KAISER PERMANENTE®

Well-Care Questionnaire
for pre-teens aged 10 to 12

TO BE COMPLETED BY PRETEEN: This worksheet can give your health care team information to help you take better care of yourself. You don't have to answer any questions you don't want to.

Name you would like us to call you (nickname):_____ Pronouns:_____	
Have you had a physical exam in the last year?	☐ Yes ☐ No
Have you seen a dentist in the last year?	☐ Yes ☐ No
Friends and Hobbies	
Are you happy with the way things are at home?	☐ Yes ☐ No
Do you have a best friend? ☐ Yes – how long have you been friends: _____ ☐ No	
What activities or hobbies do you enjoy?	
School History	
Are you currently enrolled in elementary or middle school? ☐ Yes ☐ No Do you like school? ☐ Yes ☐ No Optional: If you're interested in sharing, please tell us what you like most or least about school: _____ Do you attend school most days? ☐ Yes ☐ No If **no**, what do you do during the day: _____	
Nutrition	
Do you eat breakfast?	☐ Yes ☐ No
Do you drink soda or juice more than once a day?	☐ Yes ☐ No
Do you eat fruits and vegetables every day?	☐ Yes ☐ No
Are you a vegetarian?	☐ Yes ☐ No
Are you taking any multi-vitamins or supplements?	☐ Yes ☐ No
Physical Activity	
How many days most weeks do you exercise (enough to make you sweat) for 30 minutes or more? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more	
What type of exercise do you do regularly? _____	
While exercising or playing sports, have you ever:	
• Passed out or nearly passed out while exercising?	☐ Yes ☐ No
• Had discomfort, pain, tightness, or pressure in chest while exercising?	☐ Yes ☐ No
• Had your heart skip beats or feel abnormal in another way while exercising?	☐ Yes ☐ No
• Felt lightheaded while exercising?	☐ Yes ☐ No
• Been more tired or short of breath than your friends while exercising?	☐ Yes ☐ No
• Broken a bone, or had a dislocation or other significant sports injury?	☐ Yes ☐ No
Safety	
Do you always wear a helmet when you ride on a four-wheeler, bicycle, skateboard, snowboard, or ski?	☐ Yes ☐ No
Do you always use your seat belt when in a car?	☐ Yes ☐ No
Do you know how to swim?	☐ Yes ☐ No
Are there guns in your home?	☐ Yes ☐ No ☐ Unsure
If yes, are they stored unloaded and locked?	☐ Yes ☐ No ☐ I don't know

Continued on next page

Safety continued

Please check any of the items below that you have concerns about or have ever experienced. Check all that apply.

- ☐ Alcohol, marijuana, or other drug use by a friend or family member
- ☐ Being arrested or been in other trouble with the law
- ☐ Being (or seeing someone else being) hit, kicked, shoved, or yelled out in an abusive manner
- ☐ Being touched in a way that made you uncomfortable or afraid, being abused
- ☐ Eating in secret or feeling guilty about eating
- ☐ Feeling like running away now or having run away in the past
- ☐ Gangs (belonging to a gang, being afraid you will be hurt by or recruited to join a gang)
- ☐ Not being able to walk away from fights
- ☐ Not being part of the 'in group'
- ☐ Not making a school or team club
- ☐ Poor grades or a drop in grades

Does anyone in your home smoke or use any form of tobacco?	☐ Yes ☐ No
Have you ever ridden in a car driven by someone who was high or had been using alcohol or drugs?	☐ Yes ☐ No

Tobacco, Alcohol, Marijuana and Other Substances

Have you used any of the following in the past 12 months:

Nicotine/tobacco (cigarettes, e-cigs, vapes, Juul)	☐ Yes ☐ No
Alcohol (do not count a few sips, such as at a family or religious event)	☐ Yes ☐ No
Marijuana (smoked, vaped, edibles)	☐ Yes ☐ No
Other drugs and/or medicines not prescribed to you	☐ Yes ☐ No

Mood

In the past 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
In the past 2 weeks, how often have you felt down, depressed, irritable, or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Gender

What is your gender:

☐ Female ☐ Male ☐ Transgender female, male-to-female ☐ Transgender male, female-to-male ☐ Non-binary ☐ Questioning
☐ Genderfluid ☐ Other: _____ ☐ Choose not to answer

For females and/or if you have a uterus and ovaries:

Have your periods started?	☐ Yes ☐ No
If **Yes**: How old were you when they started? _____	
Are they regular (meaning they come about once a month, almost every month)?	☐ Yes ☐ No
Do you have any questions or concerns about your periods?	☐ 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
Do you have any questions about masturbation?	☐ Yes ☐ No

Are you romantically and/or sexually attracted to (check all that apply):

☐ Males ☐ Females ☐ People who are non-binary ☐ No one ☐ Unsure ☐ Other: _____

Have you ever had any kind of sex?	☐ Yes ☐ No