

Well-Care Questionnaire

for pre-teens aged 10 to 12

Patient Label

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.

1. General Information	
a. Name you would like us to call you (nickname): _____	b. Pronouns: _____
c. Have you seen a dentist in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Friends and Hobbies	
a. Are you happy with the way things are at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you have at least one good friend?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. What activities or hobbies do you enjoy?	
3. School History	
a. Did you move to a new school in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you like school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Optional: If you're interested in sharing, please tell us what you like most or least about school: _____	
d. Do you attend school most days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Nutrition	
a. Do you eat breakfast?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you drink soda or juice more than once a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you eat fruits and vegetables every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are you a vegetarian or vegan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Are you taking any multi-vitamins or supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Physical Activity	
a. How many days most weeks do you exercise (enough to make you sweat) for 30 minutes or more? <input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more	
b. What type of exercise do you do regularly?	
While exercising or playing sports, have you ever:	
c. Passed out or nearly passed out while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had a concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Had discomfort, pain, tightness, or pressure in chest while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Had your heart skip beats or feel abnormal in another way while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Felt lightheaded while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Been more tired or short of breath than your friends while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Broken a bone, or had a dislocation or other significant sports injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Have you had COVID-19? <input type="checkbox"/> No <input type="checkbox"/> Yes – when did you have it: _____	
6. Safety	
a. Do you always wear a helmet when you ride on a four-wheeler, bicycle, skateboard, snowboard, or ski?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you always use your seat belt when in a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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c. Are there guns in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes, are they stored unloaded and locked?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
d. Please check any of the items below that you have ever experienced or have concerns about. Check all that apply.	
<input type="checkbox"/> Alcohol, cannabis, tobacco, or other drug use by a friend or family member <input type="checkbox"/> Being arrested or been in other trouble with the law <input type="checkbox"/> Being (or seeing someone else being) hit, kicked, shoved, or yelled at in an abusive manner <input type="checkbox"/> Being touched in a way that made you uncomfortable or afraid, being abused <input type="checkbox"/> Eating in secret or feeling guilty about eating <input type="checkbox"/> Feeling like running away now or having run away in the past <input type="checkbox"/> Feeling lonely or socially isolated <input type="checkbox"/> Gangs (belonging to a gang, being afraid you will be hurt by or recruited to join a gang) <input type="checkbox"/> Not being able to walk away from fights <input type="checkbox"/> Poor grades or a drop in grades	
7. Tobacco, Alcohol, Cannabis and Other Substances	
Have you used any of the following in the past 12 months:	
a. Nicotine/tobacco (cigarettes, e-cigs, vapes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Alcohol (do not count a few sips, such as at a family or religious event)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cannabis (THC containing products - smoked, vaped, edibles)	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Other drugs and/or medicines not prescribed to you	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Mood	
a. In the past 2 weeks, how often have you had little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
b. In the past 2 weeks, how often have you felt down, depressed, irritable, or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
9. Gender	
a. What is your gender:	
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender female, male-to-female <input type="checkbox"/> Transgender male, female-to-male <input type="checkbox"/> Non-binary <input type="checkbox"/> Questioning <input type="checkbox"/> Genderfluid <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to answer	
10. For females and/or if you have a uterus and ovaries:	
a. Have your periods started?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If Yes : How old were you when they started? _____	
c. Are they regular (meaning they come about once a month, almost every month)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you have any questions or concerns about your periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Sexuality	
a. Do you have any questions about puberty or any of the changes happening to your body?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you talked about sex with an adult in your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Are you romantically and/or sexually attracted to (check all that apply):	
<input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> People who are non-binary <input type="checkbox"/> No one <input type="checkbox"/> Unsure <input type="checkbox"/> Other: _____	
d. Have you ever had any kind of sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No