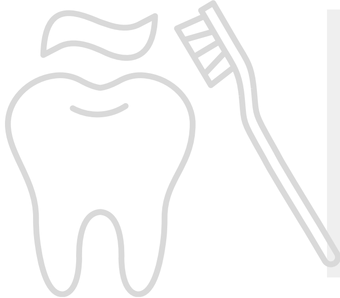
Wellness Check-in (Grades 9-12)

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 We don't have guns**

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

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 <u>less</u> stressed?

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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**

Have you ever had sex? **Yes (which types: oral vaginal rectal ask me)** **No**

Are you interested in screening for sexually transmitted infections? **Yes** **No**

Do you want condoms or birth control? (both are free) **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:

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