

# Adolescent Health Questionnaire

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.

Patient name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_

**Your answers on this form will remain confidential.**

## Substance use (CRAFFT):

In the last 12 months, did you:

	<b>No</b>		<b>Yes</b>
Drink any alcohol (more than a few sips)?	<input type="checkbox"/>	}	<input type="checkbox"/>
Smoke any marijuana or hashish?	<input type="checkbox"/>		<input type="checkbox"/>
Use anything else to get high?	<input type="checkbox"/>		<input type="checkbox"/>

If you answered No to all three questions, answer #1 below.

If you answered Yes to any questions, answer questions #1-6 below

	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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>



## Mood (PHQ-2):

	<b>No</b>	<b>Yes</b>
Over the past month, have you been bothered by little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>
Over the past month, have you been bothered by feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes to either question, answer all questions on back

