Pediatrics of Steamboat Springs

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Dear Parent:

The **GAPS (Guidelines for Adolescent Prevention Survey)** questionnaire was created by the American Medical Association to assist health care providers in identifying health, behavioral and lifestyle concerns regarding adolescents. In an effort to provide more comprehensive and preventive health care to your family, we request your cooperation in completing the following questionnaire. Your adolescent has also been given a questionnaire to complete at this time. We ask that you and your child complete the surveys independently and not share your answers.

Completing the questionnaires independently of one another creates a privacy space which might allow for more candid responses from your teen. The results of these questionnaires are confidential and designed to create an open line of communication between the provider and the patient on subjects directly related to adolescent health, behavior and safety. While we hope that all parents and their teens have open communication on these topics, it is not always so. This method of inquiry allows the teen to be very frank about matters that could greatly affect his/her health that may otherwise go undetected.

Colorado State Law

In the State of Colorado a patient 13 years of age or older must give consent to providers to disclose information discovered on examination relating to substance abuse (drugs and alcohol), mental health (psychotherapy notes), sexually transmitted disease, sexual activity, and contraception and pregnancy counseling/evaluation.

Pediatrics of Steamboat Springs staff and providers will do everything in our power to protect patient rights, fulfill our responsibilities to Colorado State law and provide the best healthcare possible for your family. We will also encourage good communication between parent and teen when in the best interest of the safety and wellbeing of the patient.

☐ I want my child to complete the questionnaire.

☐ I do not want my child to complete the questionnaire.

____
Parent name printed:

____ ________________
Parent Signature: Date:

Please continue for parent questions!!

Adolescent's Name _________________________ Adolescent's birthday ________________ Age ______________

Is your adolescent taking any medicines? (**Circle**)

Yes No If yes, what medicines? ____

Are you happy with that treatment plan? (**Circle**)

Yes No If yes, please explain: ____

In the past year, have there been any changes in your family? (**Circle** all that apply.)

Marriage	Loss of job	Births	Other _______________________
Separation	Recent move	Serious Illness	_______________________
Divorce	New School	Deaths	_______________________

How is your adolescent handling those changes? Concerns? ____

____

____

____

Please review the topics listed below. **Circle** if you have a concern about your adolescent.

Physical problems	Guns/Weapons
Physical development	School grades/absences/dropout
Weight	Smoking cigarettes/chewing tobacco
Change of appetite	Drug use
Sleep patterns	Alcohol use
Diet/nutrition	Dating/Partners
Amount of physical activity	Sexual behavior
Emotional development	Unprotected Sex
Relationships with parents and family	HIV/AIDS
Choice of friends	Sexual transmitted diseases (STD's)
Self-image or self-worth	Pregnancy
Excessive moodiness or rebellion	Sexual Identity (heterosexual/homosexual/bisexual)
Depression	Work or job
Lying, stealing, vandalism	Violence/gangs

Other: ____

What seems to be the greatest challenge for your adolescent? ____

____

What is it about your adolescent that makes you proud of him/her? _______________________________________

____

Is there something on your mind that you would like to talk about today? What is it? _________________________

____

Can we share your answers with your teen? (**Circle**)

Yes No

Thank you for your cooperation!