Today's date: _____ **Name:**_____ **DOB:**_____

Complete SECTIONS 1 and 2

Section 1: GAD

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
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

Total of Question 1 plus 2 = _____ If the total is 3 or more, continue to questions 3 to 7

	Not at all	Several Days	More than Half the Days	Nearly Every Day
3. Worrying too much	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
TOTALS				
If you check 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 other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely

Section 2: PHQ

Over the past 2 weeks, how often have you felt:

	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

Total of Question 1 plus 2 = _____ ***If total is 3 or more*, *continue to questions 3-9***. 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
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 thoughts of hurting yourself?	0	1	2	3
TOTALS				
If you 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 other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely

DO NOT COPY

Name:_____
DOB:_____
Date: _____

ADOLESCENT QUESTIONNAIRE

This information will help us get to know you better. The information you share with us is confidential and **will not be discussed with your parents** unless we feel it is medically necessary.

1.	Are you enjoying this year in school?	Yes	No
2.	Are you satisfied with your friendships and social groups?	Yes	No
3.	Are you getting enough sleep?	Yes	No
4.	Is any aspect of schoolwork getting too hard?	No	Yes
5.	Can you turn to a parent or adult for help and support?	Yes	No
6.	Have you been in any car, bike, or motorcycle accidents?	No	Yes
7.	Are you satisfied with your current body weight?	Yes	No
8.	Have you developed any special diets for yourself?	No	Yes
9.	Do you smoke cigarettes, vape, or use other tobacco products?	No	Yes
10.	In the last 3 months did you drink: ____beer _____wine ____wine coolers ____other alcohol?	No	Yes
11.	In the last 3 months have you used: ____marijuana ____LSD ____speed ____crack _____cocaine ____ nicotine ___crank ___ecstasy ____PCP ____glue _____heroin ____nitrates ____steroids _____other drugs?	No	Yes
12.	Have you ever had sexual intercourse? If yes, was it with a: _____male _____female _____both males and females.	No	Yes
13.	Have you ever engaged in oral sex and/or anal sex?	No	Yes
14.	Are you using something to prevent pregnancy and/or STDs (condoms, birth control)?	No	Yes
15.	Have you ever been told you had an STD? Such as: ____gonorrhea ____hepatitis ____genital warts ____herpes _____chlamydia _____abnormal PAP test _____trichomonas?	No	Yes
16.	Do you take nutritional supplements or steroids?	No	Yes
17.	Could you get a gun, rifle, or other firearms if you wanted to?	No	Yes
18.	Have you carried a gun, knife, or other weapons in the past year?	No	Yes
19.	Have you ever cut yourself on purpose?	No	Yes

Do you have any questions about:
___ Sex
___ Alcohol
___ Birth Control
___ Sexually Transmitted Disease (STDs)
___ Drugs
___ Smoking
___ Other: _____

Your cell phone number: _____

Pronouns: _____

PLEASE Complete SECTIONS 1 and 2 on REVERSE SIDE

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