HEADDS QUESTIONNAIRE – FEMALE AGE 11-13

Patient Name	Date of Birth	Today's Date

Tobacco	Smoking cigarettes		Chewing tobacco		Vaping/e-cigarette	
I use the following	◯ YES	◯ NO	◯ YES	◯ NO	◯ YES	◯ NO
I have experienced with	◯ YES	◯ NO	◯ YES	◯ NO	◯ YES	◯ NO

My parents are _____ (married, divorced, separated, etc.). I live with _____
_____.

Does anyone you live with smoke cigarettes? ◯ YES ◯ NO

Do you have any brothers or sisters? If so, what are their names: _____
_____.

Do you have any pets? ◯ YES ◯ NO Are their smoke detectors in your home? ◯ YES ◯ NO

If there is a gun in your house, is it locked up? ◯ YES ◯ NO

How do you get along with the other people in your home?

Answer these questions based on how you feel most of the time.	Not at all	Several days	More than half the days	Nearly every day
I have little pleasure or interest in doing things.	◯	◯	◯	◯
I experience feeling down, depressed, or hopeless.	◯	◯	◯	◯

Do you ever feel unsafe? ◯ YES ◯ NO Have you ever been abused by someone? ◯ YES ◯ NO

Do you regularly wear your safety belt when riding in or driving a car? ◯ YES ◯ NO

Do you wear a helmet when riding a bicycle or motorcycle? ◯ YES ◯ NO

Do you know how to swim? ◯ YES ◯ NO Do you regularly use sunscreen? ◯ YES ◯ NO

Do any of your friends smoke, drink alcohol, or use drugs? ◯ YES ◯ NO

Have you ever experimented with drugs (marijuana, cocaine, molly, etc.)? ◯ YES ◯ NO

Have you ever experimented with alcohol? ◯ YES ◯ NO

Have you started dating? ◯ YES ◯ NO Do you have any questions about dating? ◯ YES ◯ NO

Do you ever feel pressured by your peers? ◯ YES ◯ NO

Have you had a period yet? ◯ YES ◯ NO If yes, what age did you begin? _____ Are they regular? ◯ YES ◯ NO

How many days do they last? _____ Are they regular? ◯ YES ◯ NO How heavy are they? _____

Do you have much cramping with your periods? _____

Where do you go to school? _____ What grade are you in? _____

What grades are you making? _____ Have you ever failed a class or a grade? ◯ YES ◯ NO

How are things at school? _____

What do you do when you are not in school? _____

What do you plan on doing after graduating from high school? _____

Do you have any close friends? ◯ YES ◯ NO Who do you go to with problems? _____

Have you ever thought about hurting yourself? ◯ YES ◯ NO

Are you satisfied with your body weight? ◯ YES ◯ NO Do you think feel like you eat a well-balanced diet? ◯ YES ◯ NO

Do you eat fast food often? ◯ YES ◯ NO Do you drink carbonated beverages (coke, pepsi, energy drinks? ◯ YES ◯ NO

How much time/day do you spend watching TV, playing video games, or on the computer? _____

Do you exercise at least 3 times a week? ◯ YES ◯ NO Do you own a smart phone? ◯ YES ◯ NO