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: _____