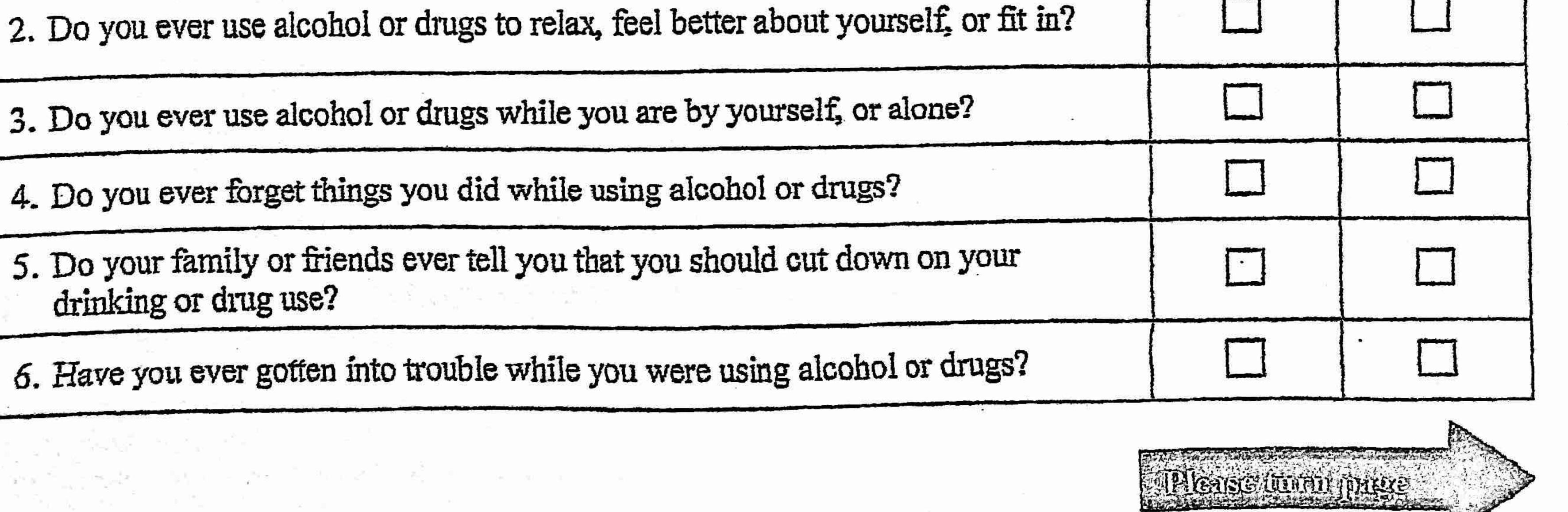
			= e:		
Ve ask all our teen patients about alcohol and mood because hese factors can affect your health. Please ask your doctor if ou have any questions. Your answers on this form will emain confidential.		Patient name: Date of birth:			
S2BI:					
In the PAST YEAR, how many times have you used:	Never	Once or twice	Monthly	Weekly	
Tobacco:					
Alcohol:					
Marijuana:					
If you answered "Never" to all questions above, turn the page. Otherwise, please cor	you can sl atinue answ	cip to CRAFFT questions	estion #1 and below.	then	
Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)					
Illegal drugs: (such as cocaine or ecstasy)					
Inhalants: (such as nitrous oxide)					
Herbs or synthetic drugs: (such as salvia, "K2", or bath salts)					
If you answered "Never" or "Once or twice" to all question #1 below and then turn the page. Otherwise.	l questions ise, please	above, you can ans continue answering	wer only CRA all questions	IPFT below.	
CRAFFT questions			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?					
		7.50 0			

drinking or drug use?



PHQ-9 Modified for Teens:

How often have you been bothered by each of the following symptoms during the past TWO 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?							
If you answered 'Not at all' to both questions above, you are finished answering questions. Otherwise, please continue answering all the questions below.							
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?							
9. Thoughts that you would be better off dead, or of hurting yourself in some way?							
	A STATE OF THE STA		2				
In the PAST YEAR, have you felt depressed or sad most days, even if you felt okay sometimes?] Yes	III No			
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							
Has there been a time in the past month when you have had serious thoughts about ending your life?							
Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?				LI No			