RAAPS

Rapid Adolescent Prevention Screening

CONFIDENTIAL - ADOLESCENT HEALTH RAAPS

Name: _____ Sex: _____ Grade: _____ Insurance: _____

Birthdate: _____ Ethnicity/Race: _____ Reg #: _____

Health Risk Profile: Confidential	**Your answers will only be seen by the center staff**				**Office Use Only**
1. **In the past 3 months,** have you taken diet pills or laxatives, made yourself vomit (throw up) after eating, or starved yourself to **lose weight**?		No		Yes	
2. Do you eat some fruits and vegetables every day?		Yes		No	
3. Are you active after school or on weekends (walking, running, dancing, swimming, biking, playing sports) for **at least 1 hour, on at least 3 or more days each week?**		Yes		No	
4. When you are driving or riding in a car, truck or van do you **always** wear a lap/seat belt?		Yes		No	
5. Do you **always wear a helmet** when you do **any** of these activities: ride a bike, rollerblade, or skateboard; ride a motorcycle, snowmobile or ATV; ski or snowboard? ☐ I don't do any of these activities.		Yes		No	
6. **During the past month,** have you been threatened, teased, or hurt by someone (on the internet, by text, or in person) causing you to feel sad, unsafe, or afraid?		No		Yes	
7. Has an adult **ever physically injured** you (by hitting, slapping, kicking) or has anyone ever **forced you** to have sex or be involved in sexual activities when you didn't want to?		No		Yes	
8. Do you carry a weapon (gun, knife, club, other) **to protect yourself** from another person?		No		Yes	
9. **In the past 3 months,** have you used any form of nicotine including **vaping** (e-cigarettes, Juul, RUBI, Suorin, Blu, hookah, vape pens), **smoking** (cigarettes, cigars, black and mild) or **chewing** tobacco (dip, chew, snus)?		No		Yes	
10. **In the past 12 months,** have you driven a car while texting, drunk or high, or ridden in a car with a driver who was?		No		Yes	
11. **In the past 3 months,** have you drunk more than a few sips of alcohol (beer, wine coolers, liquor, other)?		No		Yes	
12. **In the past 3 months,** have you used marijuana (weed, pot, cannabis, THC) in any form such as vaping, smoking, edibles, drinks, pills, oil, or any other type?		No		Yes	
13. **In the past 3 months,** have you taken a prescription medication (codeine, OxyContin, Norco, Vicodin, Adderall, Ritalin, Xanax, other) **without a prescription,** taken **more than the prescribed amount** or continued to **take it after you no longer needed it**?		No		Yes	
14. Have you **ever** had **any type** of sex (vaginal, anal or oral sex)?		No		Yes	
15. Are you physically attracted to people who are the same gender as you (girl if you are a girl/guy if you are a guy) or do you feel that you are gay, lesbian or bisexual?		No		Yes	
16. **If you have had sex,** do you **always** use a condom and/or another method of birth control to prevent sexually transmitted infections and pregnancy? ☐ I have never had sex		Yes		No	
17. **During the past month,** did you **often** feel sad or down as though you had nothing to look forward to?		No		Yes	
18. Do you have any serious problems or worries at home or at school?		No		Yes	
19. **In the past 12 months,** have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself?		No		Yes	
20. Do you have at least one adult in your life that you can talk to about any problems or worries?		Yes		No	
21. Do you destroy things, hurt yourself, or hurt other people **when you are angry**?		No		Yes	

For Office Use Only

Evaluation: _____ **Date:** _____ At Risk: _____ No current risk: _____

Provider Signature: _____ Referred to: _____