<u>Adolescent</u> Bi-Annual Questionnaire (12-17 years)

Twice a year, all of our patients are asked to complete this form because these factors can affect your health as well as the medications you may take. Please help us provide you with the best medical care by answering the questions below. **All information is confidential and cannot be used for legal purposes.**

Patient Name Label

Today's Date:_____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
PHQ-2 Score [Total score for Questions 1-2]				

IF YOUR TOTAL SCORE IS <u>3 OR MORE</u>, PLEASE ANSWER THE FOLLOWING QUESTIONS:
IF YOUR SCORE WAS <u>2 OR LESS</u>, PLEASE TURN THE PAGE OVER AND COMPLETE THE BACK OF THIS FORM.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. If you checked off any problems, how difficult have those 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 difficult / Extremely difficult	

For Office Use Only	
Total score for Questions 3-9	
PHQ-9 Score [Total of all questions 1-9]	

Please turn over and complete the questions on the back of this form.

CRAFFT:

In the last 12 months, did you:	No	Yes
Drink any alcohol (more than a few sips)?	☐	☐
Smoke any marijuana or hashish?	☐	☐
Use anything else to get high?	☐	☐

If you answered No to all three questions, **answer #1 below.**

If you answered Yes to any questions, answer **questions #1-6 below**

	No-0	Yes-1
1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	☐	☐
4. Do you ever forget things you did while using alcohol or drugs?	☐	☐
5. Does your family or friends ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into trouble while you were using alcohol or drugs?	☐	☐