hutchinson CLINIC
Setting a gold standard

Well-Care Questionnaire – Page 1 of 2
for pre-teen (10-12)

Name	Chart#	D.O.B.	Date

What is your MAIN reason for today's visit? ☐ Physical ☐ Sport's exam ☐Camp exam
☐ Other concern (please list):

Who are the people who live with you (names, ages, relationship)

Are you in school? ☐ Yes ☐ **No** If yes – what grade are you in? _____ Which school? _____
What activities or sports do you enjoy? _____
Are you having a hard time in school? ☐ No ☐ **Yes**
In a typical month, how often do you miss a class or day of school (# of days)?_____

MEDICATIONS – what medicine are you taking, including prescription, herbal, and over-the-counter?

MEDICAL HISTORY: check box if you have, or ever had, any of the following:

☐ Asthma
☐ Behavioral problems
☐ Learning disability/ADD
☐ Allergies
☐ Developmental concerns
☐ Seizure/Epilepsy
☐ Stomach/Gastrointestinal problem
☐ Heart problem
☐ Chickenpox - @ age?_____
☐ Surgeries

List other major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):

FAMILY HISTORY ☐ check here if you know you were adopted

☐ Depression/suicide _____
☐ Diabetes _____
☐ Alcohol/drug problems _____
☐ Asthma/allergies _____
☐ Other illnesses/conditions

SPORTS – have you ever:

Passed out while exercising?	☐ **Yes**	☐ No
Gotten dizzy or had headaches while exercising?	☐ **Yes**	☐ No
Been knocked out?	☐ **Yes**	☐ No
Had a significant joint or bone problem?	☐ **Yes**	☐ No
Had a serious injury?	☐ **Yes**	☐ No
Can you run 10 minutes without stopping?	☐ Yes	☐ **No**
Do you have a family member with heart disease?	☐ **Yes**	☐ No
Do you have a family member who died suddenly before age 50?	☐ **Yes**	☐ No

NUTRITION

Do you eat fruits and vegetables every day?	☐ Yes	☐ **No**
Do you eat or drink dairy products?	☐ Yes	☐ **No**
Are you a vegetarian?	☐ **Yes**	☐ No
Do you have any questions or concerns about your eating habits?	☐ **Yes**	☐ No

SAFETY

Do you always wear a helmet when on a bike, skateboard, or ATV?	☐ Yes	☐ **No**
Do you always wear seatbelt when in car or truck?	☐ Yes	☐ **No**

Do you ever ride with a driver who had alcohol or drugs?	☐ **Yes**	☐ No	
Do you or any of your friends have access to guns?	☐ **Yes**	☐ No	
Has anyone ever touched you in a way that made you uncomfortable or afraid?	☐ **Yes**	☐ No	
FAMILY and PEERS			
Do you get along with your family?	☐ Yes	☐ **No**	
Are you having a hard time at home?	☐ **Yes**	☐ No	
Do you have a friend you can talk to about problems you have?	☐ Yes	☐ **No**	
Are you having a hard time with friends?	☐ **Yes**	☐ No	
Are you having trouble with fighting or bullying?	☐ **Yes**	☐ No	
Are you feeling pressure to do what others are doing?	☐ **Yes**	☐ No	
STRESS and DEPRESSION			
During the past 2 years, have you or anyone in your family had any major good or bad changes?	☐ **Yes**	☐ No	
Do you have any concerns about your body or weight?	☐ **Yes**	☐ No	
Do you ever eat in secret or feel guilty about eating?	☐ **Yes**	☐ No	
Do you ever make yourself throw up?	☐ **Yes**	☐ No	
Have you recently lost interest or pleasure in doing things?	☐ **Yes**	☐ No	PHQ-9 Adolescents for YES
Have you been feeling down, depressed, irritable, or hopeless?	☐ **Yes**	☐ No	
Tobacco, Alcohol, Marijuana & Other Drugs			
Have you ever used tobacco (smoke, chew, e-cigs) or other vapor product?	☐ **Yes**	☐ No	
Are you around people who smoke?	☐ **Yes**	☐ No	
Do you drink alcohol?	☐ **Yes**	☐ No	
Do you do anything to get high such as huffing, sniffing, smoking marijuana or using any other drugs?	☐ **Yes**	☐ No	
SEXUALITY			
Do you have any questions about puberty or any of the changes happening to your body?	☐ **Yes**	☐ No	
Have you talked about sex with an adult in your family?	☐ Yes	☐ **No**	
For Females			
Have your periods started?	☐ **Yes**	☐ No	
If YES, how old were you when they started? _____			
Do menstrual cramps keep you from doing your normal activities?	☐ **Yes**	☐ No	

Person Completing Form: _____

Signature: _____ Date: _____