



Your name	
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Your date of birth	
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Welcome to the J2 adolescent check-up! The J2 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

- Which school and year are you in?

- Are you happy with school, your teachers, and your performance?
Yes
No
Sort of
- Do you feel comfortable at school and in your class?
Yes
No
Sort of
If no, why not? _____
- Do you have any problems at school? Yes No
If yes, what kind? _____

Family and Friends

- Do you get on well with your parents?
Yes
No
Sort of
If no, why not? _____
- Do you get on well with your siblings?
Yes
No
Sort of
If no, why not? _____
- Can you talk to your parents about problems?
Yes
No
Rarely
- Do you have friends your own age? Yes No
- Can you talk to your friends about problems?
Yes
No
Rarely



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