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 receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	**No**		**Yes**
2.	Do you brush your teeth twice a day?	**Yes**		**No**
3.	Do you floss once a day?	**Yes**		**No**
4.	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**
5.	Do you eat more than 1 fast food meal per week?	**No**	**Sometimes**	**Yes**
6.	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**
7.	Do you drink more than 1 soda or juice drink each day?	**No**		**Yes**
8.	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**
9.	Do you have any concerns or questions about the size or shape of your body, or physical appearance?	**No**		**Yes**
10.	Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?	**No**		**Yes**
11.	Have you talked about body changes and puberty with your parents?	**Yes**		**No**
12.	Do you have a TV in your bedroom?	**No**		**Yes**
13.	Have you talked to your parents about waiting to have sex?	**Yes**		**No**

School and Friends: Social and Academic Competence

14.	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**
15.	Do you try to see things from another person's point of view?	**Yes**		**No**
16.	Do you try to think through solutions by yourself?	**Yes**		**No**

Violence and Injuries: Violence and Injury Prevention

17.	Do you always wear a seat belt when riding in a car, truck, or van?	**Yes**	**Sometimes**	**No**
18.	Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	**Yes**	**Sometimes**	**No**
19.	Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	**No**		**Yes**
20.	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

21.	Even with usual ups and downs, do you feel you enjoy life?	**Yes**		**No**
22.	Do you clearly discuss with your parents their rules and how you should act?	**Yes**		**No**
23.	Do you worry a lot or feel overly stressed out?	**No**	**Sometimes**	**Yes**
24.	When you are angry, do you do violent things?	**No**		**Yes**
25.	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*

26.	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**
27.	Do you talk with your parents about relationships and sex?	**Yes**		**No**
28.	Do you talk with your parents about alcohol and drugs?	**Yes**		**No**
29.	Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?	**No**		**Yes**

Healthy Behavior Choices: Risk Reduction

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