Whole Child Assessment- Version 3
For 18 – 20+ Years

Please answer all the questions on this form as best you can. It will help us know how we can help you be healthy. ***You may skip any question if you do not know an answer or do not want to answer.*** *You may add comments to explain your answers. We will keep this information confidential, unless there is concern that you are being hurt.*

1	Person completing form	□ Self	If patient unable to complete, who helped fill out forms? □ Parent □ Friend □ Other *(specify)*			
	Do you live with…?	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*				
2	Since the last visit, have you • Been seen in another clinic? • Developed a new illness? • Been seen in the Emergency Room? • Been hospitalized? • Had an operation?		No No No No No	Unsure Unsure Unsure Unsure Unsure	Yes Yes Yes Yes Yes	1 Interval History
3	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to you?		No	Unsure	Yes	
4	Do you have any questions or concerns about your health? *If yes, please describe:*		No	Unsure	Yes	
5	Has a family member or close contact had tuberculosis disease during your lifetime?		No	Unsure	Yes	10 Tuberculosis
6	Were you born in the United States?		Yes	Unsure	No	
7	Have you lived or traveled outside of the United States for at least a **month**?		No	Unsure	Yes	
8	Do you brush **and** floss your teeth twice daily?		Often	Sometimes	Never	9 Dental
9	In the past year, have you been seen twice by a dentist?		Yes	Unsure	No	
10	How many servings of fruit (about the size of your fist) do you eat each **day**?		3+	2	0-1	8 Nutrition
11	How many servings of vegetables (about the size of your fist) do you eat each **day**?		4+	2-3	0-1	
12	How many servings a **day** do you drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, **OR** tofu?		3+	2	0-1	
13	How many times a **day** do you drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, **OR** other sweetened drinks?		0-1	2	3+	
14	How many times a **week** do you eat breakfast?		6-7	3-5	0-2	
15	How many times a **week** do you eat high-fat foods, such as fried foods, pizza, **OR** other fast food?		0-1	2-3	4+	
16	How many times a **week** do you snack on chips, pretzels, **OR** crackers?		0-1	2-3	4+	
17	How many times a **week** do you eat ice cream, cookies, **OR** other desserts?		0-1	2-3	4+	

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18	How many times a **week** do you engage in moderate to strenuous exercise or physical activity (causes you to breathe hard or sweat)?	6-7	3-5	0-2	7 Physical Activity
19	On those days that you engage in moderate to strenuous exercise or physical activity, how many **minutes** to you exercise?	60+	30-59	0-29	
20	Do you have trouble falling asleep or staying asleep?	Never	Sometimes	Often	6 Sleep
21	Did you **ever** live with anyone who **often** shouted or yelled at you?	No	Unsure	Yes	5 Relationships
22	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes	
23	Are your parents separated, divorced, or not living together?	No	Deceased parent / Unsure	Yes	
24	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes	Never	
25	Do you feel that your family loves you or thinks that you are important or special?	Often	Sometimes	Never	
26	Do you have someone you can count on to listen to you when you need to talk?	Yes	Unsure	No	
27	Has your parent or anyone you **ever** lived with been arrested, deported, gone to prison, jail, or another correctional facility?	No	Unsure	Yes	
28	Have you ever been arrested or gone to jail or juvenile hall?	No	Unsure	Yes	
29a	What sex were you assigned at birth?	❑ Female ❑ Male ❑ Don't know (not sure) Prefer not to answer			
29b	What is your current gender identity?	❑ Female ❑ Male ❑ Nonbinary ❑ Other (another gender) ❑ Transgender female ❑ Transgender male ❑ Don't know (not sure) Prefer not to answer			
29c	Do you think of yourself as…?	❑ Gay ❑ Lesbian ❑ Straight (heterosexual) ❑ Bisexual ❑ Pansexual ❑ Asexual ❑ Something else ❑ Don't know (not sure) Prefer not to answer			
30	Do you have any questions about sex, preventing pregnancy, or preventing infections from oral, vaginal, or anal sex?	No	Unsure	Yes	
31	In the past year, have you been sexually active with more than one partner?	No	Unsure	Yes	

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32	Before age 18, did anyone touch you in a way that was unwanted, or forced you to touch that person in a sexual way?	No	Unsure		Yes	
33	Before age 18, did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you?	No	Unsure		Yes	
34	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	4 Mental Health
	A1. Little interest or pleasure in doing things	0	1	2	3	A:
	A2. Feeling down, depressed, or hopeless	0	1	2	3	
	B1. Feeling nervous, anxious, or on edge	0	1	2	3	B:
	B2. Not being able to stop or control worrying	0	1	2	3	
35a	In the past few weeks, have you wished you were dead?	No	Unsure		Yes	
35b	In the past few weeks, have you felt that you or your family would be better off if you were dead?	No	Unsure		Yes	
35c	In the past week, have you been having thoughts about killing yourself?	No	Unsure		Yes	
35d	Have you ever tried to kill yourself?	No	Unsure		Yes	
36	Was your parent or anyone you **ever** lived with depressed, mentally ill, **OR** suicidal?	No	Unsure		Yes	
37	Do you smoke, vape, use e-cigarettes, chew tobacco, **OR** spend time with anyone who does?	No	Unsure		Yes	3 Substances
38	In the past year, how many times have you had 4 or more drinks containing alcohol in **one day**?	0	1		2+	
39	During the **past 12 months**, on how many days did you use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "synthetic marijuana" (like "K2," "Spice")?	0	1		2+	
40	During the **past 12 months**, on how many days did you use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)?	0	1		2+	
41	Have you ever ridden in a **car** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Unsure		Yes	
42	Did your parent or anyone you **ever** lived with have a problem with drugs **OR** alcohol?	No	Unsure		Yes	
43	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure		No	2 Safety
44	Do you ever forget to wear a seat belt?	No	Unsure		Yes	
45	Do you ever forget to wear a helmet when on roller blades, a bike, skateboard, scooter, or motorcycle?	No	Do not ride		Yes	
46	Is there a gun in your home or place where you live?	No	Unsure		Yes	
47	Have you **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure		Yes	
48	Did you **ever** live with anyone who physically hurt you in anger?	No	Unsure		Yes	

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49	Have you **ever** been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes	
50	In the **past year**, have you been afraid of someone you were dating or had sex with?	No	Unsure	Yes	
51	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the **last year**?	Not at all	A little	Somewhat	Fairly Very

If you have additional concerns, comments, or questions, please describe here:

Clinic Use Only		
21 or 22 = 23 = 24 or 25 = 27 = 32 = 33 = 36 = 42 = 47 = 48 = ∑ = ACEs		
PCP's Signature	Print Name	Date