

Name: _____ ID #: _____

Date of Birth: _____ Today's Date: _____

Health Risk Profile: Confidential	Your answers will only be seen by the center staff			Office Use Only
Circle one				
1. In the past 3 months , have you taken diet pills or laxatives, made yourself vomit (throw up) after eating, or starved yourself to lose weight ?	No	Yes		
2. Do you eat some fruits and vegetables every day?	Yes	No		
3. Are you active (walking, running, dancing, swimming, biking, playing sports) for at least 1 hour, on at least 3 or more days each week?	Yes	No		
4. When you are driving or riding in a car, truck or van do you always wear a lap/seat belt?	Yes	No		
5. Do you always wear a helmet when you do any of these activities: ride a bike, rollerblade, or skateboard; ride a motorcycle, snowmobile or ATV; ski or snowboard? <input type="checkbox"/> I don't do any of these activities.	Yes	No		
6. During the past month , have you been threatened, teased, or hurt by someone (on social media, by text, or in person) causing you to feel sad, unsafe, or afraid?	No	Yes		
7. Has an adult ever physically injured you (by hitting, slapping, kicking) or has anyone ever forced you to have sex or be involved in sexual activities when you didn't want to?	No	Yes		
8. Do you carry a weapon (gun, knife, club, other) to protect yourself from another person?	No	Yes		
9. In the past 3 months , have you used any form of nicotine including vaping (e-cigarettes, Juul, RUBI, Suorin, Blu, hookah, vape pens), smoking (cigarettes, cigars, black and mild) or orally (dip, chew, snus, gummies, or lozenges)?	No	Yes		
10. In the past 12 months , have you driven a car while texting, drunk or high, or ridden in a car with a driver who was?	No	Yes		
11. In the past 3 months , have you drunk more than a few sips of alcohol (beer, wine coolers, liquor, other)?	No	Yes		
12. In the past 3 months , have you used marijuana (weed, pot, cannabis, THC) in any form such as vaping, smoking, edibles, drinks, pills, oil, or any other type?	No	Yes		
13. In the past 3 months , have you taken a prescription medication (codeine, OxyContin, Norco, Vicodin, Adderall, Ritalin, Xanax, other) without a prescription , taken more than the prescribed amount or continued to take it after you no longer needed it ?	No	Yes		
14. Have you ever had any type of sex (vaginal, anal or oral sex)?	No	Yes		
15. Are you physically attracted to people of the same gender as you or do you identify as gay, lesbian, bisexual or another identity other than straight?	No	Yes		
16. If you have had sex , do you always use a condom and/or another method of birth control to prevent sexually transmitted infections and pregnancy? <input type="checkbox"/> I have never had sex	Yes	No		
17. During the past month , did you often feel sad or down as though you had nothing to look forward to?	No	Yes		
18. Do you often feel anxious or worry a lot about things at home or at school?	No	Yes		
19. In the past 12 months , have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself?	No	Yes		
20. Do you have at least one adult in your life that you can talk to about any problems or worries?	Yes	No		
21. Do you destroy things, hurt yourself, or hurt other people when you are angry ?	No	Yes		

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Risk Discussed: _____ No Current Risk: _____

Provider Signature: _____ Date: _____