# School-Based Health Center Assessment Form

**for clients age 11 and older**

**Massachusetts Department of Public Health**

1. **School-Based Health Center:**
2. **Assessment Date:** __ __ / __ __ / __ __ __ __
3. **Client Identifier:**
4. **Client Name:**
5. **Date of Birth:** __ __ / __ __ / __ __ __ __
6. **Current Gender Identity:**
   - □ Female
   - □ Male
   - □ Transgender female/transwoman/MTF
   - □ Transgender male/transman/FTM
   - □ Genderqueer/Gender non-conforming
   - □ Additional Category (Specify) ___________
   - □ Decline to answer
7. **Provider Type:**
   - □ NP/PA
   - □ MD – Primary Care
   - □ Other (Specify) _______________________
8. **Primary ICD Diagnosis Code (Chief Complaint):**
   - Code: __________
   - Description: _______________________

## Comprehensive Risk & Resiliency Assessment

*Please mark only the behaviors that were assessed during this visit*

### Home

**Trusted Adult**

Do you feel comfortable asking a parent or other adult family member for help? (Select one) □ No □ Yes □ Sometimes

If yes or sometimes, who? (Select all that apply) □ Mom □ Dad □ Aunt □ Grandmother □ Other (Specify) ___________

Comments: ___________

Are there any other adults in your life that you can talk to when you are having a hard time? (Select one) □ No □ Yes □ Sometimes

If yes or sometimes, who? (Select all that apply) □ Counselor/Therapist □ Friend(s) □ Teacher □ Other (Specify) ___________

Comments: ___________

**Resiliency Identified?** □ No □ Yes

### Education

**School Connectedness**

Do you feel like your school is a caring place? (Select one) □ No □ Yes □ Sometimes

Comments: _______________________

Are your teachers fair? (Select one) □ No □ Yes □ Sometimes

Comments: _______________________

Do your teachers expect you to do well? (Select one) □ No □ Yes □ Sometimes

Comments: _______________________

**Resiliency Identified?** □ No □ Yes

### Motivation to Succeed in School

How do you feel like school is going for you this year? _______________________

How important is it to you to graduate on time? _______________________

What do you plan on doing after graduation? _______________________

**Resiliency Identified?** □ No □ Yes

### Truancy

Do you ever skip school/classes? (Select one)

□ No □ Yes □ Sometimes □ In the past

Comments: _______________________

How often? ___________

Why do you skip? (Select all that apply) □ Boredom □ Illness □ Work

□ Does not like school/class □ Did not feel like coming to school

□ Had trouble waking up □ Family Issues □ Taking care of someone

□ Transportation problems □ Other (Specify) ___________

**Interventions**

□ Develop action plan for addressing risk

□ Schedule follow up with SBHC medical provider

□ Advocate to school on behalf of student

□ Referral to school services

□ Participate in Student Support team and/or 504 plan for accommodations

**Risk Identified?** □ No □ Yes
### School Failure

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are you doing in school?</td>
<td></td>
<td></td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>How are your grades?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you failing anything?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been suspended or expelled?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Interventions

- □ Develop action plan for addressing risk
- □ Schedule follow up with SBHC medical provider
- □ Advocate to school on behalf of student
- □ Referral to school services
- □ Participate in Student Support team and/or 504 plan for accommodations

### Activities

#### Sports Involvement

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you involved in any sports?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Are you interested in becoming involved?</td>
<td>□ No</td>
<td>□ Yes □ Maybe</td>
<td></td>
</tr>
<tr>
<td>How does it feel to be on a team?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you like the coach?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you getting enough play time?</td>
<td>□ No</td>
<td>□ Yes □ Sometimes</td>
<td></td>
</tr>
</tbody>
</table>

### Civic Engagement

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What community issues interest you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you volunteer for projects aimed at making a difference in your community?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Participation in Gay-Straight Alliance (GSA)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you know we have a GSA?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Have you ever been to a GSA meeting?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Community-based LGBTQ support

