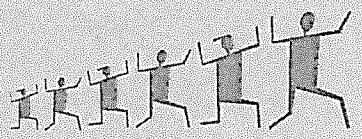

Guidelines for Adolescent Preventive Services

Younger Adolescent Questionnaire

Confidential (Your answers will not be given out.)

Chart# _____

Name _____ Today's Date _____
Last First Middle Initial month day year

Birthdate _____ Grade in School _____ **Boy** or **Girl** (*circle one*) Age _____
month day year

Address _____ City _____ State _____ Zip _____

Phone Number _____ Pager/Beeper Number _____
area code

What languages are spoken where you live? _____

Are you: ☐ White ☐ African-American ☐ Asian/Pacific Islander
☐ Latino/Hispanic ☐ Native American ☐ Other _____

Medical History

1. Why did you come to the clinic/office today? _____

_____

2. Are you allergic to any medicines?
☐ No ☐ Yes, name of medicine(s): _____ ☐ Not Sure

3. Do you have any health problems?
☐ No ☐ Yes, problem(s): _____ ☐ Not Sure

4. Are you taking any medicine now?
☐ No ☐ Yes, name of medicine(s): _____ ☐ Not Sure

5. Have you been to the dentist in the last year? ☐ No ☐ Yes ☐ Not Sure

6. Have you stayed overnight in a hospital in the last year? ☐ No ☐ Yes ☐ Not Sure

7. Have you ever had any of the problems below?

	Yes	No	Not Sure		Yes	No	Not Sure
Allergies or hay fever	☐	☐	☐	Seizures	☐	☐	☐
Asthma	☐	☐	☐	Cancer	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	Diabetes	☐	☐	☐

For Girls Only

8. Have you started having periods? ☐ No ☐ Yes
   a. *If yes*, are your periods regular (once a month) ? ☐ No ☐ Yes
   b. *If yes*, what was the 1st day of your last period? Month _____ Day _____
9. Have you ever been pregnant? ☐ Yes ☐ No

Family Information

10. Who do you live with? (Check all that apply).

☐ Mother	☐ Stepmother	☐ Brother(s)/ages_____
☐ Father	☐ Stepfather	☐ Sister(s)/ages_____
☐ Guardian	☐ Other adult relative	☐ Other/(explain)_____

11. Do you have older brothers or sisters who live away from home? ☐ Yes ☐ No ☐ Not Sure

12. During the past year, have there been any changes in your family such as: (Check all that apply)

☐ Marriage	☐ Loss of job	☐ Births	☐ Other changes_____
☐ Separation	☐ Moved to a new neighborhood	☐ Serious Illness/Injury	_____
☐ Divorce	☐ A new school	☐ Deaths	_____

Specific Health Issues

13. Please check whether you have questions or are worried about any of the following:

☐ Height	☐ Neck or back	☐ Muscle or pain in arms/legs	☐ Anger or temper
☐ Weight	☐ Breasts	☐ Menstruation or periods	☐ Feeling tired
☐ Eyes or vision	☐ Heart	☐ Wetting the bed	☐ Trouble sleeping
☐ Hearing or earaches	☐ Coughing or wheezing	☐ Trouble urinating or peeing	☐ Fitting in/belonging
☐ Colds/runny or stuffy nose	☐ Chest pain or trouble breathing	☐ Drip from penis or vagina	☐ Cancer
☐ Mouth or teeth or breath	☐ Stomach ache	☐ Wet dreams	☐ HIV/AIDS
☐ Headaches	☐ Vomiting or throwing up	☐ Skin (rash/acne)	☐ Dying
☐ Other_____			

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Health Profile

Eating/Weight/Body

14. Do you eat fruits and vegetables every day? ☐ No ☐ Yes
15. Do you drink milk and/or eat milk products every day? ☐ No ☐ Yes
16. Do you spend a lot of time thinking about ways to be skinny? ☐ Yes ☐ No
17. Do you do things to lose weight (skip meals, take pills, starve yourself, vomit, etc) ☐ Yes ☐ No
18. Do you work, play, or exercise enough to make you sweat or breathe hard at least 3 times a week? ☐ No ☐ Yes
19. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No

School

20. Is doing well in school important to you? ☐ No ☐ Yes
21. Is doing well in school important to your family and friends? ☐ No ☐ Yes
22. Are your grades this year worse than last year? ☐ Yes ☐ No ☐ Not Sure
23. Are you getting failing grades in any subjects this year? ☐ Yes ☐ No ☐ Not Sure
24. Have you been told that you have a learning problem? ☐ Yes ☐ No
25. Have you been suspended from school this year? ☐ Yes ☐ No

Friends and Family

26. Do you know at least one person who you can talk to about problems? ☐ No ☐ Yes
27. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? ☐ No ☐ Yes
28. Have your parents talked with you about things like alcohol, drugs, and sex? ☐ No ☐ Yes ☐ Not Sure
29. Are you worried about problems at home or in your family? ☐ Yes ☐ No ☐ Not Sure
30. Have you ever thought seriously about running away from home? ☐ Yes ☐ No

Weapons/Violence/Safety

31. Is there a gun, rifle, or other firearm where you live? ☐ Yes ☐ No ☐ Not Sure
32. Have you ever carried a gun, knife, club, or other weapon to protect yourself? ☐ Yes ☐ No
33. Have you ever been in a physical fight where you or someone else got hurt? ☐ Yes ☐ No
34. Have you ever been in trouble with the police? ☐ Yes ☐ No
35. Have you ever seen a violent act take place at home, school, or in your neighborhood? ☐ Yes ☐ No
36. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not Sure
37. Do you usually wear a helmet and/or protective gear when you rollerblade, skateboard, or ride a bike? ☐ No ☐ Yes
38. Do you always wear a seat belt when you ride in a car, truck, or van? ☐ No ☐ Yes

