Name (Please Print) _____ DOB: _____ Date of Visit: _____

# A PHQ-9 Modified for Teens

As part of routine screening for your health includes reviewing mood and emotional concerns please complete below:

| **During the past two weeks**, how often have you been bothered by the following problems? | (0) Not At All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable or hopeless | | | | |
| 2. Little interest or pleasure in doing things | | | | |
| 3. Trouble falling or staying asleep or sleeping too much | | | | |
| 4. Poor appetite, weight loss, or overeating | | | | |
| 5. Feeling tired or having little energy | | | | |
| 6. Feeling bad about yourself –or feeling that you are a failure, or have let yourself or your family down | | | | |
| 7. Trouble concentrating on things, like school work, reading, or watching TV | | | | |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual | | | | |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | | | | |

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficu ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes ☐ ☐ lo

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with you Health Care Clinician, go to a hospital emergency room or call 911.*

**For Office Use Only:** Total Score: _____

PCP Initials: _____

Please Print): _____ DOB: _____ Date: _____

Name (Please Print) _____ DOB: _____ Date of Visit: _____

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# Severity Measure for Generalized Anxiety Disorder—Child Age 11-17

**Instructions:** The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (□ or x) one box per row.**

| | | | | | | | Clinician Use |
|---|---|---|---|---|---|---|---|
| | During the PAST 7 DAYS, I have… | Never | Occasionally | Half of the time | Most of the time | All of the time | Item score |
| 1. | Felt moments of sudden terror, fear, or fright | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 2. | Felt anxious, worried, or nervous | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 3. | Had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 4. | Felt a racing heart, sweaty, trouble breathing, faint, or shaky | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 5. | Felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 6. | Avoided, or did not approach or enter, situations about which I worry | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 7. | Left situations early or participated only minimally due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 8. | Spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 9. | Sought reassurance from others due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 10. | Needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people) | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| | | | | | | **Total/Partial Raw Score:** | |
| | | | | | | **Prorated Total Raw Score: (if 1-2 items left unanswered)** | |
| | | | | | | **Average Total Score:** | |

**For Office Use Only:** Total Score: _____

Practitioner Initials: _____

Patient Name (Please Print):_____DOB:_____Date of Visit: _____

# The CRAFFT+N Questionnaire

**To be completed by patient**

Please answer all questions **honestly**; your answers will be kept **confidential**.

**During the PAST 12 MONTHS, on how many days did you:**

| | | |
|---|---|---|
| **1.** Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none. | ☐ | # of days |
| **2.** Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none. | ☐ | # of days |
| **3.** Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none. | ☐ | # of days |
| **4.** Use **any tobacco or nicotine** products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? | ☐ | # of days |

**READ THESE INSTRUCTIONS BEFORE CONTINUING:**

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.**

| | No | Yes |
|---|---|---|
| **5.** Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐ | ☐ |
| **6.** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? | ☐ | ☐ |
| **7.** Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? | ☐ | ☐ |
| **8.** Do you ever **FORGET** things you did while using alcohol or drugs? | ☐ | ☐ |
| **9.** Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? | ☐ | ☐ |
| **10.** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? | ☐ | ☐ |

**For Office Use Only:** Total Score: _____

Practitioner Initials: _____