

## TEEN SURVEY



### FOR OFFICE USE ONLY:

SITE: \_\_\_\_\_ HEALTH EDUCATOR: \_\_\_\_\_ PATIENT ID: \_\_\_\_\_ DATE: \_\_\_\_\_

SESSION TYPE:  INITIAL  1 MONTH  3 MONTH  6 MONTH  12 MONTH  
 SA1  SA 2

### INSTRUCTIONS:

*Please answer each question by checking or writing in a response.  
There is not a right or wrong answer, so please answer as you wish.  
All of your responses will be confidential and will be used to help us improve our program.*

1. How old are you? \_\_\_\_\_

2. What grade are you in (check a box below)?

5<sup>th</sup>  6<sup>th</sup>  7<sup>th</sup>  8<sup>th</sup>  9<sup>th</sup>  10<sup>th</sup>  11<sup>th</sup>  12<sup>th</sup>  
 Not in School  GED  Technical/Vocational School  College  Other

3. Are you Hispanic or Latina?  NO  YES

4. What is your race? (You can mark an X on more than one box)

American Indian or Alaska Native  White  Asian  Black or African -American  
 Native Hawaiian or Other Pacific Islander  Some other race (please describe): \_\_\_\_\_

5. What language do you usually speak at home? (You can mark an X in more than one box)

English  Spanish  Chinese  Hmong  Other language: \_\_\_\_\_

6. Have you ever had vaginal sex (penis in vagina)?  NO  YES

7. Have you ever had anal sex (penis in anus)?  NO  YES

8. Have you ever had oral sex (mouth on penis and/or vagina)?  NO  YES

9. In the last six months, how many times have you had any type of sex? \_\_\_\_\_

10. Have you ever used a condom?  NO  YES

11. In the last six months, how many times have you used a condom? \_\_\_\_\_

12. Have you ever had a Sexually Transmitted Infection (STI)?  NO  YES

13. Please mark any Sexually Transmitted Infections (STIs) you have ever had?

Chlamydia  Gonorrhea  Genital Herpes  Syphilis  HIV/AIDS  
 Other (please describe): \_\_\_\_\_  I've never had a sexually transmitted infection

14. Are you currently doing anything to prevent you from becoming pregnant?  NO  YES

15. Have you ever used any of the following methods? (Please mark ALL that apply to you)

- |   |   |  |                                  |
|---|---|--|----------------------------------|
| <input type="checkbox"/> The Shot (Depo Provera)  | <input type="checkbox"/> The Ring (NuvaRing)            | <input type="checkbox"/> The Patch           | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> IUD (Mirena or Paragard) | <input type="checkbox"/> Implant (Implanon)             | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> None    |
| <input type="checkbox"/> Don't Know               | <input type="checkbox"/> Other (please describe): _____ |  |                                  |

16. Which of the following birth control methods do you currently use (Please mark ALL that you use):

- |   |   |  |                                  |
|---|---|--|----------------------------------|
| <input type="checkbox"/> The Shot (Depo Provera)  | <input type="checkbox"/> The Ring (NuvaRing)            | <input type="checkbox"/> The Patch           | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> IUD (Mirena or Paragard) | <input type="checkbox"/> Implant (Implanon)             | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> None    |
| <input type="checkbox"/> Don't Know               | <input type="checkbox"/> Other (please describe): _____ |  |                                  |

17. Have you ever had an abortion?  NO  YES

18. How many times have you been pregnant? \_\_\_\_\_

19. How many times have you given birth? \_\_\_\_\_

20. After having this visit today, how likely are you to have sexual intercourse in the next year?

- Much more likely    More likely    About the same    Less likely    Much less likely

21. After having this visit today, how likely are you to use a birth control method?

- Much more likely    More likely    About the same    Less likely    Much less likely

22. After having this visit today, how likely are you to ask your partner to use a condom?

- Much more likely    More likely    About the same    Less likely    Much less likely

23. After having this visit today, how likely are you to abstain from sexual intercourse (not have sex) in the next year in order to avoid becoming pregnant or getting a STI?

- Much more likely    More likely    About the same    Less likely    Much less likely

24. How well respected by the health educator did you feel?

- Highly respected    Somewhat respected    Not respected at all

25. After having this visit today, how likely are you to return and see a *Teen Program* health educator?

- Much more likely    More likely    About the same    Less likely    Much less likely

26. After having this visit today, how likely are you to refer a friend to the *Teen Program*?

- Much more likely    More likely    About the same    Less likely    Much less likely

27. How important is it for you to be able to talk to your parents about sex?

- Extremely Important    Kind of Important    Not Important

28. How satisfied are you with your ability to talk to your parents about sex?

- Extremely Satisfied    Kind of Satisfied    Not Satisfied

29. What may prevent you from coming back for another visit? (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Transportation  | <input type="checkbox"/> Child care                                    | <input type="checkbox"/> Other (please describe): _____ |
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> The clinic hours do not work with my schedule |   |

30. Could you please give us any information to improve our program?