Welcome to Cape Fear Pediatrics! This information is strictly **Confidential** Its purpose is to give you better care.

Today's Date: ________________ **What county do you live in?** ________________________

Why did you come here today? ____

There are many things people think about, but have a hard time asking. It might be easier if you just check any item you would be interested in asking or learning about. Do you think anything could be wrong with your:

☐ Height ☐ Weight ☐ Head ☐ Eyes ☐ Back
☐ Appearance ☐ Ears ☐ Nose ☐ Mouth ☐ Teeth
☐ Neck ☐ Chest ☐ Breasts ☐ Heart ☐ Stomach
☐ Skin ☐ Sex Organs ☐ Mind/Thinking ☐ Lungs ☐ Arms/Legs/Hands/Feet

Do you have questions about:

☐ Smoking ☐ Having Children ☐ Exercise ☐ Your Future ☐ Menstrual Periods
☐ Dating ☐ Masturbation ☐ Habits ☐ Drugs/Alcohol ☐ Dying
☐ Pregnancy ☐ Homosexuality ☐ Diet/Foods ☐ Jobs ☐ Birth Control
☐ Sex ☐ Sexual identity ☐ Sexually Transmitted Diseases ☐ Nutrition

Do you have any problems with:

☐ Friends ☐ Brothers/Sisters ☐ Parents/Family ☐ Nutrition ☐ Privacy
☐ Grades ☐ Teachers ☐ Ability to Learn ☐ Others at School ☐ Eating
☐ Sleeping ☐ Gangs ☐ Drugs ☐ Feeling Unsafe ☐ Weight
☐ Family/Friends who drink too much ☐ Body Hygiene ☐ Sex/Sexuality ☐ Other: _______

EDUCATIONAL INFORMATION

Have you ever been suspended? .... ☐ NO ☐ YES
Have you dropped out of school in the last year? .... ☐ NO ☐ YES
Do you plan to graduate or have you already graduated from high school? .... ☐ YES ☐ NO
If no, do you plan to get a GED? .... ☐ YES ☐ NO
If not graduated from high school, do you plan to attend college or a technical school? .... ☐ YES ☐ NO
School Name ______________________ Grade _________ ☐ College ☐ Getting GED ☐ Not in School

If not in school, please skip down to the **JOB/CAREER SECTION**

What grade do you usually make in .... English? ________________ Math? ____________________
Are you failing any of your classes? .... ☐ NO ☐ YES
How many days were you absent last semester? .... ____________
How many days would you say you were absent due to illness? .... ____________
How do you get along in school? (Please circle a number) (Terrible) 1 2 3 4 5 (Great)

JOB/CAREER INFORMATION

Are you currently working? ☐ Yes ☐ No If yes, where? ____________________ Hours per week?__________
What are your future plans/career goals? ____

FAMILY INFORMATION

Have there been any changes in the past year in your family such as: (Check all that apply)

☐ Marriage ☐ Deaths ☐ Divorce ☐ Serious Illness ☐ Births ☐ Separation
☐ Loss of Job ☐ Move to a new house ☐ Out of Home Placement ☐ Other: __________________

How do you get along at home? (Please circle) (Terrible) 1 2 3 4 5 (Great)
Are there family problems or issues you would like to talk about? .... ☐ NO ☐ YES

(OVER)

SELF INFORMATION

Have you ever been abused, hit, or beaten by anyone? ☐ NO ☐ YES

Have you been abused, hit, or beaten by anyone in the past 12 months? ☐ NO ☐ YES

What other places do you go for health care or counseling? ______________________

Are you currently receiving or have you recently received mental health care or counseling? ☐ NO ☐ YES

When was your last: Dental exam? __________ Eye exam? __________ Physical exam? __________

How well do you like yourself? (Please circle a number): (Not much) 1 2 3 4 5 (A Lot!)

Do you have friends you can count on? ☐ YES ☐ NO

Do you have family you can count on? ☐ YES ☐ NO

Have you ever felt sad/depressed for a two-week period? ☐ NO ☐ YES

Have you felt sad/depressed for a two-week period in the last 12 months? ☐ NO ☐ YES

Have you thought about suicide? ☐ NO ☐ YES

Have you attempted suicide? ☐ NO ☐ YES

Have you ever been in a serious fight? ☐ NO ☐ YES

Have you been in a serious fight in the last 12 months? ☐ NO ☐ YES

Do you think you have problems controlling your anger? ☐ NO ☐ YES

Have you threatened someone with a weapon in the past 12 months? ☐ NO ☐ YES

Have you been threatened with a weapon in the past 12 months? ☐ NO ☐ YES

Do you carry a weapon? ☐ NO ☐ YES

Are you a member of a gang? ☐ NO ☐ YES

Have you been in trouble with the police/arrested in the past 12 months? ☐ NO ☐ YES

HEALTH BEHAVIOR INFORMATION

Do you wear your seatbelt? ☐ YES ☐ NO

Do you wear a helmet when bicycling or skating? ☐ YES ☐ NO

Have you drank alcohol or taken other judgment altering substances and driven in the past 12 months? ☐ NO ☐ YES

Have you smoked or used tobacco products in the last 12 months? ☐ NO ☐ YES

Have you used any of the following in the last twelve months? (Check all that apply)

☐ Laxatives ☐ Pain pills ☐ No Doz ☐ Sleeping pills ☐ Water pills ☐ Diet pills ☐ Marijuana

☐ Speed ☐ Heroin ☐ Cocaine ☐ Ritalin ☐ Inhalants ☐ Acid ☐ Steroids

☐ Beer/Wine ☐ Liquor ☐ Intravenous drugs __________ ☐ Other: __________

Do you currently have a boy/girlfriend? ☐ NO ☐ YES

If yes, how old is he/she? __________

Have you ever felt pressured to have sex? ☐ NO ☐ YES

Have you felt pressured to have sex in the last 12 months? ☐ NO ☐ YES

Have you ever had sex? ☐ NO ☐ YES

If yes, how old were you when you had sex the first time? __________

Have you had sex in the past 12 months? ☐ NO ☐ YES

If yes, how often did you or your partner use birth control? (check one) ☐ Every time ☐ Sometimes ☐ Never

If yes, what kind of birth control have you and your partner used? (Check all that apply)

☐ Not currently having sex ☐ Rhythm ☐ Foam ☐ Withdrawal

☐ Diaphragm ☐ Condoms ☐ Pill/Depo ☐ IUD ☐ Other: __________

Have you ever received medical care for a sexually transmitted disease (STD)? ☐ NO ☐ YES

Have you received medical care for a sexually transmitted disease (STD) in the past 12 months? ☐ NO ☐ YES

FOR FEMALE PATIENTS ONLY

Have you ever been pregnant? ☐ NO ☐ YES

If yes, how old were you when you were pregnant? __________

FOR MALE PATIENTS ONLY

Have you ever gotten anyone pregnant? ☐ NO ☐ YES

If yes, how old were you when you got someone pregnant? __________