Adolescent Health Questionnaire

We ask all our adolescent patients to complete this form at least once a year, because substance abuse and mood can affect your health. Please ask your doctor if you have any questions.
Your answers on this form will remain confidential.

Patient Name:_____

Date of Visit:_____

Substance Use (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 3 questions, **answer #1 below**		If you answered Yes to any questions, **answer #1-6 below**.
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. Do 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?				

Mood (PHQ-9)

Instructions: How often have you been bothered by each of the following symptoms during the past 2 weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.	**Not At All (0)**	**Several Days (1)**	**More Than Half the Days (2)**	**Nearly Every Day (3)**
1. Feeling down, depressed, irritable or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, 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 that you 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?	O Yes	O 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? O Not difficult at all O Somewhat difficult O Very difficult O Extremely difficult		
Has there been a time in the past month when you have had serious thoughts about ending your life?	O Yes	O No
Have you ***ever*** in you ***whole life,*** tried to kill yourself or made a suicide attempt?	O Yes	O No