MR # DOB

NAME

DATE

BASSETT MEDICAL CENTER
Cooperstown, NY 13326-1394

9-11-YEAR-OLD CONFIDENTIAL – ADOLESCENT HEALTH RAAPS-OC

H-9370 7/14;5/16 (d\forms\hosp\.ofm)

Name: _____ Sex: _____ Insurance: _____

Birthdate: _____ Ethnic/Race: _____ Reg #: _____

Health Risk Profile: Confidential **Your answers will only be seen by the centerstaff**					**Office Use Only**
1. Do you think that you need to lose weight?		No		Yes	
2. Do you eat some fruits and vegetables every day?		Yes		No	
3. Are you active after school or on weekends (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 **more than 2 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. When you do **any** of these activities: ride a bike, rollerblade, skateboard, ride a motorcycle or snowmobile, ski or snowboard, do you **always** wear a helmet? ☐ I don't do any of these activities.		Yes		No	
8. **In the past month,** have your feelings been hurt by someone on the internet, by text, or in person?		No		Yes	
9. Has anyone **ever abused** you (punched, slapped, kicked or beat you up)?		No		Yes	
10. Has anyone **ever** touched you or asked you to touch them in places that you didn't want toor that made you feel uncomfortable?		No		Yes	
11. Have you **ever** carried a weapon (gun, knife, club, other) to **protect** yourself?		No		Yes	
12. Have you **ever** smoked a cigarette or tried any kind of tobacco (e-cigarettes, cigars, hookah, chewing tobacco, dip, snus, vape pens)?		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, grass) or sniffed / huffed household products?		No		Yes	
16. When you are angry, do you do things that could get you in trouble?		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 orkill 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	

For Office Use Only

Evaluation: _____ At Risk Counseled _____ At Risk Needs f/u _____ No Current Risk **Referred to:** _____

Provider Signature: **Provider #** **Date:**

RAAPS