Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**\*Circle questions you do not know the answer to. Please explain “Yes” answers below.**

**\*\*This information will be kept confidential between you and your doctor.**

Have you experienced:

* 1. Cough, wheeze, or trouble breathing with exercise? YES NO
  2. Dizziness or passed out with exercise? YES NO
  3. Chest pain with exercise? YES NO
  4. Racing heart or skipped heartbeats? YES NO
  5. Diagnosed with a heart murmur? YES NO
  6. Experienced head injury or concussion? YES NO
  7. Experienced Seizure? YES NO

|  |  |
| --- | --- |
| 1. Do you have problems with being bullied, either in person or over social media/the internet? | YES       NO |
| 1. Have you ever been involved with a group who did things that could have gotten them in trouble? | YES       NO |
| 1. Do you or your friends carry a weapon? | YES       NO |
| 1. Have you experienced violence to yourself or others? | YES       NO |
| 1. Have you ever been in a romantic relationship?    1. If so, have you always felt safe and respected? | YES               NO  YES       NO |
| * 1. Have you been in a sexual relationship? | YES       NO |
| * 1. Do you have any questions about Sexually Transmitted Infections? | YES       NO |
| 1. Have you ever smoked or vaped? | YES       NO |
| 1. Have you ever experimented with drugs (marijuana, prescription drugs that are not yours, etc.)?    1. If yes, what? | YES       NO  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you drank alcohol?    1. If yes, what have you tried, how often, and how much? | YES       NO  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Do you worry a lot or feel stressed out? | YES       NO |
| 1. Do you worry about weighing too much or too little? | YES       NO |
| 1. Are you doing anything to change your weight? | YES       NO |

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several Days | More than half of the days | Nearly every day |
| 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much? | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy? | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating? | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself-or feeling that you are a failure, or that you have let yourself or your family down? | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things like school work, reading, or watching TV? | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed? Or the opposite-being to fidgety or restless that you have been moving around more than usual? | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead, or of hurting yourself in some way? | 0 | 1 | 2 | 3 |
| 1. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? | Not difficult | Somewhat difficult | Very difficult | Extremely difficult |
| 1. In the past year, have you felt depressed or sad most days, even if you felt okay sometimes? | Yes | | No | |
| 1. Has there been a time in the past month when you have had serious thoughts about ending your life? | Yes | | No | |
| 1. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? | Yes | | No | |