Adolescent annual questionnaire

We ask all our adolescent patients to complete this form at least once a year, because substance use 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 birth: _____

S2BI questions

In the **PAST YEAR**, how many times have you used:	**Never**	**Once or twice**	**Monthly**	**Weekly**
Tobacco:	☐	☐	☐	☐
Alcohol:	☐	☐	☐	☐
Marijuana:	☐	☐	☐	☐

If you answered "Never" to all three questions above, please skip to **CRAFFT question #1** and then turn the page. Otherwise, please continue answering all questions below.

Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)	☐	☐	☐	☐
Illegal Drugs: (such as cocaine or Ecstasy)	☐	☐	☐	☐
Inhalants: (such as nitrous oxide)	☐	☐	☐	☐
Herbs or synthetic drugs: (such as salvia, "K2", or Bath salts)	☐	☐	☐	☐

If you answered "Never" or "Once or twice" to all questions above, please answer only **CRAFFT question #1** below and then turn the page. Otherwise, please continue answering all questions below.

CRAFFT questions

	No	**Yes**
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?	☐	☐

Please turn page

Mood (PHQ-9 Modified for Teens):

How often have you been bothered by each of the following symptoms during the past **TWO WEEKS?**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐

If you answered "Not at all" to both questions above, you are finished answering questions.
Otherwise, please continue answering all the questions below.

3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired, or having little energy?	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
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?	☐	☐	☐	☐
	0	1	2	3

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 difficult ☐ 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	☐ No

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)