

WELCOME

tell us about you

so we can make this visit yours



As you fill this out, circle or write what you would like to discuss. Let's get started!

What name
do you go by?

Date

1 Would you like to **become pregnant** in the next year?
 Yes No
 Unsure Okay Either Way

2 Are you **having sex**?
 Yes No

3 In the last year, have you been screened and/or diagnosed with any **sexually transmitted infections**, such as chlamydia, gonorrhea, herpes, syphilis, HIV/AIDS?
 Yes No

4 Do you ever feel **unsafe at home, work, or school**?
 Yes No

5 Do you have family or friends that you **can count on** for help if you need it?
 Yes No I'm not sure

6 How well are you **coping with the stress** in your life?



Great Fine Not sure Not Really Not at all

7 In the last six months, have you had **little interest or pleasure in doing things or thoughts of self-harm**?
 Yes
 No

8 In the last six months, have you felt **down, depressed, or hopeless**?
 Not at all
 Several Days
 More than half the days
 Nearly every day

...almost there!!

9 Do you use **tobacco**?
smoking vaping smokeless
(circle)
 Former
 Current
 Never
 Interested in quitting

10 Does anyone **smoke or vape**
in your home or vehicle?
 Yes No

11 How many times in the past month
have you had **four or more**
alcoholic drinks in one day?
(1- 12oz. beer, 1- 6oz wine, 1.5oz
hard liquor)
 None
 1 or More

12 How many times in the past six
months have you **used drugs**
(weed, pills, party drug) or used
a **prescription medication for**
non-medical reasons?
 None
 1 or More

13 Have you ever been **diagnosed** with:
 Diabetes
 High blood pressure
 Asthma
 Other Condition _____
 None / Not Applicable

14 What are your **weight goals**?
 I would like to gain weight
 I would like to lose weight
 I'd like to maintain my current
weight
 I am not concerned about my
weight

15 Are you **regularly eating fruits**
and vegetables most days?
 Yes No

16 Are you **taking a multivitamin**
most days?
 Yes No

17 What would **you like to discuss**?

