healthcare
CORPORATE HEALTH SERVICES

✦ 15 - 17 Year ✦ Questionnaire

Please provide the following information.

Today's Date: _____

Child's Name: _____

Date of Birth: _____

Important Points to Remember:

- ☑ Parents please complete the *Parent Checklist*.
- ☑ Encourage your child to complete the *Patient Checklist*.
- ☑ Bring these questionnaires with you to your child's appointment.

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Parent Checklist ▪ 15 - 17 Year Old

Name _____ Age _____ MR# _____ Date _____

Please check under the heading that best fits you and your child:	Yes	No
1. Does your teen have good friends?	☐	☐
2. Does your teen have friends who come over to visit and does she visit other children's homes?	☐	☐
3. Can your teen disagree at times with his/her friends?	☐	☐
4. Are parents always home when teens visit each other?	☐	☐
5. Does your teen enjoy physical activity on a team or at home?	☐	☐
6. Do both parents agree about rules and consequences for your teen?	☐	☐
7. Does your teen understand the “family rules" and what his "jobs" are in the family?	☐	☐
8. Do you feel comfortable negotiating limits with your teen?	☐	☐
9. Do you and your teen feel good about his school performance?	☐	☐
10. Does your teen know *exactly* what you expect of his school work and use of drugs and alcohol?	☐	☐
11. Does your teen have any special interests or hobbies?	☐	☐
12. Do you sense your teen is moving toward a career path?	☐	☐
13. Does your child have a supportive relationship with an adult outside of the home?	☐	☐
14. Does your teen always wear his/her seatbelt and bike helmet?	☐	☐
15. Do both parents live in the same home?	☐	☐
16. Do you have someone to discuss parenting issues with?	☐	☐

1. Does your child work more than 20 hours a week?	☐	☐
2. Are you concerned about the amount of time your teen spends on video games, the Internet or watching TV?	☐	☐
3. Does your teen spend time in a location where guns are stored?	☐	☐
4. Has your teen had trouble with the law?	☐	☐
5. Do you have worries about your teen’s growth, development, eating or sleeping habits?	☐	☐
6. Do you think there is an unusual amount of conflict with your teen?	☐	☐
7. Do you think your teen is using drugs, vaping devices, alcohol or cigarettes?	☐	☐
8. Are cigarettes and/or alcohol available in your home?	☐	☐
9. Are you concerned about your teen’s sexual interest or activity?	☐	☐
10. Is your household experiencing family, financial or marital stress?	☐	☐
11. Are you concerned that a family member may be depressed?	☐	☐
12. Are you concerned about a family member’s use of alcohol or drugs?	☐	☐
13. Does someone in your home smoke?	☐	☐

Jot down any questions or concerns on the back.

Reviewed and Updated 2020

Patient Checklist ▪ 15 - 17 Year Old

Name _____ Age _____ MR# _____ Date _____

We believe we can do a better job taking care of you if we know more about you. It would help us if you would take a minute to fill out this form. No one other than the nurse practitioner or doctor who checks you will see this form. ***Please bring this form to your appointment.*** If you would rather not fill in some of the questions, we can talk about them instead.

What are you really good at?		
What do you do for fun?		
What physical exercise or sports do you enjoy?		
What do you enjoy about school and how are your grades?		
How do you get along with your parents and family?		
How do you feel about the way you look?		
What changes in your body do you have questions about today?		
How often do you feel over stressed and how do you cope with stress?		
Who can you talk to if you are really worried or upset?		
Are you close to any adults outside your household?	Yes ☐	No ☐
Have you noticed that you feel sad or worried or really irritable?	Yes ☐	No ☐
Has anyone ever made you feel uncomfortable in the way they touched you, or talked to you?	Yes ☐	No ☐

 Reviewed and Updated 2021

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐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?

☐Yes ☐No

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

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Generalized Anxiety Disorder (GAD-7) Scale

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.	☐ # of days
4.	Use a **vaping device containing nicotine or flavors** (like e-cigarettes, vapes, vape pens, pod mods like JUUL or Puff Bars), cigarettes, hookahs, or other **tobacco** products? Put "0" if none.	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.**

		No	Yes
5.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
6.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
7.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
8.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
9.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
10.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.