

Dear Adolescent,

The **Gaps (Guidelines for Adolescent Prevention Survey)** questionnaire was created by the American Medical Association to assist health care providers in identifying health behavioral and lifestyle concerns regarding adolescents. In an effort to provide more comprehensive and preventive health care to you, we request your cooperation in completing the following questionnaire. Your parent or guardian had also been given a survey to complete at this time. We ask that you and parent or guardian complete the surveys independently and do not share your answers.

The results of these questionnaires are confidential.

If today's visit is a sports physical, we also ask that you complete the injury prevention survey and appropriate health forms required by the schools prior to meeting with your health care provider.

**Guidelines for Adolescent Preventive Services –GAP Survey**

**Adolescent Questionnaire** Confidential (Your answers will not be given out.)

**Family Information**

- Who do you live with (check all that apply)?  
 Mother                       Stepmother                       Brother(s)/ages \_\_\_\_\_  
 Father                          Stepfather                          Sister(s)/ages \_\_\_\_\_  
 Guardian                       Other Adult                          Other/explain \_\_\_\_\_
- In the past year have there been changes in your family?  
 Marriage                          Loss of job                          Births  
 Separation                       Moved                              Serious illness/injury  
 Divorce                          New School                          Death
- Do you get along with your family?.....  No  Yes

**Health Issues**

- Do you spend a lot of time thinking of ways to be skinny? .....  Yes  No
- Do you do things to lose weight (skip meals, take pills, starve yourself, vomit) .....  Yes  No
- Do you work, play or exercise enough to make you sweat or breath hard at least three times a week? .....  No  Yes

**School**

- Are your grades worse than they used to be? .....  Yes  No
- Have you ever been getting failing grades in any subjects this year.....  Yes  No
- Have you been told that you have a learning problem? .....  Yes  No
- Have you been suspended from school this year? .....  Yes  No
- Do you go to school regularly? .....  No  Yes

**Friends/Family**

- Do you know at least one adult who you can talk to about your problems? .....  No  Yes
- Do you think that your parent(s) usually listen to you?.....  No  Yes
- Have your parents talked to you about things like alcohol, drugs, sex?.....  No  Yes
- Are you worried about problems at home or in your family? .....  Yes  No
- Have you thought seriously about running away from home? .....  Yes  No

**Safety**

- Is there a gun, rifle, or other firearms where you live?.....  Yes  No
- Have you ever carried a weapon to protect yourself?.....  Yes  No
- Have you ever been in a physical fight with someone? .....  Yes  No
- Have you ever been in trouble with the police?.....  Yes  No
- Are you worried about your safety? .....  Yes  No
- Do you wear a helmet when you rollerblade, skateboard, or ride a bike? .....  No  Yes
- Do you wear a helmet when riding an ATV or snowmobile? .....  No  Yes
- Do you always wear a seatbelt when you ride in a vehicle? .....  No  Yes
- Do you ever drive a motor vehicle after drinking alcohol?.....  Yes  No
- Are you ever a passenger in a vehicle being driven by someone who has been drinking? .....  Yes  No

**Tobacco/Alcohol**

- 27. Do you use or have you ever tried cigarettes or chewing tobacco? .....  Yes  No
- 28. Does anyone you live with smoke cigarettes or chew tobacco? .....  Yes  No
- 29. Have you ever tried beer, wine or other alcohol? .....  Yes  No
- 30. Does anyone in your family drink so much that it worries you? .....  Yes  No
- 31. Have you ever taken things to get high, stay awake, calm you down or go to sleep? .....  Yes  No
- 32. Have you used marijuana, cocaine, speed, meth, or any other drug? .....  Yes  No

**Development/Relationships**

- 33. Are you thinking about having sex or have you ever had sex? .....  Yes  No
- 34. Have you ever felt pressured by anyone to have sex or had sex when you did not want to?.....  Yes  No
- 35. Have you ever been told that you have a sexually transmitted disease like herpes, gonorrhea, or Chlamydia?.....  Yes  No
- 36. Would you like to know how to avoid getting pregnant, getting HIV, or getting sexually transmitted diseases? .....  Yes  No

**Emotions**

- 37. When you get angry do you do violent things? .....  Yes  No
- 38. Do you often feel sad or down as though you have nothing to look forward to?.....  Yes  No
- 39. Have you ever thought about hurting or killing yourself? .....  Yes  No
- 40. Do you sometimes find that you cut yourself? .....  Yes  No
- 41. Is there something you often worry about or fear? .....  Yes  No
- 42. Have you ever been physically, emotionally or sexually abused?.....  Yes  No

**Specific Health Issues**

Please check whether you have questions or are worried about any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Height           | <input type="checkbox"/> Neck/back            | <input type="checkbox"/> Muscle pain in arms/legs | <input type="checkbox"/> Anger/temper     |
| <input type="checkbox"/> Weight           | <input type="checkbox"/> Breasts              | <input type="checkbox"/> Menstruation/periods     | <input type="checkbox"/> Feeling tired    |
| <input type="checkbox"/> Eyes/vision      | <input type="checkbox"/> Heart                | <input type="checkbox"/> Wetting the bed          | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Hearing          | <input type="checkbox"/> Coughing/wheezing    | <input type="checkbox"/> Trouble urinating/peeing | <input type="checkbox"/> Having friends   |
| <input type="checkbox"/> Colds/runny nose | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Drip from penis/vagina   | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Stomach Ace      | <input type="checkbox"/> Mouth/teeth/breath   | <input type="checkbox"/> Wet dreams               | <input type="checkbox"/> HIV/AIDS         |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Vomiting/throwing up | <input type="checkbox"/> Skin (rash/acne)         | <input type="checkbox"/> Dying            |

Other:\_\_\_\_\_

**Self**

What two words describe yourself?

- ◆ \_\_\_\_\_
- ◆ \_\_\_\_\_

If you could have three wishes come true what would they be?

- ◆ \_\_\_\_\_
- ◆ \_\_\_\_\_
- ◆ \_\_\_\_\_

May we share this information with your parents? .....  Yes  No

This survey was modified from the AMA Guidelines for Adolescent Prevention Survey