NHS
Isle of Wight
NHS Trust

Isle of Wight
Children in Care
Health Service

Young Person's Health Questionnaire
+11

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Young Person's Health Questionnaire

Thank you for agreeing to complete this form. If you do not want to answer any of the questions or you are unsure of the answers please leave them blank. When you have finished the form will be returned to the nurses in the CIC health service.

Isle of Wight Children in Care Health Team
Telephone No: 01983 822099

I give consent for the doctor/nurse to share this questionnaire with key professionals ie *my social worker, *Gp, *School Nurse

I would like my *foster carer/keyworker to receive a copy (*delete as appropriate):

Name:- ……………………………………………………………………………………
Date of Birth:- ……../……../……..

Signature:- ……………………………… Date:- ……../……../……...

Address:- …………………………………………………………………………………
…………………………………………………………………………………

Telephone/ Mobile:- ……………………………………………………………………

Name of carer/keyworker:- ……………………………………………………
Name of social worker:- ………………………………………………………

Education

Do you attend school or college? Yes / No
If so, which one?

……………………………………………………………………………………………………

Do you enjoy what you are doing?

……………………………………………………………………………………………………

Are there any problems, eg bullying, difficulties with other students?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Immunisations

Do you remember having any in the last two years?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Is there anything else you would like to say or ask?

……………………………………………………………………………………………………

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Lifestyle

When you are out and about on your own, what do you do to keep yourself safe ?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Do you smoke? Yes / No

If yes, how many a day?

0 - 5 6 -10 11-15 16-20 21 - 25 +26

Do you drink alcohol? Yes / No

If yes, how much a week and what type?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Do you take or have you taken other drugs? Yes / No

If you have answered YES to any of the 3 questions above, would you like some help/support or advice from local drug and alcohol services? Yes / No

Are you sexually active or thinking of becoming sexually active? Yes / No

Have you attended local clinics? Yes / No

Would you like any help, advice or support around your sexual health, contraception or sexually transmitted infections?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Physical health

When did you last see your GP?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Do you have any medical conditions?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Have you got any worries about your health? Yes / No

If you have what are they?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Are you allergic to anything? If yes, what?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Do you take any medicines? Yes / No

If yes, what do you take and how often?

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Are you registered with a Dentist? Yes / No

Name of Dental Surgery:

……………………………………………………………………………………………………

Date of last visit: ……../……../………

Did you need any treatment? Yes / No

How often do you brush your teeth? (please circle)

Not at all Once a day Twice a day Three times a day

Physical health

Are you registered with an optician? Yes / No

Name of Optician:…………………………………………………………………………

Date of last visit: ……../……../………

Have you been prescribed glasses? Yes / No

Do you wear your glasses? Yes / No

Do you have any concerns about your hearing? Yes / No

Do you attend appointments with any other health professionals?

Eg Speech and Language/ CAMHS / Hospital Outpatients

…………………………………………………………………………………………………

…………………………………………………………………………………………………

If yes, when did you last see them?

…………………………………………………………………………………………………

What physical activities do you enjoy doing?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

What do you like to do in your free time?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

What time do you go to bed?……………………………

Do you wake up during the night or have nightmares? Yes / No

If yes, how often?

…………………………………………………………………………………………………

What time do you wake up?……………………………

Emotional health

Are you happy with your appearance ? Yes / No

If not, what is it that you are not happy with?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

What makes you happy?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Are you happy with life at the moment? Yes / No

Do you have someone to talk to about any worries you have?

…………………………………………………………………………………………………

If yes, who do you talk to?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Do you self harm? Yes / No

Are you happy with your placement? Yes / No

If not, what's wrong?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Lifestyle

How many fast food meals do you eat each week? Please circle

0 1 2 3 4 5 6 7 8 9 +10

What do you think is a healthy diet?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Do you think you have a healthy diet? What do you eat?

…………………………………………………………………………………………………

…………………………………………………………………………………………………