Adolescent Well Visit Intake Form (Ages 14–17) Date: _____

Patient Name: _____ DOB: _____

Preferred Name: _____ Gender Identity:_____

To Be Completed by Parent/Guardian

1. General Health

- Any recent concerns about your teen's health? □ No □ Yes →: _____

- Any chronic health conditions? □ No □ Yes: _____

- Any surgeries, hospitalizations, or ER visits in the past year? □ No □ Yes _____

- Is your child taking any medications or supplements?

□ No □ Yes → List: _____

- Any allergies (medications, food, etc.)? □ No □ Yes → List: _____

2. Family/Social History

- Any major changes at home (divorce, move, death, etc.)?

□ No □ Yes → _____

- Family history of:

□ Diabetes □ High BP □ Mental Health Issues □ Cancer (type: _____)

□ Substance Use □ Other: _____

- Concerns about your teen's:

□ Eating □ Exercise □ Sleep □ School □ Mood □ Friends □ Screen Time

3. Immunization History

- Received vaccines outside our office?

□ No □ Yes → List: _____

Confidential Time Consent

We provide time for teens to speak privately with their provider.

□ I understand and agree to confidential time with my teen.

□ I'd like to discuss this with the provider first.

Parent/Guardian Signature: _____

Date: _____

Patient Name: _____ Birth Date: _____

Preferred Name: _____ Gender Identity:_____

To Be Completed by Teen (Confidential)

1. General

- How do you feel about your health? □ Great □ Okay □ Not Good → Why? _____

- Any changes in sleep, appetite, energy? □ No □ Yes → _____

2. School & Activities

- Are you in: □ School □ Working □ Neither

- How is it going? □ Good □ Okay □ Struggling → Why? _____

- Do you feel safe at school/home/online? □ Yes □ No

3. Mental Health

In the past 2 weeks have you felt:

- Little interest or pleasure in doing things? □ No □ Yes

- Down, depressed, or hopeless? □ No □ Yes

- Thoughts of self-harm? □ No □ Yes

4. Substance Use

Have you ever used:

- Cigarettes/vapes? □ No □ Yes

- Alcohol? □ No □ Yes

- Marijuana/other drugs? □ No □ Yes

5. Sexual Health

- Have you ever had sex? □ No □ Yes

If yes:

- Do you use barrier protection (such as condoms)? □ Yes □ No

- Are you preventing undesired pregnancy? □ Yes □ No

- Any concerns or questions? □ Yes □ No

6. Anything you want to discuss privately?

□ Yes □ No → Topic: _____