STUDENT HEALTH QUESTIONNAIRE

For Middle School Students in Grades 6 – 8

NOTE: The information you provide on this form is CONFIDENTIAL and will not be shared outside of this clinic without your permission. The only exceptions to this are if you are thinking about harming yourself or someone else or if you are being abused. By law, our staff has to report this information. We will also assist you in getting the help that you need. We would like you to fill this form out completely, but you can choose to skip questions you do not want to answer. This form will help us give you the best care possible.

Name: _____ Date of Birth: _____
Last First Middle Initial

Age: _____ Grade: _____ Today's Date: _____

Which of the following best describes you? (check all that apply) □ Male □ Female □ Transgender □ Self-identify: _____

Are you Hispanic or Latino/a? □ Yes □ No

What is your race? (Check all that apply)
□ American Indian or Alaskan Native □ White □ Native Hawaiian or other Pacific Islander
□ Black or African American □ Asian

Which of the following best describes you? □ Heterosexual (straight) □ Gay or Lesbian □ Bisexual □ Not sure

HOME/SCHOOL

1. Who do you live with? (Check all that apply)
   - □ Two mothers □ Two fathers □ Mother □ Father
   - □ Step-Mother □ Step-Father □ Mother's boyfriend/partner □ Father's Girlfriend/partner
   - □ Foster parent □ Sister □ Brother □ Grandparent(s)
   - □ Aunt □ Uncle □ Cousin □ Friend
   - □ Other _____

2. Who do you feel you can really talk to? (Check all that apply)
   - □ Friend □ Parent □ Other adult _____
   - □ Brother/Sister □ Teacher □ Online friend
   - □ Other _____ □ Other relative _____

3a. Are you having any of the following problems at home? (Check all that apply)
   - □ Violence □ Concerns with a family member □ Other_____
   - □ Fighting □ Parent/guardian out of work □ I don't have any of these problems

3b. Are you having any of the following problems at school? (Check all that apply)
   - □ Missing school □ Grades □ Other_____
   - □ Suspension □ Bullying (in person, or through social media) □ I don't have any of these problems

PHYSICAL HEALTH

4. Do you usually participate in physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour every day?	□ Yes □ No
5. Do you usually watch TV, play video games, or spend time on a computer, tablet or smartphone for more than 2 hours per day (not including computer time for school or work)?	□ Yes □ No
6. Do you usually eat 5 or more servings of vegetables and fruits every day?	□ Yes □ No
7. Do you usually get 8 or more hours of sleep every night?	□ Yes □ No
8. In the last 6 months, have you seen a dentist or gone to a dental clinic?	□ Yes □ No
9. Do you have any tooth pain right now?	□ Yes □ No

SAFETY/INJURIES

10. Do you always wear a seatbelt when riding in a car, truck or van?	□ Yes □ No
11. Do you always wear a helmet when rollerblading, biking, motorcycling, skateboarding, ATV, skiing or snowboarding?	□ Yes □ No □ Does not apply to me
12. Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	□ Yes □ No
13. Has a boyfriend/girlfriend ever hit, slapped or hurt you on purpose?	□ Yes □ No
14. Have you ever carried a weapon (gun, knife, club, etc.) to protect yourself?	□ Yes □ No
15. Have you ever been in foster care, a group home, homeless or had to live with another family member or friend?	□ Yes □ No
16. Have you ever been in jail or in a detention center?	□ Yes □ No

FEELINGS/WELL-BEING

17. Do you often worry about or feel like something bad might happen?	□ Yes □ No
18. Are you often tense, stressed out, and/or have difficulty relaxing?	□ Yes □ No

*19. Over the past 2 weeks, how often have you been bothered by any of the following problems?

a) Little interest or pleasure in doing things?