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know how to get support out in the community or on the web?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Are you interested in meeting LGBT teens?</td>
<td>□ No</td>
<td>□ Yes □ Not Sure</td>
<td></td>
</tr>
</tbody>
</table>

### Diet/Wellness

#### Obesity/Overweight/Underweight

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI: ______  Previous BMI: ______</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know what BMI is?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you happy about your weight?</td>
<td>□ No</td>
<td>□ Yes □ Sometimes/Somewhat</td>
<td></td>
</tr>
<tr>
<td>What did you eat for breakfast?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you use steroids or sports supplements (such as powdered protein or creatine drinks) to make yourself stronger?</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Interventions

- □ Education and counseling
- □ Develop action plan for addressing risk
- □ Schedule follow up with SBHC medical provider
- □ Referral to SBHC-sponsored exercise opportunity
- □ Provide medical management
- □ Referral to other medical provider
- □ Referral to SBHC behavioral health provider
- □ Referral to other behavioral health provider
- □ Referral to school/community resources
- □ Referral to online or telephone resources

#### Lack of Physical Activity

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Risk Identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you do after school?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What do you do for exercise?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many hours per day do you spend in front of a screen?</td>
<td>□ 0</td>
<td>□ &lt;1 □ 1 □ 2 □ 3 □ 4 □ ≥5</td>
<td></td>
</tr>
</tbody>
</table>

### Interventions

- □ Education and counseling
- □ Develop action plan for addressing risk
- □ Schedule follow up with SBHC medical provider
- □ Referral to SBHC-sponsored exercise opportunity
- □ Referral to school/community resources
### Diet/Wellness – continued

#### Sleep Hygiene

<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
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<tbody>
<tr>
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<tr>
<td>□ Develop action plan for addressing risk</td>
</tr>
<tr>
<td>□ Schedule follow up with SBHC medical provider</td>
</tr>
<tr>
<td>□ Referral to SBHC behavioral health provider</td>
</tr>
<tr>
<td>□ Referral to other behavioral health provider</td>
</tr>
<tr>
<td>□ Referral to school/community resources</td>
</tr>
</tbody>
</table>

- Do you feel like you’re getting enough sleep? □ No □ Yes
  Comments: ____________________________
- Do you have a set bedtime? □ No □ Yes
  Comments: ____________________________
- Are you waking up at night? (Select one) □ No □ Yes □ Sometimes
  If yes, why? (Select all that apply) □ Go to the bathroom □ Get food/water □ Answer a text/call □ Use social media □ Other (Specify) ____________________________
  Comments: ____________________________

#### Risk Identified? □ No □ Yes

### Drugs

#### Tobacco Use

- Have you ever used tobacco products? □ No □ Yes
- What products have you used? (Select all that apply)
  □ Cigarettes □ Cigars/cigarillos/little cigars □ Hookah pipes (non-electronic)
  □ Smokeless/snus/dissolvable tobacco □ Other (Specify) ____________________________

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<tr>
<td>□ Education and counseling</td>
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<td>□ Develop action plan for addressing risk</td>
</tr>
<tr>
<td>□ Schedule follow up with SBHC medical provider</td>
</tr>
<tr>
<td>□ Referral to online or telephone resources</td>
</tr>
<tr>
<td>□ Referral to support group(s)</td>
</tr>
<tr>
<td>□ Prescribe smoking cessation pharmacotherapy</td>
</tr>
</tbody>
</table>

- If yes to cigarettes, how often? (Select one)
  □ Prior to the last 30 days □ Within the past 30 days □ Daily
- If yes to cigars/cigarillos/little cigars, how often? (Select one)
  □ Prior to the last 30 days □ Within the past 30 days □ Daily
- If current user, are you interested in quitting? (Select one) □ No □ Yes □ Maybe
- Have you ever used e-cigarettes, e-hookah, or vape pens? □ No □ Yes
- If yes, how often? (Select one)
  □ Prior to the last 30 days □ Within the past 30 days □ Daily
- Are you using e-cigarettes to try to quit tobacco use? □ No □ Yes

