NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD)

SMR060915

For Young Person to Complete

PLEASE READ: This form tells us about things that are important for your health and wellbeing and it helps us take better care of you. You do not have to answer any questions that make you feel uncomfortable. Please talk to one of the healthcare workers if you have any questions about the form or confidentiality, or need help to fill in the form.

Date: ___/___/_____ Your name (What do you like to be called?): _____ Gender: _____

Your preferred contact details: email _____ and/or phone _____

What is your cultural background? _____

Do you have a regular doctor/GP? ☐ YES ☐ NO If Yes, name _____

Are you happy to continue to see this doctor for your health care? ☐ YES ☐ NO

General Health

Why are you being seen today? _____

_____

Do you have a chronic illness/disability? ☐ YES ☐ NO If Yes, do you need help with your transition to adult services? ☐ YES ☐ NO

Do you have any other health issues? (if so, please list) _____

Have you ever had to stay in a hospital overnight before? ☐ YES ☐ NO

Do you have any allergies? ☐ YES ☐ NO ☐ UNSURE

Are you taking any medications (including alternatives therapies, vitamins)? ☐ YES ☐ NO Details: _____

Do you usually take these medicines as prescribed? ☐ ALWAYS ☐ USUALLY ☐ SOMETIMES ☐ NEVER ☐ N/A

When was your last dental check up? ☐ 6 month ☐ 1 year ☐ more than 1 year ☐ UNSURE

Home Environment

Where do you live?

☐ Parent home ☐ Own home ☐ Other family/Friends ☐ Supported accommodation/Refuge ☐ Foster care

☐ Sleeping rough ☐ Share housing ☐ Couch surfing (or temporary accommodation) ☐ Other _____

Do you feel safe and OK where you live? ☐ YES ☐ NO If No, why? _____

_____

Do you have anyone who you look after at home? ☐ YES ☐ NO If Yes, who? _____

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SMR060.915

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Education/ Employment

Do you attend school/TAFE/University/other education? ☐ YES ☐ NO If Yes, where? _____

Do you have a job? ☐ YES ☐ NO If Yes, for how many hours per week? _____

How do you feel you are coping with study/work? ☐ Well ☐ OK ☐ Not well ☐ Not at all

How many days of study/work have you missed in the last month? _____ Why? _____

If you don't have a job, do you have a source of money? ☐ YES ☐ NO

Eating and Nutrition

Are you ever worried about your body image, weight or diet? ☐ YES ☐ NO

Is anyone else worried about your body image, weight or diet? ☐ YES ☐ NO

If Yes, what have you done about these worries? _____

Activities and Leisure

Do you play sports or exercise? ☐ YES ☐ NO If yes, specify: _____

What activities do you enjoy in your spare time? _____

Who do you enjoy spending time with? _____

On average, how many hours a day do you spend on a computer/tablet/phone that are NOT school or work related? _____

Sleep, Mental Health and Wellbeing

What time do you usually Go to Sleep? _____ Wake Up? _____

Do you have any sleeping problems? ☐ SOMETIMES ☐ OFTEN ☐ NEVER

Are you ever worried about your mood, anxiety or mental health? ☐ YES ☐ NO

Is anyone else worried about your mood, anxiety or mental health? ☐ YES ☐ NO

Have you or are you experiencing any form of bullying including online? ☐ YES ☐ NO

In the past 12 months, have you thought about or done things, to harm yourself? ☐ YES ☐ NO

Have you ever spoken to anyone about your mood, anxiety or mental health? ☐ YES ☐ NO Who? _____

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Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Substance Use - In the last 12 months, how frequently have you used any of the following?

Substance	Not At All	Once Only/ Rarely	Monthly or More	Weekly or More	Daily
Tobacco/Cigarettes/e-cigarettes/Vapes					
Caffeine/Energy drinks					
Alcohol					
Marijuana/Cannabis					
Hallucinogens (e.g. LSD, ketamine, mushrooms)					
Inhalants (e.g. glue, petrol, aerosols)					
Stimulants (e.g. speed, ice, cocaine)					
Pills (e.g. MDMA, ecstasy)					
Opioids (e.g. heroin, codeine, endone)					
Other:					

Have you ever injected drugs? ☐ YES ☐ NO

Are you ever worried about your substance use? ☐ YES ☐ NO

Is anyone else worried about your substance use? ☐ YES ☐ NO

Relationships and Sexual Health

Do you have any questions or worries about how your body is growing/puberty? ☐ YES ☐ NO

Are you currently in a relationship? ☐ YES ☐ NO

Have you ever engaged in sexual activity? ☐ YES ☐ NO

Which do you use to prevent sexually transmitted infection (STI) transmission? ☐ Condoms ☐ Other _____ ☐ Nothing

Which do you use to prevent pregnancy? ☐ Condoms ☐ Pill ☐ Implanon /IUD ☐ Other _____ ☐ Nothing

Do you think you or your partner could be pregnant? ☐ YES ☐ NO ☐ N/A

Have you ever been pregnant? ☐ YES ☐ NO ☐ UNSURE

Do you have children? ☐ YES ☐ NO

Have you ever been pressured to be involved in sexual activities? ☐ YES ☐ NO

Are you ever worried about your sexuality, sexual health and / or relationships (including contraception or pregnancy)? ☐ YES ☐ NO

Other Information

Do you have a trusted person you can go to if you have any problems? ☐ YES ☐ NO

Who is this person (e.g. friend, parent)? _____

Do you have any other worries you would like to talk about? ☐ YES ☐ NO

Details: _____

Completed by: ☐ Young Person ☐ Someone else: _____

Your name : _____

Signature _____ **Date:** ____/____/____

END OF QUESTIONS - THANK YOU

NSW GOVERNMENT Health

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For Staff to Complete

(Please refer to the resources provided in the Guideline GL2018_003 if required)

Reviewed By: ☐ Nurse ☐ Doctor/Medical Officer ☐ Other _____

Comments:

_____

_____

_____

_____

Referrals Made:

Health Professional	Referral Made By		If Relevant, Patient Seen (Sign and Date)
	Name	Date	
Aboriginal Liaison Officer		__/__/____	
Adolescent CNC or Youth Nurse		__/__/____	
Adult Mental Health Service		__/__/____	
Carer Support Service		__/__/____	
Child and Adolescent/Youth Mental Health Service		__/__/____	
Child Protection Family Community Service		__/__/____	
Child Wellbeing Unit		__/__/____	
Dental		__/__/____	
Dietetics		__/__/____	
Drug and Alcohol		__/__/____	
GP		__/__/____	
Occupational Therapy		__/__/____	
Physician/surgeon		__/__/____	
School Teacher/Counsellor		__/__/____	
Sexual Health		__/__/____	
Social Work		__/__/____	
		__/__/____	

Was a Healthcare Interpreter used? ☐ YES ☐ NO

Details _____

Any concerns raised about Child Protection and/ or Domestic and Family Violence then USE MANDATORY REPORTER GUIDE AND ACTIVATE LOCAL CHILD PROTECTION RESPONSE/ PROCEDURE

Name: _____ **Signature**: _____

Designation: _____ **Date**: _____/ _____/ _____

NO WRITING