



Risk Assessment 15-17 Years

Do you have at least one responsible adult in your life who cares and you can go to if needed for help? **YES NO**

Do you have at least one friend or group of friends with whom you are comfortable? **YES NO**

Have you become more independent and made more of your own decisions **YES NO**

Do you have any concerns about body image? **NO YES**

Vision and Hearing Screen:

Is blackboard at school difficult to see? **NO YES**

Failed School vision test **NO YES**

Do you squint? **NO YES**

Do you have problems hearing over the telephone? **NO YES**

Do you find yourself asking people to repeat themselves? **NO YES**

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

TB risk

Were you born in a country outside the U.S. **NO YES**

Have you traveled or had contact with High Risk Tb population **NO YES**

Has a family member or contact had tuberculosis or positive skin test **NO YES**

Have you tested positive for HIV **NO YES**

Anemia Risk

Have you been diagnosed with iron deficiency anemia **NO YES**

Does your diet include iron-rich foods
Such as meat, eggs, iron fortified cereal or beans **YES NO**

Do you go to school **YES NO**

Having any problems in school **NO Sometimes YES**

Do you receive healthcare from anyone besides pediatrician **NO YES**

Do you live in parent's home **YES Sometimes NO**

Do you eat meals together as family at least once a week **YES NO**

Always wears a seat belt when riding in car, truck or van **YES Sometimes NO**

Do you or anyone you live with have a gun, rifle or firearm **NO Sometimes YES**

Wears helmet/protective gear when biking, skating, skiing, or snowboarding	YES	Sometimes	NO
Are you starting to learn to drive	YES	Sometimes	NO
Do you ever use a cellphone or headphones while driving	NO		YES
Do you get along with your family	YES		NO
In general do you follow your family's rules	YES		NO

Cardiac Risk: Have you ever had:

Fainting during or after exercise, emotion or startle?	NO		YES
Extreme shortness of breath with exercise?	NO		YES
Discomfort, pain, or pressure in chest during exercise?	NO		YES

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3