Whole Child Assessment- Version 2 for 12 – 17 Years

Please answer all the questions on this form as best you can. It will help us know how we can help you be healthy. ***You may skip any question if you do not know an answer or do not want to answer.*** *You may add comments to explain your answers. We will keep this information confidential, unless there is concern that you are being hurt.*

1	Person completing form	□ Self	If patient unable to complete, who helped fill out forms? □ Parent □ Friend □ Other *(specify)*										
	Do you live with…?	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*											
2	What grade are you in school?	6	7	8	9	10	11	12					1 Interval History
	Are you in special ed OR are your grades below average?		No			Unsure					Yes		
3	Since the last visit, have you • Been seen in another clinic? • Developed a new illness? • Been seen in the Emergency Room? • Been hospitalized? • Had an operation?		 No No No No No			 Unsure Unsure Unsure Unsure Unsure					 Yes Yes Yes Yes Yes		
4	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to you?		No			Unsure					Yes		
5	Do you have any questions or concerns about your health or development? *If yes, please describe:*		No			Unsure					Yes		
	Girls only- Do you have any questions or concerns about your periods?		No			Unsure					Yes		
6	Has a family member or close contact had tuberculosis disease during your lifetime?		No			Unsure					Yes		10 Tuberculosis
7	Were you born in the United States?		Yes			Unsure					No		
8	Have you lived or traveled outside of the United States for at least a **month**?		No			Unsure					Yes		
9	Do you brush **and** floss your teeth twice daily?		Often			Sometimes					Never		9 Dental
10	In the past year, have you been seen twice by a dentist?		Yes			Unsure					No		
11	How many servings of fruit (about the size of your fist) do you eat each **day**?		3+			2					0-1		8 Nutrition
12	How many servings of vegetables (about the size of your fist) do you eat each **day**?		4+			2-3					0-1		
13	How many servings a **day** do you drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, **OR** tofu?		3+			2					0-1		
14	How many times a **day** do you drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, **OR** other sweetened drinks?		0-1			2					3+		
15	How many times a **week** do you eat breakfast?		6-7			3-5					0-2		
16	How many times a **week** do you eat high-fat foods, such as fried foods, pizza, **OR** other fast food?		0-1			2-3					4+		
17	How many times a **week** do you snack on chips, pretzels, **OR** crackers?		0-1			2-3					4+		
18	How many times a **week** do you eat ice cream, cookies, **OR** other desserts?		0-1			2-3					4+		

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19	How many times a **week** do you engage in moderate to strenuous exercise or physical activity (causes you to breathe hard or sweat)?	6-7	3-5		0-2	7 Physical Activity
20	On those days that you engage in moderate to strenuous exercise or physical activity, how many **minutes** to you exercise?	60+	30-59		0-29	
21	Outside of schoolwork, how many **hours a day** do you spend on screen time (TV, phone, computer, tablet, video games, etc.)?	0-1	2+ Sometimes		2+ Often	
22	Do you have trouble falling asleep or staying asleep?	Never	Sometimes		Often	6 Sleep
23	Did you **ever** live with anyone who **often** shouted or yelled at you?	No	Unsure		Yes	5 Relationships
24	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure		Yes	
25	Are your parents separated, divorced, or not living together?	No	Deceased parent	Unsure	Yes	
26	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes		Never	
27	Do you feel that your family loves you or thinks that you are important or special?	Often	Sometimes		Never	
28	Do you have someone you can count on to listen to you when you need to talk?	Yes	Unsure		No	
29	Has your parent or anyone you **ever** lived with been arrested, deported, gone to prison, jail, or another correctional facility?	No	Unsure		Yes	
30	Have you ever been arrested or gone to jail or juvenile hall?	No	Unsure		Yes	
31	Do you have any questions about sex, preventing pregnancy, or preventing infections from oral, vaginal, or anal sex?	No	Unsure		Yes	
32	Has anyone ever touched you in a way that was unwanted, or forced you to touch that person in a sexual way?	No	Unsure		Yes	
33	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	4 Mental Health
	A1. Little interest or pleasure in doing things	0	1	2	3	A:
	A2. Feeling down, depressed, or hopeless	0	1	2	3	
	B1. Feeling nervous, anxious, or on edge	0	1	2	3	B:
	B2. Not being able to stop or control worrying	0	1	2	3	
34	During the past **few months**, have you had thoughts that you would be better off dead, or of hurting yourself?	No	Unsure		Yes	
35	Was your parent or anyone you **ever** lived with depressed, mentally ill, **OR** suicidal?	No	Unsure		Yes	
36	Do you smoke, vape, use e-cigarettes, chew tobacco, **OR** spend time with anyone who does?	No	Unsure		Yes	3 Substances
37	Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?	No	Unsure		Yes	
38	How about you—in the **past year** have you had more than a few sips of beer, wine, or any drinking containing alcohol?	No	Unsure		Yes	
39	In the past year, how many times have you had an illegal drug or used a prescription medication for non-medical reasons?	0	1		2+	

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40	Did your parent or anyone you **ever** lived with have a problem with drugs **OR** alcohol?	No	Unsure	Yes	
41	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure	No	2 Safety
42	Do you ever forget to wear a seat belt?	No	Unsure	Yes	
43	Do you ever forget to wear a helmet when on roller blades, a bike, skateboard, scooter, or motorcycle?	No	Do not ride	Yes	
44	Do you spend time near a swimming pool, river, lake, or hot tub?	No	Unsure	Yes	
45	Do you spend time with anyone who carries a weapon, or spend time in a home where a gun is kept?	No	Unsure	Yes	
46	Have you **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure	Yes	
47	Did you **ever** live with anyone who physically hurt you in anger?	No	Unsure	Yes	
48	Have you **ever** been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes	
49	In the **past year**, have you been afraid of someone you were dating or had sex with?	No	Unsure	Yes	
50	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the **last year**?	Not at all	A little	Somewhat	Fairly Very

If you have additional concerns, comments, or questions, please describe here:

Clinic Use Only: *circle each question with a positive response, sum number of circled questions*		
Child-ACE Exposures: 23 24 25 26 27 29 32 35 40 46 47 50 ∑ =		
PCP's Signature	Print Name	Date