7. Have you had an infection from sex (STD or VD)?	YES	NO
8. Have you ever thought of suicide?	YES	NO
9. Has anyone ever hurt you physically or sexually?	YES	NO
10. Are you having problems getting along with your family?	YES	NO

Concerns you want to discuss:

_____

_____

_____