18-21 Year Pre-Visit Questionnaire

Instructions: *Please answer the questions below by circling or putting an X on the correct choice. These questions help us assess your health, development, and safety.*

General Health

1	Do you have any concerns about your health today?	NO	YES
2	Do you receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

3	Do you eat 5 or more helpings of fruits/vegetables each day?	YES	NO
4	When you eat grains (cereal, bread, pasta, crackers, waffles, rice, etc.), are the mostly whole grains?	YES	NO
5	Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
6	Do you eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than two to three times per week?	NO	YES
7	Do you snack more than 1-2 times a day on foods other than fruits and vegetables?	NO	YES
8	Do you drink soda, juice or other sweetened drinks more than once or twice per week?	NO	YES
9	Do you have any concerns or questions about the size or shape of your body?	NO	YES
10	In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	NO	YES
11	Are you taking any vitamins or supplements?	NO	YES

Oral Health

12	Do you see a dentist at least twice a year?	YES	NO

Activity

13	Do you play any competitive sports?	NO	YES
14	Is there any family history of heart problems or sudden death?	NO	YES
15	Do you spend more than 2 hours/day on screens (outside of time for work or school)?	NO	YES
	a. Do you have screen time (TV, video games, computer, tablet, smart phone) in your bedroom?	NO	YES
16	Are you active (exercising/heart rate elevated) for at least 1 hour every day?	YES	NO

17 Do you have a hard time falling asleep or staying asleep at night?	NO	YES
18 Are you sleeping 8-10 hours at night?	YES	NO
19 Do you work?	YES	NO
a. If yes, where do you work?		
b. If yes, how many hours per week?		

School

20 Are you having problems in school or work?	NO	YES
21 Are your grades worse than last year?	NO	YES
22 Do you have trouble concentrating?	NO	YES
23 Do you have problems doing your homework or completing activities for your job?	NO	YES
24 Do you have an IEP or other learning plan?	NO	YES

Injury Prevention

25 Do you always wear a seat belt when you are in a car?	YES	NO	
26 Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	YES	NO	
27 Do you ever carry a gun?	NO	YES	
28 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
29 Have you ever used a cellphone, texted, or used headphones while you were driving?	NO	YES	

Tuberculosis

30 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
31 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
32 Were you born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
33 Have you traveled to a high-risk country for more than a month?	NO	YES

Emotional Wellbeing

34 Do you feel stressed out, anxious, moody or overly worried?	NO	YES

35 Does your nervousness/worrying make it hard for you to do well in school/at home/or with your other activities?	NO	YES
36 When you are angry, do you do violent things?	NO	YES
37 Have you ever seriously thought about hurting or killing yourself or someone else?	NO	YES
38 Do you get along with your family and follow their rules?	YES	NO
39 Have you experienced bullying or harassment on social media (Facebook, Snapchat, Intagram, etc?)	NO	YES
40 Is there someone you are dating or a person at home or at school that is hurting you?	NO	YES

Review of Systems

41 Do you have any concerns about eating habits, weight loss, or lack of energy?	NO	YES
42 Do you have any sleep problems, including a lot of snoring?	NO	YES
43 Do you have concerns about your eyes or vision?	NO	YES
44 Do you have concerns about recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
45 Do you have concerns about chest pain, shortness of breath, or irregular heartbeat?	NO	YES
46 Do you have concerns about frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
47 Do you have concerns about abdominal (stomach) pain, vomiting, diarrhea, constipation?	NO	YES
48 Do you have concerns about kidney or bladder problems, infections, or blood in your urine (pee)?	NO	YES
49 Do you have concerns about your skin, hair, or nails?	NO	YES
50 Do you have concerns about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
51 Do you have concerns about recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES
52 Have you had excessive thirst or increased urination?	NO	YES
53 Have you had paleness, anemia, easy bruising, swollen glands?	NO	YES

For women:

a. Do you have any problems or questions about menstruation (getting your period)?	NO	YES
b. Do you get your periods every 21-42 days?	YES	NO
c. When was your last period?		