Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Your Name _____ Today's Date _____

Your Age _____ Your Sex (circle one): M F Your Grade (in school) _____

Your Growing and Changing Body: Physical Growth and Development

1.	Do you live in your parents' home?	Yes	Sometimes	No
2.	Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Do you brush your teeth twice a day?	Yes		No
4.	Do you floss once a day?	Yes		No
5.	Have you seen a dentist in the past year?	Yes		No
6.	Do you eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Do you eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Do you drink more than 1 soda or juice drink each day?	No		Yes
11.	Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	No		Yes
13.	Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
14.	Are you on a diet to lose weight?	No		Yes
15.	Do you eat meals together as a family?	Yes		No
16.	Have you talked about body changes and puberty with your parents?	Yes		No
17.	Do you have a TV in your bedroom?	No		Yes
18.	Have you talked to your parents about waiting to have sex?	Yes		No
19.	For females: Have you gotten your period?	Yes		No
20.	If yes, are you having any problems with or do you have any questions about your period?	No	Sometimes	Yes

School and Friends: Social and Academic Competence

21.	Do you go to school?	Yes		No
22.	Are you having any problems in school? Circle all that apply: grades worse than last year failing grade homework suspension this year fighting missing school other _____	No	Sometimes	Yes
23.	Is doing well in school important to you?	Yes		No
24.	Do your parents know your friends and their families?	Yes		No
25.	Do you try to see things from another person's point of view?	Yes		No
26.	Do you try to think through solutions by yourself?	Yes		No

Violence and Injuries: Violence and Injury Prevention

27.	Do you always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
28.	Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	No	Sometimes	Yes
29.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	Yes	Sometimes	No
30.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	No		Yes
31.	Do you have a person you can call for a ride if you're feeling unsafe with someone?	Yes		No

How You Are Feeling: Emotional Well-being

32.	Even with usual ups and downs, do you feel you enjoy life?	Yes		No
33.	Do your parents praise you when you do something good or learn something new?	Yes		No
34.	Do you spend time talking with your parents every day?	Yes		No
35.	Do you clearly discuss with your parents their rules and how you should act?	Yes		No
36.	Do you worry a lot or feel overly stressed out?	No	Sometimes	Yes
37.	When you are angry, do you do violent things?	No		Yes
38.	Do you continue to remember or think about an unpleasant experience that happened in the past?	No		Yes

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Feeling Happy: Emotional Well-being *continued from page 2*

39.	Do you do things as a family?	**Yes**		**No**
40.	During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to?	**No**		**Yes**
41.	Do you talk with your parents about relationships and sex?	**Yes**		**No**
42.	Do you talk with your parents about alcohol and drugs?	**Yes**		**No**
43.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	**No**		**Yes**

Healthy Behavior Choices: Risk Reduction

44.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	**No**	**Sometimes**	**Yes**