

HEADDS QUESTIONNAIRE – FEMALE AGE 14 AND UP

Patient Name _____	Date of Birth _____	Today's Date _____
Tobacco	Smoking cigarettes	Chewing tobacco
I use the following	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
I have experienced with	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
Vaping/e-cigarette	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO

My parents are _____ (married, divorced, separated, etc.). I live with _____

Does anyone you live with smoke cigarettes? YES NO

Do you have any brothers or sisters? If so, what are their names: _____

Do you have any pets? YES NO Are their smoke detectors in your home? YES NO

If there is a gun in your house, is it locked up? YES NO

How do you get along with the other people in your home?

Answer these questions based on how you feel most of the time.	Not at all	Several days	More than half the days	Nearly every day
I have little pleasure or interest in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experience feeling down, depressed, or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you ever feel unsafe? YES NO Have you ever been abused by someone? YES NO

Do you regularly wear your safety belt when riding in or driving a car? YES NO

Do you wear a helmet when riding a bicycle or motorcycle? YES NO

Do you know how to swim? YES NO Do you regularly use sunscreen? YES NO

Do any of your friends smoke, drink alcohol, or use drugs? YES NO

Have you ever experimented with drugs (marijuana, cocaine, molly, etc.)? YES NO

Have you ever experimented with alcohol? YES NO

Have you started dating? YES NO Do you have any questions about dating or sex? YES NO

Has anyone tried to force you to have sex? YES NO Have you felt pressured to have sex? YES NO

Have you ever had sex or came close to having sex? YES NO If you had sex, did you use a condom? YES NO

Have you had a period yet? YES NO If yes, what age did you begin? _____ Are they regular? YES NO

How many days do they last? _____ Are they regular? YES NO How heavy are they? _____

Do you have much cramping with your periods? _____

Where do you go to school? _____ What grade are you in? _____

What grades are you making? _____ Have you ever failed a class or a grade? YES NO

How are things at school? _____

What do you do when you are not in school? _____

What do you plan on doing after graduating from high school? _____

Do you have any close friends? YES NO Who do you go to with problems? _____

Have you ever thought about hurting yourself? YES NO

Are you satisfied with your body weight? YES NO Do you think feel like you eat a well-balanced diet? YES NO

Do you eat fast food often? YES NO Do you drink carbonated beverages (coke, pepsi, energy drinks? YES NO

How much time/day do you spend watching TV, playing video games, or on the computer? _____

Do you exercise at least 3 times a week? YES NO Do you own a smart phone? YES NO