Northside Group
Part of Ramsay Health Care

Youth Health & Safety Screening (14-25 Years Old)

MRN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: _____

(please affix Patient Identification label here, if available)

To be completed by the Young person

This form helps the team take better care of you during admission by identifying important information about your health and wellbeing. You do not have to answer any questions that make you feel uncomfortable. Please speak with the admissions team or admitting nurse If you have any questions and/or require assistance completing the form.

Your Name (What do you like to be called?)**:** _____ **Gender:** _____

Contact details: Email: _____ Mobile Number: _____

What is your cultural background? _____

Do you have a regular GP? ☐ No ☐ Yes If yes, Name _____

General Health

Do you have a Chronic illness/disability? ☐ Yes ☐ No

Do you have any other health issues? _____

Do you have any allergies? ☐ Unsure ☐ No ☐ Yes If yes, _____

Are you taking any medications? (Including alternatives therapies, vitamins)

☐ No ☐ Yes If yes, Details: _____

Do you usually take these medicines as prescribed?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A

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? ☐ No ☐ Yes If yes, who? _____

_____

Education

Do you attend school/TAFE/University/Other education? ☐ No ☐ Yes

If yes, Where? _____

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

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

_____

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Employment

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

How do you feel you are coping with work? _____ Why? _____

If you do not 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? ☐ No ☐ Yes 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
Do you have a trusted person you can go to if you have any problems?		☐ Yes	☐ No
Is anyone else worried about your body image, weight or diet?		☐ Yes	☐ No

Who is this person (e.g Friend, carer)**?** _____

Do you have any other concerns you would like to talk about? ☐ Yes ☐ No

Details: _____

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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 / Vapes					
Alcohol					
Marijuana / Synthetic 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)					
Caffeine / Energy drinks					
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

Completed by: ☐ Young Person ☐ Someone else: _____

Your name: _____

Signature: _____

Date: _____ /_____ /_____

Please submit completed form to the admissions team at Northside Clinic. Thank you

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