



Adolescent and Young Adult Health Questionnaire (11-21 Years)

Your name/What you like to be called: _____ Pronouns: _____

Your sex assigned at birth (as on your original birth certificate): _____

Your gender identity: _____

What four words best describe you?

What do you want to get out of today's visit?

| We ask every resident these questions about things that can affect your health and well-being. Some of the questions might not fit you. It is okay to leave some questions blank. Please answer these questions on your own, without help from your parent/case worker or friends, and be as honest as possible. Your answers are private. | PLEASE CIRCLE YOUR ANSWER | WANT MORE INFO? |
|--|---------------------------|--------------------------|
| 1. In general, are you happy with the way things are going for you? | Yes Sometimes No | <input type="checkbox"/> |
| 2. Do you wear a seat belt in a car/truck? | Yes Sometimes No | <input type="checkbox"/> |
| 3. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile, or ATV? | Yes Sometimes No | <input type="checkbox"/> |
| 4. Do you get along with your family? | Yes Sometimes No | <input type="checkbox"/> |
| 5. Do you have at least one adult you can really talk to? | Yes Sometimes No | <input type="checkbox"/> |
| 6. Do you feel safe at home, at school and in your community? | Yes Sometimes No | <input type="checkbox"/> |
| 7. Do you get 60 minutes of physical activity most days of the week? | Yes Sometimes No | <input type="checkbox"/> |
| 8. Do you think you are about the right weight and height? | Yes Sometimes No | <input type="checkbox"/> |
| 9. Do you ever skip meals, use laxatives or diet pills, or throw up on purpose to lose weight or to control your weight? | Yes Sometimes No | <input type="checkbox"/> |
| 10. Have you missed more than 7 days of school in the last year? | Yes Sometimes No | <input type="checkbox"/> |
| 11. Are your grades worse than they used to be? | Yes Sometimes No | <input type="checkbox"/> |
| 12. Do you or anyone you live with have a gun or carry around a gun? | Yes Sometimes No | <input type="checkbox"/> |
| 13. Do you worry about money, a place to live, food or clothing? | Yes Sometimes No | <input type="checkbox"/> |
| 14. Have you ever run away from home? | Yes Sometimes No | <input type="checkbox"/> |
| 15. Have you ever been in a gang (now or in the past)? | Yes Sometimes No | <input type="checkbox"/> |

AYA QUESTIONNAIRE

| Your answers are private between you Pathway to Everyday Life. We will only talk to your parent/guardian about this information if we have a serious concern about your health and safety. Before we talk to a parent/guardian, we will talk about it with you. | PLEASE CIRCLE YOUR ANSWER | WANT MORE INFO? |
|---|---------------------------|--------------------------|
| 16. Do you ever hurt or cut yourself on purpose? | Yes Sometimes No | <input type="checkbox"/> |
| 17. Have you ever texted/sent or received a sexual message or picture? | Yes Sometimes No | <input type="checkbox"/> |
| 18. Have you ever had any kind of sex? | Yes Sometimes No | <input type="checkbox"/> |
| 19. Have you ever had an infection that is spread by having sex? (like herpes, gonorrhea, chlamydia, genital warts, pelvic inflammatory disease, HIV, syphilis) | Yes Sometimes No | <input type="checkbox"/> |
| 20. Have you ever traded sex or sexual activity for money, food, a place to live, or anything else? | Yes Sometimes No | <input type="checkbox"/> |
| 21. Are you, or do you ever wonder if you are gay, lesbian, bisexual, pansexual, asexual, or queer? | Yes Sometimes No | <input type="checkbox"/> |
| 22. Are you, or do wonder if you are transgender, genderqueer, genderfluid, nonbinary, or a gender that is different from what you were called (boy or girl) at birth? | Yes Sometimes No | <input type="checkbox"/> |
| 23. Have you ever been physically, sexually, or emotionally abused or hurt by anyone? (such as kicked, hit, forced or tricked into having sex, touched in a way that made you feel uncomfortable, called worthless) | Yes Sometimes No | <input type="checkbox"/> |
| 24. Have you ever tried to kill yourself? | Yes Sometimes No | <input type="checkbox"/> |
| 25. Have you had any stressful or scary events that still bother you? | Yes Sometimes No | <input type="checkbox"/> |

If you could change one thing about your life or yourself, what would it be?

What is the most important thing you want us to focus on while at Pathway to Everyday Life?

Questions about tobacco, alcohol, marijuana, other drugs

| In the PAST YEAR, how many times have you used: | Never | Once or twice | Monthly | Weekly |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Tobacco: cigarettes, cigars, chew, or e-cigarettes or vapes, such as JUUL, suorin, blu, VUSE, or logic? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marijuana | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you tried any other drugs for fun, curiosity or coping, such as prescription pills, drugs that you sniff or huff, salvia, K2, or other illegal drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |