Patient name:_____Patient #:_____

This questionnaire is designed to be filled out by our adolescent patients independently and confidentially. At any time, you may update this confidentiality release. However, as with all of our interactions we are required to report any concerns regarding child abuse, concerns for harm to others, or concerns of self-harm or suicide.

What is your given name/legal name? _____

What is your preferred name?_____

What is your preferred pronoun? (He or she or other?)_____

Phone numbers where we could reach you confidentially:_____

Who came with you to the clinic today?_____

I give my permission to Pediatrics South to discuss the following information about my Mental Health (circle all that apply): Do Not Share, Biological Mother, Biological Father, Other_____

In the past 2 weeks have you been bothered by:	Not at all	Several Days	More than Half	Everyday
• Little interest or pleasure in doing things	0	1	2	3
• Feeling down, depressed, or hopeless	0	1	2	3
• Trouble falling or staying asleep, or sleeping too much	0	1	2	3
• Feeling tired or having little energy	0	1	2	3
• Poor appetite or overeating	0	1	2	3
• Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
• Trouble concentrating on things, such as reading or watching television	0	1	2	3
• Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
• Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

If you checked off any problems above, 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? (circle one below)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

I give my permission to Pediatrics South to discuss the following information about my health related to drugs and alcohol (circle all that apply): Do Not Share, Biological Mother, Biological Father, Other_____

- Do you ever use e-cigarettes/vape, smoke cigarettes/cigars, or chew tobacco? _____
- Do you ever use alcohol, marijuana, or other drugs? _____

I give my permission to Pediatrics South to discuss the following information about my Sexual health (circle all that apply): Do Not Share, Biological Mother, Biological Father, Other_____

- I am romantically and/or sexually attracted to (please circle): males, females, both, neither, or unsure
- Have you ever had sex?
    - Have you had sex without a condom?
    - Are you using a method to prevent pregnancy? Which?

Do you have any questions or concerns that you wanted to discuss confidentially today?

Signature:_____ Date:___/___/___