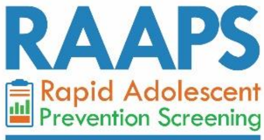

CONFIDENTIAL - ADOLESCENT HEALTH RAAPS-OC

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. Do you want to change your weight or are you concerned about the size of your body?		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. Do you watch TV, play video games, or spend time using a smartphone, tablet, or computer for **more than 3 hours** every day for **fun**?		No		Yes	
5. Do you know how to swim?		Yes		No	
6. Do you **always** wear a seatbelt when you are riding in a car, truck, or van?		Yes		No	
7. 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? ☐ I don't do any of these activities		Yes		No	
8. **In the past month,** have your feelings been hurt by someone on social media, by text, or in person?		No		Yes	
9. Has an adult **ever physically injured** you (by punching, slapping, or kicking)?		No		Yes	
10. Has anyone **ever** touched you or asked you to touch them in places that you didn't want to or that made you feel uncomfortable?		No		Yes	
11. Have you ever carried a weapon (gun, knife, club, other) **to protect yourself** from another **person**?		No		Yes	
12. Have you **ever** smoked a cigarette or tried any other kind of **nicotine** (e-cigarettes, Juul, cigars, vapes, gummies)?		No		Yes	
13. Have you **ever** ridden in a car with a driver who was texting, drunk, or high while driving?		No		Yes	
14. Have you **ever** drunk more than a few sips of alcohol (beer, wine coolers, liquor, other)?		No		Yes	
15. Have you **ever** used marijuana (pot, weed) or sniffed/huffed household products?		No		Yes	
16. Do you destroy things, hurt yourself, or hurt other people **when you are angry**?		No		Yes	
17. **On most days**, do you feel sad or alone?		No		Yes	
18. **On most days**, do you worry a lot or feel like something bad is going to happen?		No		Yes	
19. Have you **ever** felt like you didn't want to live anymore, thought about or tried to hurt or kill yourself?		No		Yes	
20. Do you have a good friend that you can talk to about anything?		Yes		No	
21. When you have a problem, do you have an adult in your life that you can talk to?		Yes		No	

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Risk Discussed: ________________________________ **No Current Risk:** ____________________

Provider Signature: ____________________________ **Date:** ______________________________

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