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**

1. Who do you live with (check all that apply)?
   - Mother
   - Stepmother
   - Brother(s)/ages
   - Father
   - Stepfather
   - Sister(s)/ages
   - Guardian
   - Other Adult
   - Other/explain

2. 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

3. Do you get along with your family? .................................................................................................................................................. _No _Yes

**Health Issues**

4. Do you spend a lot of time thinking of ways to be skinny? ........................................................................................................ _Yes _No
5. Do you do things to lose weight (skip meals, take pills, starve yourself, vomit) ......................................................................................................................... _Yes _No
6. Do you work, play or exercise enough to make you sweat or breath hard at least three times a week? ..................................................................................................................................................... _No _Yes

**School**

7. Are your grades worse than they used to be? ........................................................................................................................................ _Yes _No
8. Have you ever been getting failing grades in any subjects this year? ........................................................................................................ _Yes _No
9. Have you been told that you have a learning problem? ........................................................................................................ _Yes _No
10. Have you been suspended from school this year? ..................................................................................................................... _Yes _No
11. Do you go to school regularly? ................................................................................................................................................... _No _Yes

**Friends/Family**

12. Do you know at least one adult who you can talk to about your problems? ............................................................................... _No _Yes
13. Do you think that your parent(s) usually listen to you? ................................................................................................................... _No _Yes
14. Have your parents talked to you about things like alcohol, drugs, sex? ........................................................................................... _No _Yes
15. Are you worried about problems at home or in your family? ............................................................................................................ _Yes _No
16. Have you thought seriously about running away from home? ........................................................................................................ _Yes _No

**Safety**

17. Is there a gun, rifle, or other firearms where you live? ................................................................................................................... _Yes _No
18. Have you ever carried a weapon to protect yourself? ..................................................................................................................... _Yes _No
19. Have you ever been in a physical fight with someone? ..................................................................................................................... _Yes _No
20. Have you ever been in trouble with the police? ..................................................................................................................... _Yes _No
21. Are you worried about your safety? ................................................................................................................................................ _Yes _No
22. Do you wear a helmet when you rollerblade, skateboard, or ride a bike? .................................................................................................................. _No _Yes
23. Do you wear a helmet when riding an ATV or snowmobile? .................................................................................................................. _No _Yes
24. Do you always wear a seatbelt when you ride in a vehicle? .................................................................................................................. _No _Yes
25. Do you ever drive a motor vehicle after drinking alcohol? .................................................................................................................. _Yes _No
26. 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:

- Height
- Weight
- Eyes/vision
- Hearing
- Colds/runny nose
- Stomach
- Headaches
- Neck/back
- Breasts
- Heart
- Coughing/wheezing
- Chest pain
- Drip from penis/vagina
- Mouth/teeth/breath
- Vomiting/throwing up

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