#### Risk Identified? □ No □ Yes

### Alcohol and Drug Use

#### PART A: During the past 12 months, on how many days did you...

<table>
<thead>
<tr>
<th>PUT 0 IF NO USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink more than a few sips of beer, wine, or any drink containing alcohol? ____________________________</td>
</tr>
<tr>
<td>Use any marijuana (for example, pot, weed, hash, or in foods) or “synthetic marijuana” (for example, “K2” or “Spice)? Say “0” if none. ____________________________</td>
</tr>
<tr>
<td>Take a prescription medication or pill that was NOT prescribed to you or MORE than was prescribed to you (for example, prescription pain pills or ADHD medications)? ____________________________</td>
</tr>
<tr>
<td>Use anything else to get high? (for example, other illegal drugs, over-the-counter medications, and things that you sniff or “huff”)? ____________________________</td>
</tr>
</tbody>
</table>

#### PART B: CRAFFT Questions

- Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? □ No □ Yes
- Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? □ No □ Yes
- Do you ever use alcohol or drugs while you are by yourself, or ALONE? □ No □ Yes
- Do you ever FORGET things you did while using alcohol or drugs? □ No □ Yes
- Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? □ No □ Yes
- Have you ever gotten into TROUBLE while you were using alcohol or drugs?
  CRAFFT Score: ________
  Risk Identified? □ No □ Yes

#### Risk Identified? □ No □ Yes

Updated 6/6/17
Sexuality

**Sexual Behaviors**
Have you had sex? □ No □ Yes
Do your parents know? (Select one) □ No □ Yes □ Not Sure
Comments: 
Are you having sex with girls, boys or both? (Select one) □ Boys □ Girls □ Both
Are you having oral sex? □ No □ Yes
Vaginal sex? □ No □ Yes
Anal sex? □ No □ Yes
Have you ever had sex while you were intoxicated (drunk or high)? □ No □ Yes
Comments: 
How do you keep yourself safe from infection/pregnancy? 
Have you ever had an STI? (Select one) □ No □ Yes □ Not Sure
Where do you get information about sex? (Select all that apply)
□ Internet □ TV □ Friends □ Mom □ Dad
□ Doctor/medical health provider □ Other (Specify) 

**Interventions**
□ Education and counseling
□ Develop action plan for addressing risk
□ Schedule follow up with SBHC medical provider
□ Provide reproductive health services
□ Referral to other reproductive health services
□ Referral to SBHC behavioral health provider
□ Referral to other behavioral health provider
□ Referral to online or telephone resources

**Suicide/Depression**

**Depression**
Y-PSC Score: _____
PHQ-9 Score: _____
Risk Identified? □ No □ Yes

**Interventions**
□ Develop action plan for addressing risk
□ Schedule follow up with SBHC medical provider
□ Referral to SBHC behavioral health provider
□ Referral to other behavioral health provider
□ Cognitive Behavior Therapy

**Anxiety**
Do you find yourself worrying a lot? (Select one) □ No □ Yes □ Sometimes
Does the worrying get in the way of enjoying life? (Select one)
□ No □ Yes □ Sometimes
Do you hurt yourself as a means to cope with feeling overwhelmed or emotionally
distressed (like cut, burn)? □ No □ Yes
Comments: 

**Interventions**
□ Develop action plan for addressing risk
□ Schedule follow up with SBHC medical provider
□ Referral to SBHC behavioral health provider
□ Referral to other behavioral health provider
□ Cognitive Behavior Therapy

**Suicidal Ideation/Plan**
Do you ever wish you were dead? □ No □ Yes
Comments: 
Do you think about hurting or killing yourself? (Select one)
□ No □ Yes □ Sometimes □ In the past
Comments: 
Do you have a plan? (Select one) □ No □ Yes □ In the past
Comments: 
What is the plan? 
Do you have….a rope/gun/means to complete? □ No □ Yes
Comments: 

