Total Teen Assessment

Thank you for taking this survey! We will ask you questions about your health (mental, sexual, and reproductive) so that we can better understand how to support your unique needs. The information that you share will be confidential (your parent/caregiver won't have access to the information shared) and only the clinic staff will see the your answers.

Please answer as many questions as you can as completely as possible. If there are questions that you don't want to answer or that make you feel uncomfortable feel free to skip them.

Thanks for giving us some additional information so that we can provide you with the right services and support!

Demographic Information

What name do you go by? _____

Legal First Name _____

Legal Last Name _____

What pronouns do you use? _____

Ethnicity

- ☐ Hispanic/Latino/Spanish Origin
- ☐ Not Hispanic/Latino/Spanish Origin

Race (choose all that apply)

- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino/a/e
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Multiracial or Biracial
- ☐ Other _____

Age _____

Sexual/Reproductive Health Assessment

Sexuality

The following questions are related to your sexual health. We ask these questions so we know how to best support you. Sometimes people have questions, but they are too shy to ask. Your provider is here to help address all of your health needs.

This information is confidential.

Sex Assigned at Birth

- ☐ Male
- ☐ Female
- ☐ Intersex

Gender Identity

- ☐ Man/Boy
- ☐ Girl/Woman
- ☐ Gender Queer/Gender Nonconforming/Nonbinary
- ☐ Other _____

What is your sexual orientation?

- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual or pansexual
- ☐ Questioning/Unsure
- ☐ Asexual
- ☐ Queer
- ☐ Straight (heterosexual)
- ☐ Something else

Sexual Behaviors

Have you ever had any sexual experience (the act of engaging in sexual behaviors with another person—such as oral, anal, or vaginal intercourse)?

- ☐ Yes
- ☐ No
- ☐ Unsure

Are you currently having sex or have had any kind of sex within the past 6-12 months?

- ☐ Yes
- ☐ No
- ☐ Unsure

Are you thinking about starting to have sex within the next 6 months?

- ☐ Yes
- ☐ No
- ☐ Unsure

Have you or a partner ever taken a pregnancy test because you believed one of you may be pregnant?

- ☐ Yes
- ☐ No
- ☐ Unsure

Please rate the frequency to which you or your partner(s) do each of the statements.

	Never	Sometimes	About half the time	Most of the time	Always	Not sexually active
Use contraception (method to prevent pregnancy)	☐	☐	☐	☐	☐	☐
Use condoms when you have sex	☐	☐	☐	☐	☐	☐

If you or your partner(s) uses a method to prevent pregnancy, which ones do you use? (select all that apply)

- ☐ Condoms
- ☐ Birth control pills
- ☐ Shots or injections (ex: Depo-Provera)
- ☐ Contraceptive patch (OrthoEvra) or vaginal ring (NuvaRing)
- ☐ IUD (ex: Mirena, Liletta, Kyleena or Skyla)
- ☐ Contraceptive impact in the arm (ex: Nexplanon)
- ☐ Natural family planning (including rhythm method)
- ☐ Withdrawal (pulling out)
- ☐ Other: _____
- ☐ Not sure
- ☐ Not using a method to prevent pregnancy

Would you like to learn more about contraceptive options now or in the future?

- ☐ Yes - now
- ☐ Yes - in the future
- ☐ No

Have you ever been screened for a sexually transmitted infection (STI)/disease (STD)?

- ☐ Yes - I had a positive result
- ☐ Yes - I had a negative result
- ☐ No
- ☐ Unsure

Do you want to talk to your provider about any experience where you felt forced, controlled,pressured, or coerced to engage in any sexual act when you did not want to?

- ☐ Yes
- ☐ No
- ☐ Unsure

Would you like to learn more about safer sex practices or get answers to any of your sexual health questions?

- ☐ Yes
- ☐ No

Mental Health Assessment

Mental Health

The following questions are related to your mental health (depression, anxiety).

This information is confidential.

Over the last 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
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, irritable, or hopeless	☐	☐	☐	☐
Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite, weight loss, or overeating	☐	☐	☐	☐
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things like school work, work, reading, or watching TV	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐

If you checked off any problems, 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

Have you received mental health counseling services in the last 6 months?

☐ Yes ☐ No

Are you interested in speaking with a mental health provider?

☐ Yes ☐ No

Behavioral Health Assessment

Substance Use

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs.

This information is confidential.

In the past year, how many times have you used:

	Never	Once or twice	Monthly	Weekly or more
Tobacco?	☐	☐	☐	☐
Alcohol?	☐	☐	☐	☐
Marijuana?	☐	☐	☐	☐
Vaping?	☐	☐	☐	☐
Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?	☐	☐	☐	☐
Illegal drugs (such as cocaine or Ecstasy)?	☐	☐	☐	☐
Inhalants (such as nitrous oxide or poppers)?	☐	☐	☐	☐
Herbs or synthetic drugs (such as salvia, "K2", or bath salts?)	☐	☐	☐	☐

Have you ever had an overdose experience?

☐ Yes ☐ No

Thank you for taking the time to complete this assessment!