Health Screen (CRAFFT +N Questionnaire)

We ask all our teen patients about alcohol, drugs, and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient Name: _____

Date of Birth: _____

Todays Date: _____

*To be completed by the patient

During the **PAST 12 months**, on how many days did you:	Number of days
1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	
2. Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or **"synthetic marijuana"** (like "K2," "Spice")? Put "0" if none.	
3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	
4. Use any **tobacco or nicotine** products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Say "0" if none.	

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?	☐	☐

FOR OFFICE USE ONLY:
Follow-up done:_____ **Date:**_____

Adult Patient Health Questionnaire (PHQ-9 for 18 years+)

Name:_____ Date of Birth: _____ Date: _____

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

(For Healthcare Professionals) add columns _____ + _____ + _____

Total _____

10. 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

FOR OFFICE USE ONLY:
Follow-up done:_____ **Date:**_____