Beachside Pediatrics

Forms for Teens

It's important that your child feels they can fill out these forms honestly, which may require them not sharing their answers with you. Please respect this confidentiality as it is our best way to have a meaningful conversation with your child about these difficult topics!

Please note, 6th graders only need to fill out the first page (PHQ-9 form); 7-12th graders need to fill out all three forms.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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
3. Trouble falling or 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 are 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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* 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 _____

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Name:_____ Age_____ Date_____

IT IS THE POLICY IN OUR OFFICE THAT ALL INFORMATION TEENAGERS SHARE WITH THE DOCTORS AND STAFF IS CONFIDENTIAL, UNLESS THAT INFORMATION ENDANGERS THE LIFE OF THE TEEN OR OF SOMEONE ELSE, HOWEVER WE ENCOURAGE YOU TO DISCUSS THESE HEALTH MATTERS WITH YOUR PARNTS.

Circle ALL of the following that concern you or that you have questions about:

AID	Acne	Weight	Family Problems
Alcohol	Body Odor	Nutrition	Mother/Father Problems
Drugs	Breast Changes	Physical Fitness	Sister/Brother Problems
Tobacco/Vaping	Growth	School Grades	Sexual Abuse
Pregnancy/Birth Control	Bedwetting	Sports	Physical Abuse
Masturbation	Genital lesions	Death	Hearing Voices
LGBT	Vaginal/Penile Discharge	Marriage	Suicide
STD	Constipation		

PLEASE TRY TO ANSWER ALL OF THE FOLLOWING QUESTIONS. CIRCLE THE APPROPRIATE RESPONSE AS WELL AS ANSWER THE QUESTIONS. IF YOU DO NOT UNDERSTAND SOMETHING, PUT A CHECKMARK BESIDE IT.

1) Have you ever smoked/vaped any tobacco products? _____ What kind?_____ When did you start?_____
2) Have you/do you drink alcohol (except for religious rituals)? _____ If yes, how much and how often? _____
3) Have you/ do you smoke pot/other substances? _____ What type?_____ How often? _____
4) Have you/do you take street/prescription drugs? _____ What kind? _____ How often? _____
5) Have you/do you take steroids?_____ How often?_____ Pills or injections? _____
6) Have you been in a car when the driver was drinking or on drugs? _____ How often? _____
7) Do you always wear a seatbelt in a car? _____ Do you text when driving? _____
8) From where have you learned the most about sexuality? Parents Friends Books TV School Sibling Other
9) Have you had sex? _____ Oral/Anal Sex? ____ How old were you the 1st time? ____ How many partners? ____
10) Do you use protection? _____ What type?_____ How do you protect yourself from AIDS? _____
11) Have you ever been pregnant/gotten someone pregnant? _____
12) Do you have a steady boy/girlfriend? If yes, how old is he/she? _____
13) Teens sometimes have sexual feelings for other teens of the same sex, have you? _____
14) Do you ever think you are different from everyone else? _____ Why? _____
15) Has anyone ever touched you in places or ways that you felt were wrong, inappropriate, or that made you feel uncomfortable, guilty or afraid? _____
16) Have you been suspended from school? _____ In trouble with the law? _____
17) Have you ever broken a bone? _____ If yes, which one(s)? _____
18) Have you ever been in an accident? _____ What kind? _____ Spent a night in a hospital? _____
19) Have you ever had a concussion? _____ Lost consciousness? _____ How? _____ Fainted? _____
20) Do you do regular exercise? If yes, what and how many hours/wk? _____
21) List any sports injuries you have had that stopped you from playing. _____
22) What are your hobbies and/or interests? _____ What are you really good at? _____
23) What is your favorite TV show? _____ Musical Artists? _____
24) Do you hope to go to college? _____ How do you see yourself as an adult? _____
25) Are you comfortable discussing the issues above with your parents? _____ If not, who? _____

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

Part B

	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?	☐	☐