Tobacco

39. Have you ever tried cigarettes or chewing tobacco? ☐ Yes ☐ No
40. Have any of your close friends ever tried cigarettes or chewing tobacco? ☐ Yes ☐ No
41. Does anyone you live with smoke cigarettes/cigars or chew tobacco? ☐ Yes ☐ No

Alcohol

42. Have you ever tried beer, wine, or other liquor (except for religious purposes)? ☐ Yes ☐ No
43. Have any of your close friends ever tried beer, wine, or other liquor (except for religious purposes)? ☐ Yes ☐ No
44. Have you ever been in a car when the driver has been using drugs or drinking beer, wine or other liquor? ☐ Yes ☐ No
45. Does anyone in your family drink so much that it worries you? ☐ Yes ☐ No ☐ Not Sure

Drugs

46. Have you ever taken things to get high, stay awake, calm down or go to sleep? ☐ Yes ☐ No ☐ Not Sure
47. Have you ever used marijuana (pot, grass, weed, reefer, or blunt)? ☐ Yes ☐ No ☐ Not Sure
48. Have you ever used other drugs such as cocaine, speed, LSD, mushrooms, etc.? ☐ Yes ☐ No ☐ Not Sure
49. Have you ever sniffed or huffed things like paint, 'white-out', glue, gasoline, etc.? ☐ Yes ☐ No ☐ Not Sure

50. Have any of your close friends ever used marijuana, other drugs, or done other things to get high? ☐ Yes ☐ No ☐ Not Sure
51. Does anyone in your family use drugs so much that it worries you? ☐ Yes ☐ No ☐ Not Sure

Development/Relationships

52. Are you dating someone or going steady? ☐ Yes ☐ No ☐ Not Sure
53. Are you thinking about having sex ("going all the way "or "doing it")? ☐ Yes ☐ No ☐ Not Sure
54. Have you ever had sex? ☐ Yes ☐ No ☐ Not Sure
55. Have any of your friends ever had sex? ☐ Yes ☐ No ☐ Not Sure
56. Have you ever felt pressured by anyone to have sex or had sex when you did not want to? ☐ Yes ☐ No ☐ Not Sure
57. Have you ever been told by a doctor or a nurse that you had a sexually transmitted disease like herpes, gonorrhea, or chlamydia? ☐ Yes ☐ No ☐ Not Sure
58. Would you like to receive information on abstinence ("how to say no to sex")? ☐ Yes ☐ No ☐ Not Sure
59. Would you like to know how to avoid getting pregnant, getting HIV/AIDS, or getting sexually transmitted diseases? ☐ Yes ☐ No ☐ Not Sure

Emotions

60. Have you done something fun during the past two weeks? ☐ No ☐ Yes
61. When you get angry, do you do violent things? ☐ Yes ☐ No
62. During the past few weeks, have you felt very sad or down as though you have nothing to look forward to? ☐ Yes ☐ No
63. Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself? ☐ Yes ☐ No
64. Is there something you often worry about or fear? ☐ Yes ☐ No
65. Have you ever been physically, emotionally, or sexually abused? ☐ Yes ☐ No ☐ Not Sure
66. Would you like to get counseling about something that is bothering you? ☐ Yes ☐ No ☐ Not Sure

Special Circumstances

67. In the past year have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not Sure
68. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
69. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

70. What two words best describe you?
1)_____ 2)_____

71. What would you like to be when you grow up?
_____

72. If you could have three wishes come true, what would they be?

1)_____

2)_____

3)_____

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

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 at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only **Severity score:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child					
		NEVER	SOME-TIMES	OFTEN			
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider:	Phone:	Date:

Child's Name: _____ **Date of Birth:** ____/____/____

Address: _____ **City:** _____ **State:** _____ **County:** _____

Sex: ❒Male ❒Female **Hispanic:** ❒No ❒Yes **Race:** ❒White ❒Black ❒Asian ❒Am. Indian/Nat. Alaskan ❒Other _____

US Born: ❒Yes ❒No **If no, US Date of Arrival:** ____/____/____ **Country of Birth:** _____

Parent/Guardian: _____ **Phone:** _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	❒Yes ❒No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	❒Yes ❒No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	❒Yes ❒No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	❒Yes ❒No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	❒Yes ❒No	If yes, name of country: _____
6. Is the child exposed to a person who: • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❒Yes ❒No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	❒Yes ❒No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒Yes ❒No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.

MEDICAL INFORMATION:

Primary Reason for Evaluation: ❒Contact Investigation ❒Targeted Testing ❒Immigration Exam
❒Incidental Abnormal CXR/CT ❒Incidental Lab Result
❒Other: _____

Symptomatic: ❒No ❒Yes If Yes, ONSET date: _____/_____/_____

Symptoms: ❒Cough ❒Hemoptysis ❒Fever ❒Night Sweats ❒Weight Loss of _____lbs.
❒Other: _____

Tuberculin Skin Test (TST/Mantoux/PPD) **Date Given:** _____/_____/_____ **Date Read:** _____/_____/_____	**Induration:** _____ **mm** **Impression:** ❒Negative ❒Positive
Interferon Gamma Release Assay (IGRA) **Date:** _____/_____/_____	**Impression:** ❒Negative ❒Positive ❒Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date:** _____/_____/_____	**Impression:** ❒Normal ❒Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:_____ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: _____ _____mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

Health Provider Signature: _____ **Date Completed:** ____/____/____