Kinderarztpraxis

Dr. Junge & Goecke

Questionnaire — Preventive Check-Up J1

Your name	
Your date of birth	

Welcome to the J1 adolescent check-up! The J1 is not only an opportunity to assess your health — it is also an opportunity for an open and personal conversation with us. Since you know yourself, your body, your mind, and your family far better than we do, we would like to ask you to answer the following questions. This will help us to focus particularly well on you during the examination and consultation. You should also know that we treat everything you tell us in strict medical confidence — we will not share it with your parents. You are welcome to send us the questionnaire by email or bring it to the appointment. Thank you!

School

1. Which school and year are you in?

2. Are you happy with school, your teachers, and your performance?
   ◯ Yes ◯ No ◯ Sort of

3. Do you feel comfortable at school and in your class?
   ◯ Yes ◯ No ◯ Sort of

   If no, why not?

4. Do you have any problems at school? ◯ Yes ◯ No

   If yes, what kind?

Family and Friends

5. Do you get on well with your parents?
   ◯ Yes ◯ No ◯ Sort of

   If no, why not?

6. Do you get on well with your siblings?
   ◯ Yes ◯ No ◯ Sort of

   If no, why not?

7. Can you talk to your parents about problems?
   ◯ Yes ◯ No ◯ Rarely

8. Do you have friends your own age? ◯ Yes ◯ No

9. Can you talk to your friends about problems?
   ◯ Yes ◯ No ◯ Rarely

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Health

10. Do you feel healthy?
- ◯ Yes
- ◯ No
- ◯ Sort of

If no, what's wrong? _____

11. Have you had any physical symptoms recently? ◯ Yes ◯ No

If yes, what kind? _____

12. Do you have any known illnesses or allergies? ◯ Yes ◯ No

If yes, what? _____

13. Do you take medication regularly? ◯ Yes ◯ No

If yes, which? _____

14. Do you have any fears or anxieties? ◯ Yes ◯ No

If yes, what kind? _____

15. Do you have difficulty falling or staying asleep? ◯ Yes ◯ No

If yes, why? _____

16. Are there any problems with your diet? ◯ Yes ◯ No

If yes, what kind? _____

17. Do you have any special dietary habits (e.g., vegetarian)? ◯ Yes ◯ No

If yes, what? _____

18. For girls: Have you started your period yet? ◯ Yes ◯ No

If yes, in what year? _____

19. For girls: Is your period regular? ◯ Yes ◯ No

20. For girls: When was your last period? _____

Your Self-Assessment

21. I would describe myself as
- ◯ Happy
- ◯ Calm
- ◯ High-spirited
- ◯ Aggressive

22. How satisfied are you with your life?
- ◯ Satisfied
- ◯ So-so
- ◯ Dissatisfied

23. Have you ever smoked or tried cigarettes?
- ◯ No
- ◯ I smoke
- ◯ My friends smoke

If yes, do you have any questions? _____

24. Have you had any experience with alcohol?

- ◯ No
- ◯ Occasionally
- ◯ Often

If yes, do you have any questions? _____

25. Have you ever tried drugs?

- ◯ No
- ◯ I have tried them
- ◯ My friends use drugs

If yes, do you have any questions? _____

26. How do you spend most of your free time?

- ☐ Friends
- ☐ Family
- ☐ Computer
- ☐ TV
- ☐ Hanging out
- ☐ _____

27. Do you play any sport or exercise outside of school PE? ◯ Yes ◯ No

If yes, which sports? _____

28. How satisfied are you with your physical development, height, and weight?

- ◯ Satisfied
- ◯ So-so
- ◯ Dissatisfied

If dissatisfied, why? _____

Questions for Your Doctor

29. Tick the topics you would like to discuss with me. Our conversation is subject to strict medical confidentiality.

- ☐ Questions about your health and specific symptoms
- ☐ Questions about physical development, puberty, sex education, or sexuality
- ☐ Questions about medication, alcohol, drugs, smoking, or addiction
- ☐ Questions about nutrition and dietary advice
- ☐ Questions about upcoming vaccinations (e.g. HPV vaccination)
- ☐ Worries, fears, and mood swings that are affecting you
- ☐ Problems at school, in the family, or with friends
- ☐ _____