



TEEN QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____

We encourage parents to empower their teens by allowing them to develop honest and confidential relationships with their healthcare providers. It is our policy to encourage open and nonjudgmental communication between youth and their parents during the course of our visits on matters relevant to their health and well-being. Please understand that sometimes having a safe place to disclose sensitive information or ask questions is also essential to the health and well-being of teens, and as such we will honor minor adolescents' needs for confidentiality to the limits of state law. When possible, we encourage patients to complete these forms independently and return them privately.

Date of Birth: _____

Grade in School: _____

EDUCATIONAL & EXTRACURRICULAR LIFE

Current school _____

Current job _____

Have you ever repeated a grade in school? ___ yes ___ no

What grades do you usually get in school? (check all that apply).

___ As ___ Bs ___ Cs ___ Ds ___ Fs

Are you comfortable with how you do in school? ___ yes ___ no ___ not sure

List activities, clubs, hobbies, volunteer work, jobs, religious activities: _____

HOME LIFE

With whom do you live most of the time:

___ Both parents ___ Mother ___ Father Other _____

Are your Parents:

___ married ___ divorced ___ separated

___ parents were never married ___ one parent has died ___ both parents have died

Do you live in more than one home? ___ no ___ yes

If yes, primary custody ___ mother ___ father ___ shared

Ages and names of sisters or step-sisters: _____

Ages and names of brothers or step-brothers: _____

Job status	Job Title	Full Time	Part time
Mother	_____	_____	_____
Father	_____	_____	_____
Step-father	_____	_____	_____
Step-mother	_____	_____	_____

RECENT CHANGES OR STRESSORS

____ Move to new home ____ Parent loss of a job ____ Change in living situation
____ Death in family ____ Move to new school ____ Parent separation or divorce
____ Major illness in family member ____ Death of a friend Other: _____

YOUR EATING HABITS...WHEN, WHY, AND WHAT?

During the past week, how many days did you eat breakfast?

____ never ____ 1-2 days ____ 3-4 days ____ 5-6 days ____ every day

During the past week, how many days did you eat lunch?

____ never ____ 1-2 days ____ 3-4 days ____ 5-6 days ____ every day

During the past week, how many days did you eat dinner?

____ never ____ 1-2 days ____ 3-4 days ____ 5-6 days ____ every day

In the past week, how often did you eat something from a fast food restaurant (like McDonald's, Burger King, etc.)?

____ never ____ 1-2 days ____ 3-4 days ____ 5-6 days ____ every day

How many times did you snack (eat in-between meals) yesterday?

____ never ____ 1-2 days ____ 3-4 days ____ 5-6 days ____ more than 5 times

How much do you care about:

	Not all	A little bit	Somewhat	Very much
a) eating healthy food?	1	2	3	4
b) controlling your weight?	1	2	3	4
c) staying fit and exercising?	1	2	3	4
d) being healthy?	1	2	3	4

	Not all	A little bit	Somewhat	Very much
e) how you look?	1	2	3	4
f) doing well in sports?	1	2	3	4
g) doing well in school?	1	2	3	4

How do you feel about the following statements?

	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Teenagers need to be concerned about their eating habits	1	2	3	4
b) At this point in my life, I am very concerned about my health	1	2	3	4
c) Teenagers need to worry about their health	1	2	3	4
d) Eating healthy meals just takes too much time	1	2	3	4
e) Most vegetables taste bad	1	2	3	4
f) I sometimes skip meals since I am concerned about my weight	1	2	3	4
g) Most healthy foods just don't taste that great	1	2	3	4
h) I weigh myself often	1	2	3	4
i) Foods from fast food restaurants are generally unhealthy	1	2	3	4

How often are the following true?

	Never	Sometimes	Usually	Always
a) Fruits and vegetables are available in my home.	1	2	3	4
b) Vegetables are served at dinner in my home.	1	2	3	4
c) We have 'junk food' in my home.	1	2	3	4
d) Fruit juice is available in my home.	1	2	3	4
e) Milk is served at meals in my home.	1	2	3	4
f) Potato chips or other salty snack foods are available in my home.	1	2	3	4

	Never	Sometimes	Usually	Always
g) Chocolate or other candy is available in my home.	1	2	3	4
h) Soda pop is available in my home.	1	2	3	4
i) Dark bread (i.e. whole wheat) is available in my home.	1	2	3	4

If you wanted to, how sure are you that you could eat healthy foods when you are:

	Not at all sure					Very sure
Stressed out	1	2	3	4	5	6
Feeling down	1	2	3	4	5	6
Bored	1	2	3	4	5	6

How often have you gone on a diet during the last year?

