

Wellness Check-in (Grades 6-8)

Please answer these questions to help us get to know you.

Your answers are kept confidential unless you are in danger of hurting yourself or someone else, or if someone is hurting you. In that case, we would make sure that you have the support you need to be safe.

It is OK to skip any questions you are not comfortable answering.

Name: _____

Date: _____



How many times a day do you brush your teeth?	0	1	2	3		
How many times a week do you floss your teeth?	0	1	2	3	4	5 6 7
Do you need a toothbrush and floss for home?	Yes	No				
Have you seen a dentist in the past 12 months?	Yes	No				

Do you exercise regularly? **Yes** **No** How many days per week? 0 1 2 3 4 5 6 7

What kinds of physical activity do you enjoy? _____

What kinds of things do you like to do in your free time? _____

How many hours a day do you watch TV, game, or do social media? 0 1 2 3 4 5 6 7+

What time do you go to sleep? _____ What time do you wake up? _____



How much do you like yourself?	Not at all	1	2	3	4	5	A lot
How happy are you with your weight?	Not at all	1	2	3	4	5	Happy
Do you worry about how your body looks?	Yes	No					
Have you tried to change your weight by skipping meals, making yourself throw up, or taking a laxative or pills?	Yes	No					
Do you have a safe adult to talk to you if you are feeling unhappy about your body?	Yes	No					

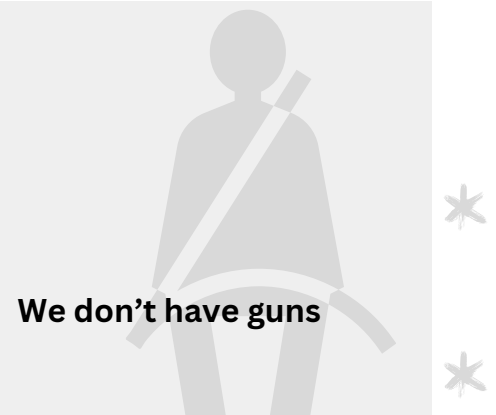
Do you always wear a seatbelt in the car? **Yes** **No**

Do you use a helmet when you ride a bike, skateboard or scooter? **Yes** **No**

Do you need help getting a helmet? **Yes** **No**

If there are guns in your home, are they locked and stored in a safe place? **Yes** **No**

Do you need help getting a gun lock? **Yes** **No**



We don't have guns





Who do you live with? _____

How well do you get along with people at home? **Not at all** 1 2 3 4 5 **Get along great**

Do you feel safe at home? **Yes** **No**

Are there times when your family does not have enough food to eat? **Yes** **No**



How do you feel you are doing in school? **Not doing well** 1 2 3 4 5 **Doing great**

What kind of grades do you normally get? **A B C D F**

Is it hard to read, write or spell? **Yes** **No**

Have you ever been suspended or had a referral? **Yes** **No**

Does anyone pick on you or bully you? **Yes** **No**



Is there anything that is making you feel worried, upset or stressed? **Yes** **No**

What kinds of things help you feel less stressed?

Do you have one good friend or a group of friends you are comfortable with? **Yes** **No**

Has anyone ever hurt, touched, or treated you in a way that made you feel scared or uncomfortable? **Yes** **No**

Who is an adult who cares about you? _____

Would you like to talk with a therapist/counselor? **Yes** **No**



What are your preferred pronouns? **She/her He/him They/them Other** _____

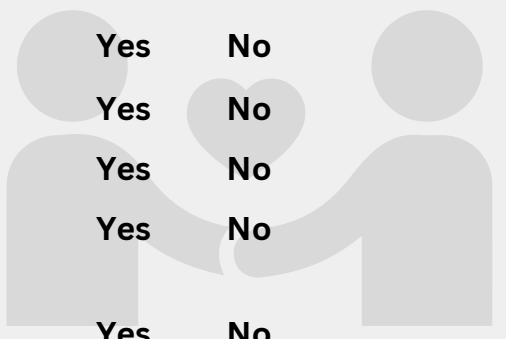
Do you feel supported in your gender and sexual identity? **Yes** **No**

Do you have questions about puberty or your body changes? **Yes** **No**

Do you know what consent means in relationships? **Yes** **No**

Do you have questions about sex or relationships? **Yes** **No**

Is there a safe adult that you feel comfortable talking to about relationships, sex, and substances like marijuana or alcohol? **Yes** **No**



Please write any questions or anything else you would like us to know about you:

