Name: _____ **Date of Birth:** _____ **Date:** _____

Adolescent Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3.Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired or having little energy?	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 school work, reading 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 in some way?	0	1	2	3

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

PHQ-9 Score:_____

Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT)

In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol _____ or used cannabis or other illegal drugs ? _____

If your friends drink, **how many drinks** do they usually drink on an occasion? _____