Several tools have been designed to support implementing the American Medical Association’s (AMA) Guidelines for Adolescent Preventive Services (GAPS) program in your clinical setting. The six forms include the Younger Adolescent Questionnaire in English and Spanish, Middle-Older Adolescent Questionnaire in English and Spanish, and the Parent/Guardian Questionnaire in English and Spanish. The GAPS Recommendations Monograph is also included for your information and reference. The questionnaires and monograph are considered master copies that you can reproduce but not alter, modify, or revise without the expressed written consent of the Child and Adolescent Health Program at the American Medical Association.
1. Why did you come to the clinic/office today? __________________________________________
2. Do you have any health problems? ☐ Yes ☐ No Problem(s) ________________________________
3. Did you have any health problems in the past 12 months? ☐ Yes ☐ No Problem(s) ________________________________
4. Are you taking any medicine now? ☐ Yes ☐ No Name of medicine ____________________________

**For Girls**
5. Date when last period started ____________________________ Are your periods regular (monthly)? ☐ No ☐ Yes
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? ☐ Yes ☐ No

### Specific Health Issues
7. Please check whether you have questions or are worried about any of the following:
   - ☐ Height/weight
   - ☐ Blood pressure
   - ☐ Diet/food/appetite
   - ☐ Future plans/job
   - ☐ Skin (rash, acne)
   - ☐ Headaches/migraines
   - ☐ Dizziness/fainting
   - ☐ Eyes/vision
   - ☐ Ears/hearing/ear aches
   - ☐ Nose
   - ☐ Lots of colds
   - ☐ Mouth/teeth/breath
   - ☐ Neck/back
   - ☐ Chest pain/trouble breathing
   - ☐ Coughing/wheezing
   - ☐ Breasts
   - ☐ Heart
   - ☐ Stomach ache
   - ☐ Nausea/vomiting
   - ☐ Diarrhea/constipation
   - ☐ Muscle or joint pain in arms/legs
   - ☐ Frequent or painful urination
   - ☐ Discharge from penis or vagina
   - ☐ Wetting the bed
   - ☐ Sexual organs/genitals
   - ☐ Menstruation/periods
   - ☐ Wet dreams
   - ☐ Physical or sexual abuse
   - ☐ Masturbation
   - ☐ HIV/AIDS
   - ☐ Trouble sleeping
   - ☐ Feeling tired a lot
   - ☐ Cancer
   - ☐ Dying
   - ☐ Sad or crying a lot
   - ☐ Stress
   - ☐ Anger/temper
   - ☐ Violence/personal safety
   - ☐ Other (explain) ________________________________

### Health Profile
These questions will help us get to know you better. Choose the answer that best describes what you feel or do.
Your answers will be seen only by your health care provider and his/her assistant.

#### Eating/Weight
8. Are you satisfied with your eating habits? ☐ No ☐ Yes
9. Do you ever eat in secret? ☐ No ☐ Yes
10. Do you spend a lot of time thinking about ways to be thin? ☐ No ☐ Yes
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ☐ No ☐ Yes
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? ☐ No ☐ Yes

#### School
13. Are your grades this year worse than last year? ☐ No ☐ Yes ☐ Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? ☐ No ☐ Yes
15. Have you been suspended from school this year? ☐ No ☐ Yes ☐ Not in school

#### Friends & Family
16. Do you have at least one friend who you really like and feel you can talk to? ☐ No ☐ Yes
17. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? ☐ No ☐ Yes
18. Have you ever thought seriously about running away from home? ☐ No ☐ Yes ☐ Not sure
19. Do you or anyone you live with have a gun, rifle, or other firearm? □ Yes □ No □ Not sure
20. In the past year, have you carried a gun, knife, club, or other weapon for protection? □ Yes □ No
21. Have you been in a physical fight during the past 3 months? □ Yes □ No
22. Have you ever been in trouble with the law? □ Yes □ No
23. Are you worried about violence or your safety? □ Yes □ No □ Not sure
24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? □ No □ Yes
25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? □ No □ Yes
26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? □ Yes □ No
27. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? □ Yes □ No
28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? □ Yes □ No
29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? □ Yes □ No □ Not sure
30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? □ Yes □ No □ Not sure
31. Have you ever been criticized or gotten into trouble because of drinking? □ Yes □ No □ Not sure
32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? □ Yes □ No □ Does not apply
33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? □ Yes □ No
34. Does anyone in your family drink or take drugs so much that it worries you? □ Yes □ No
35. Do you ever use marijuana or other drugs, or sniff inhalants? □ Yes □ No □ Not sure
36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? □ Yes □ No □ Not sure
37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor’s prescription.) □ Yes □ No
38. Have you ever used steroid pills or shots without a doctor telling you to? □ Yes □ No □ Not sure
39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? □ Yes □ No □ Not sure
40. Do you think you may be gay, lesbian, or bisexual? □ Yes □ No □ Not sure
41. Have you ever had sexual intercourse? (How old were you the first time? ______________) □ Yes □ No □ Not sure
42. Are you using a method to prevent pregnancy? (Which: __________________________) □ Yes □ No □ Not sure
43. Do you and your partner(s) always use condoms when you have sex? □ Yes □ No □ Not sure
44. Have any of your close friends ever had sexual intercourse? □ Yes □ No □ Not sure
45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? □ Yes □ No □ Not sure
46. Have you ever been pregnant or gotten someone pregnant? □ Yes □ No □ Not sure
47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? □ Yes □ No □ Not sure
48. Have you pierced your body (not including ears) or gotten a tattoo? □ Yes □ No □ Not sure
49. Have you thought about killing yourself, made a plan or actually tried to kill yourself? □ Yes □ No □ Not sure
50. During the past few weeks, have you often felt sad or down or as though you have nothing to look forward to? □ Yes □ No
51. Have you ever seriously thought about killing yourself, made a plan or actually tried to kill yourself? □ Yes □ No
52. Have you ever been physically, sexually, or emotionally abused? □ Yes □ No □ Not sure
53. When you get angry, do you do violent things? □ Yes □ No □ Not sure
54. Would you like to get counseling about something you have on your mind? □ Yes □ No □ Not sure

55. In the past year, have you been around someone with tuberculosis (TB)? □ Yes □ No □ Not sure
56. Have you ever visited a homeless shelter, jail, or detention center? □ Yes □ No
57. Have you ever lived in foster care or a group home? □ Yes □ No

58. What four words best describe you? ______________________________________________________

59. If you could change one thing about your life or yourself, what would it be? ______________________________________________________

60. What do you want to talk about today? ______________________________________________________

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