By "diet" we mean changing the way you eat so you can lose weight.

never 1-4 times 5-10 times more than 10 times I am always dieting

Are you currently trying to: lose weight stay the same weight gain weight
 I am not trying to do anything about my weight

Have you ever intentionally lost 10 pounds or more and kept it off for at least 6 months?

yes no

Have you done any of the following things in order to lose weight or keep from gaining weight during the past year?

	Yes	No
exercised	_____	_____
fasted	_____	_____
ate very little food	_____	_____
took diet pills	_____	_____
made myself vomit (throw up)	_____	_____
used laxatives	_____	_____
used diuretics (water pills)	_____	_____
used food substitute (powder/ special drink)	_____	_____
skipped meals	_____	_____
ate more fruits and vegetables	_____	_____
ate less high-fat foods	_____	_____
ate less sweets	_____	_____

	Yes	No
smoked more cigarettes	_____	_____
followed a high protein/ low carbohydrate diet (e.g. Atkins)	_____	_____
limited food from fast food restaurants	_____	_____

In the past year, have you had any of the following eating disorders? (Mark all that apply).
 ___ anorexia nervosa ___ bulimia nervosa ___ binge eating disorder ___ none of the above

Has a doctor ever told you that you have an eating disorder such as anorexia nervosa bulimia nervosa, or binge eating disorder? ___ yes ___ no

In the past year, have you ever eaten so much food in a short period of time that you would be embarrassed if others saw you (binge-eating)? ___ yes ___ no

If your answer is NO, skip the next 3 questions.

- 1) During the times when you ate this way, did you feel you couldn't stop eating or control what or how much you were eating? ___ yes ___ no
- 2) How often, on average, did you have times when you ate this way, that is, large amounts of food plus the feeling that your eating was out of control?
 ___ nearly every day ___ a few times a week ___ a few times a month
 ___ less than once a month
- 3) In general, how upset were you by overeating (eating more than you think is best for you)?
 ___ not at all ___ a little ___ some ___ a lot

If your answer was yes, continue here.

Have you ever been a vegetarian? ___ yes ___ no
 ___ but for less than one month ___ yes, for longer than one month

Are you a vegetarian now ? ___ yes ___ no

If your answer is NO, skip the next 3 questions.

- 1) About how long have you been a vegetarian ?
 ___ less than one month ___ less than 1 year (but more than 1 month)
 ___ 1-2 years ___ 3-4 years ___ 5 years or more

2) As a vegetarian, do you eat any of the following ? ___ yes ___ no
 ___ Eggs ___ Dairy food (such as milk, cheese) ___ Chicken ___ Fish

3) What are your main reason(s) for eating a vegetarian diet ? (Mark all that apply.)
 ___ to lose weight or keep from gaining weight ___ want a healthier diet
 ___ to help the environment ___ religious reasons ___ do not want to kill animals
 ___ a family member is a vegetarian ___ I don't like the taste of meat
 ___ I don't like fat in meat ___ other (please specify) _____

FAMILY AND FRIENDS MAY AFFECT YOUR EATING HABITS, SO WE'D LIKE TO KNOW MORE ABOUT THEM

During the past seven days, how many times did all, or most, of your family living in your house eat a meal together?

___ never ___ 1-2 times ___ 3-4 times ___ 5-6 times ___ 7 times ___ more than 7 times

Many of my friends:

	Not at all	A little	Somewhat	Very much	I don't know
Care about eating healthy foods	1	2	3	4	5
Care about staying fit and exercising	1	2	3	4	5
Diet to lose weight or keep from gaining weight	1	2	3	4	5

How much do you feel you can talk to your mother about your problems?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

How much do you think your mother listens to you and takes your feelings seriously?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

How much do you feel your mother cares about you?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

Compared to other mothers, how strict would you say your mother is with you?

___ much less strict ___ somewhat less strict ___ about the same
 ___ somewhat more strict ___ much more strict

My mother:

	Not at all	A little	Somewhat	Very much
Cares about eating healthy food	1	2	3	4
Cares about staying fit and exercising	1	2	3	4
Diets to lose weight or keep from gaining weight	1	2	3	4
Encourages me to eat healthy foods	1	2	3	4
Encourages me to be physically active	1	2	3	4
Encourages me to diet to control my weight	1	2	3	4

How much do you feel you can talk to your father about your problems?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

How much do you think your father listens to you and takes your feelings seriously?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

How much do you feel your father cares about you?

___ not at all ___ a little ___ somewhat ___ quite a bit ___ very much

Compared to other fathers, how strict would you say your father is with you?

