Metropolitan Pediatrics

Adolescent Mood & Stress Questionnaire

Name: _____ Birthday: _____ Visit Date: _____

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

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	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it's hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

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	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless	☐	☐	☐	☐
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 schoolwork, 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

PLEASE COMPLETE BOTH SIDES →

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**

Substance Use (CRAFFT)	**NO**	**YES**
1. In the LAST 12 MONTHS:		
a. Did you drink any alcohol (more than a few sips)?	☐	☐
b. Did you smoke any marijuana or hashish?	☐	☐
c. Did you use anything else to get high?	☐	☐
2. Have you EVER ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐	☐
	If you answered "NO" to all above questions, **you're all done!**	If you answered "YES" to any questions, **answer questions #3-7 below.**

***** 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?	☐	☐
4. Do you EVER use alcohol or drugs while you are by yourself, or alone?	☐	☐
5. Do you EVER forget things you did while using alcohol or drugs?	☐	☐
6. Do your family or friends EVER tell you that you should cut down on your drinking or drug use?	☐	☐
7. Have you EVER gotten into trouble while you were using alcohol or drugs?	☐	☐