Northwest PRIMARY CARE

PEDIATRIC DEVELOPMENTAL SCREENING
CONFIDENTIAL TEEN QUESTIONNAIRE

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature: _____

Instructions: Please answer the questions below by choosing YES or NO.

Have you ever drank alcohol?	NO	YES
Have you ever taken things to get high, stay awake, calm down, or go to sleep?	NO	YES
Have you ever used marijuana?	NO	YES
Have you ever used drugs (cocaine, crack, heroin, ecstasy, meth, inhalants, or pills?	NO	YES
Have you ever played games to make you pass out (choking game)?	NO	YES
Have you ever ridden in a car driven by someone (including yourself) who was high or had been using?	NO	YES
Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	NO	YES
Do you ever use alcohol while you are by yourself (alone)?	NO	YES
Do you ever forget things you did while using alcohol or drugs?	NO	YES
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	NO	YES
Have you ever gotten into trouble while you were using alcohol or drugs?	NO	YES
Have you pierced your body (not including ears) or gotten a tattoo?	NO	YES
Are you attracted to Males?	NO	YES
Are you attracted to Females?	NO	YES
Are you, or do you ever wonder if you are gay, lesbian, bisexual, or transgender?	NO	YES
Have you ever been forced or pressured to do something sexual that you didn't want to do?	NO	YES
Have you ever had sex (including intercourse or oral sex)?	NO	YES
Are you using a method to prevent pregnancy?	NO	YES
If yes, what method?		
Have you ever been pregnant or gotten someone pregnant?	NO	YES
Do you think you or your partner could have a sexually transmitted infection?	NO	YES
Are you worried about your mood?	NO	YES
Have you ever considered hurting yourself or someone else?	NO	YES
Has someone at home, school, or anywhere else made you feel afraid, threatened you, or hurt you?	NO	YES
Do you have other concerns you would like to discuss in private?	NO	YES