___ much less strict ___ somewhat less strict ___ about the same
___ somewhat more strict ___ much more strict

My father:

	Not at all	A little	Somewhat	Very much
Cares about eating healthy food	1	2	3	4
Cares about staying fit and exercising	1	2	3	4
Diets to lose weight or keep from gaining weight	1	2	3	4
Encourages me to eat healthy foods	1	2	3	4
Encourages me to be physically active	1	2	3	4
Encourages me to diet to control my weight	1	2	3	4

How strongly do you agree with the following statements about mealtimes in your family?

a) In my family, it is important that the family eat at least one meal a day together.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

b) In my family, mealtime is a time for talking with other family members.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

c) In my family, it is often difficult to find a time when family members can sit down to a meal together.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

d) In my family, we often watch TV while eating dinner.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

e) Mealtime in my family is generally pleasant and enjoyable.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

f) Manners are important at our dinner table.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

g) I am often just too busy to eat dinner with my family.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

h) In my family, a child should eat all the foods served even if he/she doesn't like them.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

i) In my family, we don't have to eat meals at the kitchen/dining room table.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

j) In my family, it is ok for a child to make something else to eat if he/she doesn't like the food being served.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

How strongly do you agree with the following statements?

a) It is hard to find time to sit down and eat a meal.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

b) I tend to "eat on the run".

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

c) Regular meals are important to me.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

d) I eat meals at about the same time every day.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

How would you describe your health?

poor fair good excellent

How tall are you ? feet inches

How much do you weight? pounds

At what weight do you think you would look best? pounds

How satisfied are you with your:

	Very dissatisfied				Very satisfied
Height	1	2	3	4	5
Weight	1	2	3	4	5
Body shape	1	2	3	4	5
Waist	1	2	3	4	5
Hips	1	2	3	4	5
Thighs	1	2	3	4	5
Stomach	1	2	3	4	5
Face	1	2	3	4	5
Body build	1	2	3	4	5
Shoulders	1	2	3	4	5

During the past six months, how important has your weight or shape been in how you feel about yourself ?

Weight and shape were not very important.

Weight and shape played a part in how I felt about myself.

Weight and shape were among the main things that affected how I felt about myself.

Weight and shape were the most important things that affected how I felt about myself.

At this time, do you feel that you are:

very underweight somewhat underweight about the right weight

somewhat overweight very overweight

Do you have a physical or health condition that makes it hard for you to do some things other kids your age do? (like concentrating in school, doing sports, or eating like other teenagers).

yes no

WHAT KIND OF SPORTS DO YOU PARTICIPATE IN?

In a usual week, how many hours do you spend doing the following activities :

Strenuous exercise (heart beats rapidly). Examples: biking fast, aerobic dancing, running, jogging, swimming laps, rollerblading, skating, lacrosse, tennis, cross country skiing, soccer, basketball, football

___ none ___ less than ½ hr a week ___ 1/2-2 hrs a week
___ 2 ½ - 4 hrs a week ___ 4 ½ - 6 hrs a week ___ 6+hrs a week

Moderate exercise (not exhausting). Examples: walking quickly, baseball, gymnastics, easy bicycling, volleyball, skiing, dancing, skateboarding, snowboarding

___ none ___ less than ½ hr a week ___ 1/2-2 hrs a week
___ 2 ½ - 4 hrs a week ___ 4 ½ - 6 hrs a week ___ 6+hrs a week

Mild exercise (little effort). Examples: Walking slowly (to school, to friend's house, etc.), bowling, golf, fishing, yoga

___ none ___ less than ½ hr a week ___ 1/2-2 hrs a week
___ 2 ½ - 4 hrs a week ___ 4 ½ - 6 hrs a week ___ 6+hrs a week

Are you in a sport or activity where it's important to stay a certain weight (i.e. wrestling, gymnastics, ballet, etc.)? ___ yes ___ no

During the past 12 months, on how many sports teams did you play ?

___ teams ___ 1 team ___ 2 teams ___ 3 or more teams

In your free time ON AN AVERAGE WEEKDAY (Monday-Friday), how many hours do you spend:

	0 hr	½ hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV/playstation/Wii, etc.	___	___	___	___	___	___	___
reading and doing homework	___	___	___	___	___	___	___
Using a computer or other electronic devices, not for homework	___	___	___	___	___	___	___

ON AN AVERAGE WEEKEND DAY (Saturday or Sunday), how many hours do you spend:

	0 hr	½ hr	1 hr	2 hr	3 hr	4 hr	5+hr
Watching TV/playstation/Wii, etc.	___	___	___	___	___	___	___
reading and doing homework	___	___	___	___	___	___	___
Using a computer or other electronic devices, not for homework	___	___	___	___	___	___	___

How often do you read magazine articles in which dieting or weight loss are discussed?

never hardly ever sometimes often

Do you have a television in the room where you sleep? yes no

How often do you watch television while eating meals?

always usually sometimes rarely never

How often do you snack while watching TV?

always usually sometimes rarely never

How much do you agree or disagree with the following?

a) I compare my body to the bodies of TV and movie stars.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

b) I compare my body to the bodies of people who appear in magazines.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

c) I would like my body to look like the people who are on TV.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

d) I would like my body to look like the models who appear in magazines.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

SOMETIMES, OTHER THINGS GOING ON IN YOUR LIFE CAN AFFECT THE WAY YOU EAT.
REMEMBER, YOUR RESPONSES WILL BE KEPT CONFIDENTIAL, SO PLEASE ANSWER AS HONESTLY
AS POSSIBLE.

