



Well Adult Check: (18+ years)

Your Name: _____

Do you have any concerns, questions, or problems that you would like to discuss today? If yes, please describe:

What are you most proud of about yourself?

What year are you in school and where? _____

Do you take any medications or supplements, including vitamins? No Yes: _____

Do you have known allergies to foods/medicines? No Yes: _____

Do you see any specialists outside of Oberlin? No Yes: _____

Dental:

Do you brush your teeth 2x a day? Yes No

Do you floss your teeth once a day? Yes No

Do you see the dentist regularly? Yes No

Tuberculosis screen:

Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test? No Yes

Were you or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? No Yes

Social Health:

Do you smoke cigarettes or use e-cigarettes? No Yes

Do you chew tobacco or use other tobacco products? No Yes

Do you drink alcohol? No Yes

Have you ever used drugs, including marijuana or street drugs? No Yes

Have you ever prescription drugs that were not given to you for a medical condition? No Yes

Is there anyone in your life whose alcohol, tobacco, or drug use concerns you? No Yes

MENTAL HEALTH SCREEN (PHQ-2)

In the past two weeks, how often have you been bothered by the following symptoms:

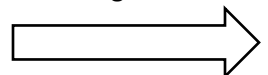
1. Feeling down, depressed, irritable, or hopeless?
Not at all Several Days More than half of the time Nearly every day

2. Little interest or pleasure in doing things?
Not at all Several Days More than half of the time Nearly every day

Sexual and Gender Health

If you have been in romantic relationships, have you always felt safe and respected? Yes No

Have you ever had sex, including oral, vaginal, or anal sex? (if no, skip to the *question) No Yes



- Have you had multiple partners in the past year? No Yes
- Do you and your partner use condoms every time? Yes No
- Do you and your partner always use another form of birth control along with a condom? Yes No
- Are you aware of emergency contraception? Yes No
- Do you sleep with... men women both? No Yes
- Have you ever been treated for an STD? No Yes
- *Do you have questions about gender identity? No Yes
- Do you identify as: male female _____

Nutrition:

- Do you get 3 servings of dairy a day? Yes No
- What milk do you drink? _____
- Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)? No Yes
- If you are a vegetarian, do you take an iron supplement? Yes No

Females:

- Do you have excessive menstrual bleeding No Yes
- Do you have problems with cramping, irregularity, etc.? No Yes

Where do you live most of the time? _____

Are parents: single married divorced separated

- Do you get along with the people you live with? Yes No
- Do you have ways that help you deal with feeling angry? Yes No

Are you physically active most days? Yes No

This includes running, playing sports, or doing physically active things with friends?

- How much time do you spend on screen time unrelated to work or school each day? _____
- Do you have trouble getting sleep at night or waking up in the morning? No Yes

Do you harm yourself, such as by cutting, hitting, or pinching yourself? No Yes

Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts? Yes No

Do you often listen to loud music? No Yes

Do you always wear a lap and shoulder seat belt? Yes No

Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV? Yes No

Do you ever use your phone or tablet while driving, even at stop signs? No Yes

Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else? Yes No

Do you have a close friend? Yes No

Do you get along with members of your family? Yes No

Do you have activities you like to do after school or work or on the weekends? Yes No

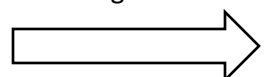
Do you help others out at home, at school, or in your community? Yes No

Do you feel really stressed out all the time? No Yes

Do you have strategies to reduce or relieve your stress? Yes No

Do you have any concerns about your weight? No Yes

Are you currently doing anything to try to gain or lose weight? No Yes



- | | | |
|---|------------------------------|------------------------------|
| Do you eat fruit and vegetables every day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink sugar sweetened beverages (juice, soda, sports drinks)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you ever skip meals? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you eat meals together with your family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | |
| Do you use sunscreen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you visit tanning parlors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | |
| Do you have access to unlocked guns? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | |
| Have you ever been hit, or physically hurt while on a date? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever been touched in a sexual way against your wishes or without your consent? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever been forced to have sexual intercourse? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you ever been in a relationship with someone who threatened or hurt you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you feel threatened by anyone? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Are you worried that you might hurt someone else? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | |
| Do you feel safe in your current living situation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In the past 12 months, did you worry that your food would run out before you got money to buy more? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| In the past 12 months, did the food you bought not last, and you did not have money to buy more? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |