Metropolitan Pediatrics, L.L.C.

Adolescent Annual Questionnaire

Name: _____ DOB: _____ MR#: _____ Date of Service: _____

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.

Substance Use (CRAFFT)

In the LAST 12 MONTHS, did you…

1.	Drink any alcohol (more than a few sips)?	❑ No	If you answered "no" to all three questions, **answer #4 below.**	❑ Yes	If you answered "yes" to any questions, **answer questions #4-9 below.**
2.	Smoke any marijuana or hashish?	❑ No		❑ Yes	
3.	Use anything else to get high?	❑ No		❑ Yes	

Based on your answers above, please complete the next question(s).

4.	Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	❑ No	❑ Yes
5.	Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	❑ No	❑ Yes
6.	Do you ever use alcohol or drugs while you are by yourself, or alone?	❑ No	❑ Yes
7.	Do you ever forget things you did while using alcohol or drugs?	❑ No	❑ Yes
8.	Does your family or friends ever tell you that you should cut down on your drinking or drug use?	❑ No	❑ Yes
9.	Have you ever gotten into trouble while you were using alcohol or drugs?	❑ No	❑ Yes

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 ½ 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 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?	❑	❑	❑	❑

MORE QUESTIONS ON THE BACK SIDE ⇨

How often have you been bothered by each of the following symptoms during the PAST 2 WEEKS?	**Not at all**	**Several days**	**More than ½ the days**	**Nearly every day**
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	❑	❑	❑	❑
	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 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

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

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