What do you typically do to relieve stress? _____

During the past 12 months, how often have you been bothered or troubled by:

	Not all	A little bit	Somewhat
a) feeling too tired to do things	1	2	3
b) having trouble going to sleep or staying asleep	1	2	3
c) feeling unhappy, sad, or depressed	1	2	3

	Not all	A little bit	Somewhat
d) feeling hopeless about the future	1	2	3
e) feeling nervous or tense	1	2	3
f) worrying too much about things	1	2	3
g) changes in your appetite	1	2	3
h) feeling angry or irritable with family or close friends	1	2	3

Do you have one or more close friends who you can talk to about your problems?

yes, always yes, sometimes no

Do your parents/guardians like your friends? yes no not sure

If we were only talking about your safety, would you say your friends are good for you?

yes no not sure

Have you ever thought about killing yourself ?

yes, during the past year yes, more than a year ago no

Has anyone ever abused you before?

	Yes	No	Not sure
Emotionally or verbally	1	2	3
Sexually	1	2	3
Physically	1	2	3

How often do any of the following things happen?

You are treated with less respect than other people.

Never Less than once a year A few times a year
 A few times a month At least once a week

People act as if they're better than you are.

Never Less than once a year A few times a year
 A few times a month At least once a week

You are called names or insulted.

Never Less than once a year A few times a year
 A few times a month At least once a week

You are teased about your appearance.

Never Less than once a year A few times a year
 A few times a month At least once a week

You are teased about your weight.

Never Less than once a year A few times a year
 A few times a month At least once a week

You have teased others about their appearance or weight.

Never Less than once a year A few times a year
 A few times a month At least once a week

How often have you used the following during the past year (12 months)?

Cigarettes

Never A few times Monthly Weekly Daily

Beer, wine, hard liquors

Never A few times Monthly Weekly Daily

Marijuana

Never A few times Monthly Weekly Daily

Drugs other than marijuana (acid, cocaine, crack, ecstasy, etc.)

Never A few times Monthly Weekly Daily

Does anyone in your family drink or use drugs so much it worries you ? yes no

How often have you used steroids in order to gain muscle during the past year (12 months) ?

never a few times monthly weekly daily

Indicate how strongly you agree with the following statements.

On the whole, I am satisfied with myself.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

I feel that I have a number of good qualities.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

At times I think I am no good at all.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

I am able to do things as well as most other people.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

I wish I could have more respect for myself.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

I certainly feel useless at times.

___ Strongly disagree ___ Somewhat disagree ___ Somewhat agree ___ Strongly agree

Have any of your close friends ever had sexual intercourse? ___ yes ___ no ___ not sure

Have you ever been in a romantic or physical relationship? ___ yes ___ no ___ not sure

Do you think you may be gay, lesbian, or bisexual? ___ yes ___ no ___ not sure

Do you feel safe in your relationships? ___ yes ___ no ___ not sure

Explain : _____

Have you ever had any kind of sexual activity (i.e. vaginal intercourse, oral sex, or anal sex)?

___ yes ___ no ___ not sure

Has anyone ever forced you to have sex you did not want to have?

___ yes ___ no ___ not sure

WE WANT TO KNOW ABOUT YOUR BODY

If female, have you experienced menstruation? ___ yes ___ no ___ not sure

How old were you when you first menstruated? ___ years

Would you describe your periods as : ___ regular or ___ irregular

If you checked "irregular", can you describe what that means to you? _____

Have you experienced any of the following within the last six months:

	Yes	No
Blurry vision	_____	_____
Headaches	_____	_____
Nasal congestion/allergies	_____	_____
Snoring	_____	_____
Sleep apnea (pauses in breathing during sleep)	_____	_____
Significant daytime sleepiness	_____	_____
Dental caries/ cavities	_____	_____
Acne	_____	_____
Eczema (skin allergies)	_____	_____
Excess hair growth on skin	_____	_____

HOW CONFIDENT ARE YOU THAT YOU CAN SUCCEED?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Somewhat confident

Very confident

THANK YOU SO MUCH FOR YOUR PATIENCE IN ANSWERING THESE QUESTIONS AS WELL AS YOUR HONESTY.

Is there anything else we should know about you? _____
