

CONFIDENTIALITY STATEMENT

Patient Information for Adolescent Visits 13 to 18 year-old Adolescents

Because of our respect for you, as a young adult, we would like to offer you time to discuss issues with your doctor without your parent's presence. We promise you confidentiality. Only if we become concerned that you are going to hurt yourself or someone else, will these matters be discussed with your parents. We will encourage you to discuss these issues openly with your family and hope to help you think of ways to do this.

During teenage years, your values may no longer match that of your family and you may be experimenting with behaviors that place your health and/or safety at risk. Please help us help you by honestly answering the following questions.

1. Do you now, or have you in the past, smoked cigarettes, cigars, or pipes or chewed tobacco?
Yes No
2. Do you now, or have you in the past, used any illegal drugs (including marijuana)?
Yes No
3. Do you now, or have you in the past, used any performance enhancing substances?
Yes No
4. Do you now, or have you in the past ever sniffed anything to get high?
Yes No
5. Do you now, or have you in the past ever drink alcohol, even just once or twice?
Yes No
6. Are you having sex now, or have you in the past had sex with anyone?
Yes No
7. If so, was this with your consent (something you wanted to do)?
Yes No
8. If so, was any kind of birth control and/or condoms, etc. used?
Yes No
9. Do you now, or have you in the past, felt depressed, anxious or thought about hurting yourself or others?
Yes No
10. Is anyone harming you physically, emotionally, or sexually?
Yes No
11. Have you ever felt that your weight was an issue or made attempts to lose weight in a manner that would put your health at risk (vomiting, pills, and/or laxatives)
Yes No
12. Have you ever used the internet in an inappropriate manner (explicit web sites, chatting with strangers)?
Yes No
13. Do you have concerns about your grades or learning issues?
Yes No
14. Have you ever been in trouble with the law?
Yes No
15. Do you wear your seatbelt when you ride in the car?
Yes No
16. Do you wear a helmet/other protective gear when bike riding, rollerblading, skateboarding, etc.?
Yes No
17. Do you have any issues you would like to discuss confidentially with the doctor today?
Yes No

Your signature: _____ **Date:** _____