□ 0= Not at all □ 1= Several days □ 2= More than half the days □ 3= Nearly every day

b) Feeling down, depressed, irritable or hopeless? □ 0= Not at all □ 1= Several days □ 2= More than half the days □ 3= Nearly every day	
20. Have you ever cut, hit, burned or done anything else to hurt yourself on purpose?	□ Yes □ No
21. Have you ever seriously thought about killing yourself, made a plan and/or actually tried to kill yourself?	□ Yes □ No
RELATIONSHIPS/SEXUAL ACTIVITY	
22. Do you have a boyfriend or girlfriend?	□ Yes □ No
23. Do you talk to your parent/guardian(s) about relationships or about sex?	□ Yes □ No
24. Have you ever had sex (including oral sex)?	□ Yes □ No
If you answered "Yes" to question 24, please complete questions a-c	
a) Do you and your partner(s) *always* use condoms when you have sex?	□ Yes □ No
b) Are you using a method to prevent pregnancy? Which types: □ Condoms □ Pills □ Depo (the shot) □ Patch □ Nexplanon/Implanon □Foam □Sponge □ Withdrawal □ Ring □ IUD	□ Yes □ No
c) Have you ever been pregnant or gotten someone pregnant?	□ Yes □ No
HEALTH BEHAVIORS/SUBSTANCE USE	
25. In the past three months, have you smoked cigarettes or used any other form of tobacco (like chew, dip, cigars, hookah and/or e-cigarettes)?	□ Yes □ No
*26. Have you ever ridden in a car driven by someone who was high or using alcohol or drugs?	□ Yes □ No
27. During the PAST 12 MONTHS, did you:	
a) drink any alcohol (more than a few sips)?	□ Yes □ No
b) smoke any marijuana or hashish?	□ Yes □ No
c) use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	□ Yes □ No
***If you answered "Yes" to questions 27, please complete questions a-e**	
a) Do you ever use alcohol and drugs to relax, feel better about yourself or fit in?	□ Yes □ No
b) Do you ever use alcohol or drugs while you are by yourself, alone?	□ Yes □ No
c) Do you ever forget things you did while using alcohol or drugs?	□ Yes □ No
d) Do your family or friends ever tell you that you should cut down on your drinking or drug use?	□ Yes □ No
e) Have you ever gotten into trouble while you were using alcohol or drugs?	□ Yes □ No
DEVELOPMENT/FUTURE PLANS	
28. Do you have any concerns or questions about the size or shape of your body or your physical appearance? If yes, please describe:_____	□ Yes □ No
29. What are your future plans for career goals? _____	
30. On the whole, how much do you like yourself? Not much 1 2 3 4 5 A lot	
31. **Please answer the following questions about yourself:**	
a) I feel I have at least one adult in my life who cares about me and who I can go to if I need help.	□ Yes □ No
b) I have at least one friend or a group of friends that I feel comfortable with.	□ Yes □ No
c) As I have gotten older I make more of my own decisions.	□ Yes □ No
How can we contact you if we need to talk to you privately (for test results, etc.) besides through school? Choose one: e-mail _____ cell phone _____ friend's number? _____	

THANKS!

*PROVIDERS: These questions are from a validated scale (PHQ-2, CRAFFT) that should be scored, with appropriate follow-up for a positive screen

Reviewed By: _____ Date: _____

Referred To: _____

This survey was developed by the Colorado Department of Health Care Policy & Financing in collaboration with the New Mexico Human Services Department, The Colorado Department of Public Health and Environment, the New Mexico Department of Health, the Cincinnati Children's Hospital Medical Center, AcademyHealth, the University of New Mexico, Parametrix Group, LLC, and Apex Education. This survey was developed for a School-Based Health Center Improvement Project under a federal grant from the U. S. Department of Health and Human Services and its Centers for Medicare and Medicaid Services (CMS), Grant Award Number 1Z0C30559-01-00. However, this survey and the contents of the survey do not necessarily represent the policies of the U. S. Department of Health and Human Services, and you should not assume endorsement by the federal government.

The States of Colorado and New Mexico are parties to a School-Based Health Center Improvement Project designed to integrate school-based health care into a medical home approach to improve the health care of underserved school-aged children and adolescents. The overarching goal of the project is to markedly improve the quality of children's health care delivered at School-Based Health Centers. This survey will be made available to School-Based Health Centers in the States of Colorado and New Mexico.

Some of the questions included in this survey were adapted from the following sources: Bright Futures (American Academy of Pediatrics), Kaiser Permanente Division of Research, Rapid Assessment for Adolescent Preventive Services (RAAPS, Regents of the University of Michigan), Youth Risk Behavior Survey (YRBS, Centers for Disease Control & Prevention), CRAFFT (Children's Hospital Boston), and Guidelines for Adolescent Preventive Services (American Medical Association).