Arch Pediatrics
Washington University Clinical Associates

Adolescent Health Survey

First Name ______________________ **Last Name** _________________________ **Date** ____________

		YES	NO
1.	Do you think something is wrong with your health?	YES	NO
2.	Do you make friends easily?	YES	NO
3.	Are you satisfied with your school performance?	YES	NO
4.	Do you think something is wrong with your weight? Your size? Your shape?	YES	NO
5.	Do you have any questions about your body and its development?	YES	NO
6.	Do you have questions regarding your gender identity?	YES	NO
7.	Are you having any difficulties at home?	YES	NO
8.	Have you smoked cigarettes in the past six months?	YES	NO
9.	Do you use smokeless tobacco? (i.e. chewing tobacco, patches)	YES	NO
10.	Do you use any inhaled nicotine products? (i.e. vaping, juuls)	YES	NO
11.	Do you have friends who take drugs?	YES	NO
12.	Do you have friends who drink alcohol?	YES	NO
13.	Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	YES	NO
14.	Are you wearing a seatbelt while riding in or driving a car?	YES	NO
15.	Are you worried that you might become pregnant or might make someone else pregnant and/or want information on birth control or sexually transmitted diseases?	YES	NO