**Interventions**
□ Develop action plan for addressing risk
□ Schedule follow up with SBHC medical provider
□ Referral to SBHC behavioral health provider
□ Refer to other behavioral health provider
□ Contact mobile crisis team for immediate evaluation
### Safety

**Bullying**
- Do you have friends at school? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- Is anyone bullying you or your friends? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- In person? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- Online? (Select one) □ No □ Yes □ Sometimes
  - If yes or sometimes, where? (Select all that apply)
    - □ Facebook □ Twitter □ Snapchat □ Email
    - □ Chatting/Instant Messaging □ Other (Specify)
  - Comments: 
- By text? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- Are you being bullied or teased because of your real or perceived sexual orientation? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- Has anyone spread rumors about your sexual orientation? □ No □ Yes
  - Comments: 
- Has anyone ever accused you of being a bully? □ No □ Yes
  - Comments: 

**Risk Identified?** □ No □ Yes

**Environment**
- Do you feel safe at home? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- At school? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- In your neighborhood? (Select one) □ No □ Yes □ Sometimes
  - Comments: 
- Are there gangs in your school or community? □ No □ Yes
  - Comments: 
- Are you involved in a gang? □ No □ Yes
  - Comments: 
- Have you ever felt the need to carry a weapon such as a knife or gun? □ No □ Yes
  - If yes, why?
  - Comments: 

**Risk Identified?** □ No □ Yes

### Interventions

- □ Follow school bullying policy
- □ Develop action plan for addressing risk
- □ Schedule follow up with SBHC medical provider
- □ Advocate on behalf of student
- □ Referral to SBHC behavioral health provider
- □ Referral to other behavioral health provider

### Physical Abuse
- Has anyone ever physically hurt you? □ No □ Yes
  - Comments: 
- Do arguments or fights ever become physical? □ No □ Yes
  - Comments: 
- Have you ever seen anyone get hurt in your home? □ No □ Yes
  - Comments: 
- Did you get help from someone? □ No □ Yes
  - Comments: 

**Risk Identified?** □ No □ Yes

**Disclosure of rape?** □ No □ Yes
### Adolescent Relationship Abuse

#### Universal Inquiry

Are you currently in a relationship, like seeing someone special? □ No □ Yes

Comments:  

Is that person kind to you and respectful of your choices? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

Do they ever tell you who you can talk to or where you can go? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

Do they ever make you have sex when you don’t want to? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

Do they ever make you afraid or physically hurt you? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

#### Condom Preferred Contraception Method

Are you able to talk with your partner about using condoms? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

Does your partner get mad at you for asking about condoms or refuse to use them? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

#### Testing for Sexually Transmitted Infections

Are you ever nervous about asking your partner to use condoms? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

Are you afraid your partner might hurt you if you told them you had an STI and they needed to be treated too? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

#### Birth Control Options

Does your partner support your using birth control? (Select one)  
□ No □ Yes □ Don’t know □ He doesn’t know

Comments:  

Does your partner mess with your birth control or try to get you pregnant when you don’t want to be? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

#### Emergency Contraceptive Visit

Was the sex you had consensual, something you wanted to do? □ No □ Yes

Comments:  

Are you concerned your partner may be trying to get you pregnant when you don’t want to be? (Select one)  
□ No □ Yes □ Sometimes

Comments:  

#### Pregnancy Test Visits

Has your partner ever tried to pressure you to or make you get pregnant?  
□ No □ Yes

Comments:  

Has your partner ever hurt or threatened you because you didn’t agree to get pregnant?  
□ No □ Yes

Comments:  

#### Risk Identified?  □ No □ Yes

Disclosure of rape? □ No □ Yes

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### Interventions

- □ Provide safety card
- □ Education and counseling
- □ Develop action plan for addressing risk
- □ Schedule follow up with SBHC medical provider
- □ Referral to SBHC behavioral health provider
- □ Referral to other behavioral health provider
- □ Referral to domestic violence advocates
- □ Referral to rape crisis center
- □ Initiate safety plan for student
- □ File 51A