Well child

Confidential adolescent questionnaire

12–18 years

Please complete this questionnaire when your parents and others are out of the room; when complete, give it directly to the medical assistant or healthcare provider.

1	Do you have concerns that you would like to discuss in private?	No	Yes

Substance use (CRAFFT questions)

Section 1:

In the last 12 months, did you:

2	Drink any alcohol (more than a few sips)?	No	Yes
3	Smoke or vape marijuana?	No	Yes
4	Use anything else to get high?	No	Yes

If you answered "YES" to any of the above, please also answer the next 5 questions in section 2. If not, skip to section 3.

Section 2:

a	Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	No	Yes
b	Do you ever use alcohol or drugs while you are by yourself, or alone?	No	Yes
c	Do you ever forget things you did while using alcohol or drugs?	No	Yes
d	Do your family or friends ever tell you that you should cut down on your drinking or drug use?	No	Yes
e	Have you ever gotten into trouble while you were using alcohol or drugs?	No	Yes

Section 3 (Additional questions)

5	Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Yes
6	Have you ever played games to make you pass out (like the choking game)?	No	Yes
7	Has someone at home, school, or anywhere else made you feel afraid, threatened you, or hurt you?	No	Yes
8	Have you ever considered seriously hurting someone else?	No	Yes
9	Are you, or do you wonder if you are gay, lesbian, or bisexual?	No	Yes
10	Are you, or do you wonder if you are transgender or non-binary?	No	Yes

11	Have you ever been forced or pressured to do something sexual that you did not want to do?	No	Yes
12	Have you ever had sex (including intercourse or oral sex)? ***If NO***, skip to the next section, on tobacco use. ***If Yes***, fill out questions A-C	No	Yes
a	Are you using a method to prevent pregnancy?	No	Yes
	If yes, what method?		
b	Have you ever been pregnant, or gotten someone pregnant?	No	Yes
c	Do you think you or your partner could have a sexually transmitted infection?	No	Yes

Tobacco Use

Section 4:

13 Have you ever smoked cigarettes, vaped or chewed tobacco? (circle below)

NEVER	
SOMETIMES	
DAILY	
QUIT	DATE QUIT:
Passive smoke exposure (I do not smoke, but someone else at home does)	

If you have ever vaped or used any tobacco products, then answer the following questions:

a	When did you first start?		
b	Number of e-cigs/pens/cigarettes/packs/can do you use in a typical day (or week)?		
c	What products? (circle any that apply)	Cigarettes E-cigs/vape pens Chew/snuff Other	Hookah
d	If you smoke/vape, would you like to quit?	Yes	No

Mood (PHQ-2/A)

Please check the appropriate boxes below and total the associated numbers:

		Not at all (0 pts each)	**Several days** (1 pt each)	**More than half the days** (2 pts each)	**Nearly every day** (3 pts each)
1	During the past 2 weeks, have you been bothered by little interest or pleasure in doing things?				
2	During the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?				

Total your points for questions 1 & 2 PHQ-2 total: _____ pts

ONLY answer the following if the PHQ-2 total above is 3 or more. If you scored less than a 3, you are DONE.

	Over the last 2 weeks, how often have you been bothered by any of the following problems? Check the box beneath the answer the best describes your feelings.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3	Trouble falling/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 that you're a failure or have let yourself down or your family down?				
7	Trouble concentrating on things, such as schoolwork, reading, or watching television?				
8	Moving or speaking so slowly that other people could have noticed, or the opposite–being so fidgety or restless that you have been moving around a lot more than usual?				
9	Thoughts that you would be better off dead, or of hurting yourself in some way?				

If you checked any of the boxes above, 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?

Circle the appropriate choice:

Not difficult at all Somewhat difficult Very difficult Extremely difficult

1	In the **past year**, have you felt depressed or sad most days, even if you feel okay sometimes?	No	Yes
2	Has there been a time in the **past month** when you have had serious thoughts about ending your life?	No	Yes
3	Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt?	No	Yes