Initials: _____ Date: _____

Adolescent Questionnaire

*Over the last **TWO WEEKS,** how often have you been bothered by the following problems?*

	Not at all	**Several days**	**More than ½ of the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Being easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Total Score of: _____

Feeling down, depressed, irritable or hopeless?	0	1	2	3
Little interest or pleasure in doing things?	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
Poor appetite, weight loss, or overeating?	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Feeling bad about yourself, or feeling that you are a failure, or that you have let your family down?	0	1	2	3
Trouble concentrating on things like schoolwork, reading or TV?	0	1	2	3
Moving or speaking so slowly that others could have noticed, or being so fidgety or restless that you were moving around a lot	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself?	0	1	2	3

Total score of: _____

Circle One Answer

In the **past year** have you felt depressed or sad most of the days, even if you felt OK sometimes?	Yes, NO
If you are experiencing any of the problems above, how **difficult** have these problems made it for you to do your work, take care of things or get along with people? 1. Not difficult, 2. Somewhat, 3. Very or 4. Extremely difficult	
In the **past month** have you had any 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

(For patients 14 years and older): *During the past **12 MONTHS,** did you?*

Drink any alcohol (do not count sips taken during family/religious events?	Yes, NO
Juule, smoke cigarette, marijuana, hashish or others? *Circle all that apply*	Yes, NO
Use, sniff or huff anything to get high including illegal drugs, over the counter or prescription drugs?	Yes, NO
Ever use alcohol or drugs while you are alone by yourself or just to relax or feel better?	Yes, NO

Many teens have questions about and sometimes struggle with gender

How do you identify yourself?	Male, female, Not sure

Sexual activity includes vaginal, rectal or oral sex

Are you currently or have you ever been sexually active?	Yes, NO, (Stop if your answer is NO)
Are your sex partners	Boys, girls or both, # of partners 1, 2, > 3
Do you or your sex partners use protection against STD	Yes, No, sometimes
Have you or any of your partners ever been diagnosed with an STD	Yes, No, Not sure

Modified from GAD-7, PHQ-9 and CRAFFT