

Household																						
Has any of the following recently happened to you or a member of your family?	<input type="checkbox"/> marriage <input type="checkbox"/> given birth <input type="checkbox"/> death <input type="checkbox"/> illness <input type="checkbox"/> divorce <input type="checkbox"/> loss of job <input type="checkbox"/> moved																					
Do you have any concerns about your safety at school or home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes																					
Are you having any problems with your parents?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes																					
Are you having any problems with other family members?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes																					
Has anyone ever tried to hurt you?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you feel safe at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you or your family own a gun?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
School/ Safety																						
How are you doing in school?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>1</u></td> <td style="text-align: center;"><u>2</u></td> <td style="text-align: center;"><u>3</u></td> <td style="text-align: center;"><u>4</u></td> <td style="text-align: center;"><u>5</u></td> <td style="text-align: center;"><u>6</u></td> <td style="text-align: center;"><u>7</u></td> <td style="text-align: center;"><u>8</u></td> <td style="text-align: center;"><u>9</u></td> <td style="text-align: center;"><u>10</u></td> </tr> <tr> <td colspan="3" style="text-align: center;">awful</td> <td colspan="7"></td> <td style="text-align: center;">great</td> </tr> </table>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>	awful										great
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awful										great												
Does anything bother you about school?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____																					
Do you have any plans or goals after school?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____																					
Do you have any problems making/keeping friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you use a seat belt regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Have you applied for your driver's permit or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you wear a helmet when you bike, skateboard, or rollerblade?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes																					
Are you concerned about your sexual development?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Have you ever had sexual intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you have any questions about the following:																						
Sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Birth control and/or pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Menstrual period	<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Do you have someone you can trust to talk to about your problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No Who? _____																					
Are there any questions or problems you would like to discuss with the doctor or practitioner today?	<input type="checkbox"/> Yes <input type="checkbox"/> No																					

By signing below, I certify that the above information I have provided is accurate to the best of my knowledge.

_____ Today's Date _____