

# Adolescent Annual Questionnaire

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Visit Date: \_\_\_\_\_

We ask all our adolescent patients to complete this form at least once a year because substance use, stress, and mood can affect your health. Please ask your doctor if you have any questions.

## Substance Use (CRAFTT)

	NO	YES
1. In the LAST 12 MONTHS:		
a. Did you drink any alcohol (more than a few sips)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you smoke any marijuana or hashish?	<input type="checkbox"/>	<input type="checkbox"/>
c. Did you use anything else to get high?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you EVER ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
	If you answered "NO" to all above questions, <b>proceed to Stress (GAD-7) section.</b>	If you answered "YES" to any questions, <b>answer questions #3-7 below.</b>

\*\*\* Based on your answers above, please skip or complete questions #3-7 below. \*\*\*

	NO	YES
3. Do you EVER use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you EVER use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you EVER forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your family or friends EVER tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you EVER gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

## Stress (GAD-7)

How often have you been bothered by each of the following symptoms during the PAST 2 WEEKS?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3

8. If you checked off any problems, how difficult have these 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

## Mood (PHQ-9)

How often have you been bothered by each of the following symptoms during the PAST 2 WEEKS?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite, weight loss, or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things like schoolwork, reading, or watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3

10. In the PAST YEAR, have you felt depressed or sad most days, even if you felt okay sometimes?

Yes       No

11. If you checked off any problems, how difficult have these 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

12. Has there been a time in the PAST MONTH when you have had serious thoughts about ending your life?

Yes       No

13. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes       No