Affinity Health Plan
Dedicated to Excellence

SAFE TEEN

A Questionnaire Just For Teens

Sexuality

1. Have you had sex?	Yes	No
2. Do you use condoms?	No	Yes
3. Do you know how to protect yourself against STDs?	No	Yes
4. Do you know how to prevent pregnancy?	No	Yes
5. Were you ever forced to have sex you did not want, or touched in a way that made you feel uncomfortable?	Yes	No

Accidents

1. Do you wear a seatbelt when you ride in a car?	No	Yes
2. Do you use a helmet when you rollerblade, skateboard, bicycle, or play contact sports?	No	Yes
3. Have you ever driven when you were drunk?	Yes	No
4. Have you ever been in a car when the driver was drunk?	Yes	No
5. Do you talk on your cell phone or text your friends when you are driving or crossing the street?	Yes	No

Firearms/Violence

1. Do you feel safe in your home and in your relationships?	No	Yes
2. Has anyone made you feel afraid, threatened you, or hurt you?	Yes	No
3. In the past year, have you carried a gun, knife, or other weapon for your protection?	Yes	No
4. Have you had a physical fight during the past 3 months.	Yes	No

Emotions

1. In general, you are happy with the way things are going these days.	No	Yes
2. During the past year, have you thought about hurting yourself or made a plan to hurt yourself?	Yes	No
3. During the past few weeks, have you felt sad or down?	Yes	No

Toxins

1. Do you smoke cigarettes or chew tobacco?	Yes	No
a. If yes, would you like to quit?	No	Yes
2. Have you ever tried drugs?	Yes	No
3. Have you taken prescription drugs not intended for you?	Yes	No

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4. In the past month, did you get drunk or very high on beer, wine, wine coolers, or other alcohol? Yes No
5. Does someone in your family have a problem with drugs or alcohol? Yes No

Environment

1. Are you doing well at school? No Yes
2. Do you have at least one friend who you really like and can talk to? Yes No
3. Are you worried about pressure to make you have sex, drink, or take drugs? Yes No
4. There is a lot of tension in your house. Yes No

Exercise

1. Do you exercise in school? No Yes
   a. How often? _____
2. Do you exercise outside of school No Yes
3. Do you like physical activities? No Yes
   a. If yes, why
      _____
   b. If no, why not
      _____

Nutrition

1. Are you worried about your diet or weight? Yes No
2. Do you eat any vegetables? No Yes
   a. Which ones _____
3. Do you eat any fruit? No Yes
   a. Which ones _____
4. Yesterday, did you eat chips, cookies, candy or soda? Yes No
5. In the past year, have you tried to lose weight by vomiting, taking diet pills or laxatives, or starving yourself? Yes No

Do you know your BMI? Do you know your BMI percentile? **No** **Yes**
If yes, what is it _____ If no, ask your doctor**.**

Tell me about yourself

1. What do you like about yourself?
   _____
2. What do you do best?
   _____

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3. If you could, what would you change about your life or yourself?

   _____

4. Do you want to ask me a question? Do you want information on preventing STDs or pregnancy? You can either ask me or write it down.

   _____
   _____
   _____
   _____

Signature Date