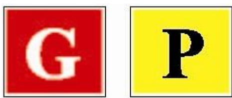

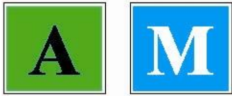


# Risk Assessment 15-17 Years

| Question | | | |
|---|---|---|---|
| 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:**

| Question | | | |
|---|---|---|---|
| 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 |

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**TB risk**

| Question | | | |
|---|---|---|---|
| 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**

| Question | | | | |
|---|---|---|---|---|
| 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** |

How old was your daughter when she had her first period (menarche)? Age____ N/A

What was the date of your daughter's last menstrual period? Date ________ N/A

**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 |

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