



Patient's Name: _____

Today's Date: _____

Please review the following checklist. Check the ones that **you are** experiencing:

____ Disrupted eating pattern
(too much or not enough)

____ Headaches

____ Disrupted sleeping pattern
(too much or not enough)

____ Nausea / Stomachaches

____ Crying

____ Nervousness

____ Sadness

____ Fearfulness

____ Low energy level

____ Mood Swings

____ Fatigue

____ Anger

____ Low motivation

____ High energy level

____ Low self-esteem

____ Impulsiveness

____ Poor Concentration

____ Easily Distracted

____ Difficulty making decisions

____ Racing thoughts

____ Hopelessness

____ Difficulty in school / work



- | | |
|--|-----------------------------------|
| _____ Helplessness | _____ Difficulty completing tasks |
| _____ Decreased interest in activities | _____ Poor organization |
| _____ Thoughts of hurting self | _____ Forgetfulness |
| _____ Thoughts of hurting others | _____ Fidgeting |
| _____ Irritability | _____ Difficulty remaining seated |
| _____ Overwhelmed | _____ Impatience |
| _____ Frustration | _____ Procrastination |
| _____ Excessive worrying | _____ Talking excessively |
| _____ Restlessness | _____ Interrupting |
| _____ Muscle tension | _____ Becoming bored easily |
| _____ Panic attacks | _____ Losing items |
| _____ Isolation | _____ Nightmares |
| _____ Difficulty following directions | _____ Flashbacks |

Checklist completed by: _____ Date: _____

Reviewed by: _____ Date: _____



Patient Health Questionnaire (PHQ-9)

Name _____ Date of Birth _____

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	Not at all	Several Days	More than Half	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling, or staying asleep? Sleeping too much?	0	1	2	3
Feeling tired or having little or no energy?	0	1	2	3
Poor appetite or over-eating?	0	1	2	3
Feeling bad about yourself-or that you are a failure? Feeling that you have let yourself or your family down?	0	1	2	3
Trouble concentrating on things such as the TV or newspaper?	0	1	2	3
Moving or speaking so slowly that others could notice? Or being so fidgety or restless / moving around more than normal?	0	1	2	3
Thoughts you would be better off dead, or of hurting yourself?	0	1	2	3

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

- Not Difficult
- Somewhat difficult
- Very Difficult
- Extremely Difficult

Total Score: _____

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
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(use " ✓ " to indicate your answer)

1. Feeling nervous, anxious, or on edge	0	1	2	3
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2. Not being able to stop or control worrying	0	1	2	3
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3. Worrying too much about different things	0	1	2	3
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4. Trouble relaxing	0	1	2	3
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5. Being so restless that it is hard to sit still	0	1	2	3
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6. Becoming easily annoyed or irritable	0	1	2	3
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7. Feeling afraid as if something awful might happen?	0	1	2	3
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(For office coding: Total Score T _____ = _____ + _____ + _____)



Name: _____ Date: _____ Date of birth: ___/___/___

The CRAFFT Screener

The CRAFFT is intended specifically for adolescents ages 14-17

Please answer all questions honestly

Part A

Place a check mark in the No or Yes box

During the PAST 12 MONTHS, did you:

No

Yes

1. Drink any <u>alcohol</u> (more than a few sips)?		
2. Smoke any <u>marijuana</u> or <u>hashish</u> ?		
3. Use <u>anything else</u> to get high?		

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you marked "No" to all of the Part A questions: simply just answer question #1 in Part B

If you marked "Yes" to any of the questions in Part A: please answer all 6 questions in Part B

Part B

Circle No or Yes

- | | | |
|--|----|-----|
| 1. Have you ever ridden in a Car driven by someone (including yourself) who was high or had been using alcohol or drugs? | No | Yes |
| 2. Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in? | No | Yes |
| 3. Do you ever use alcohol or drugs while you are by yourself Alone? | No | Yes |
| 4. Do you ever Forget things you did while using alcohol or drugs? | No | Yes |
| 5. Do your Family or Friends ever tell you that you should cut down on your drinking or drug use? | No | Yes |
| 6. Have you ever gotten into Trouble while you were using alcohol or drugs? | No | Yes |