SOUTHERN OREGON
PEDIATRICS

Name_____ **Date**_____ **Boy 13 to 14 Year screening**

Parent Questions

	Yes	No	Unsure
1. Do you think that your child has problems with his vision?			
2. Do you have concerns that your child has hearing loss?			
3. Has a family member or contact had TB (Tuberculosis) or a positive TB skin test?			
4. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?			
5. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
6. Does your child have HIV/AIDS?			
7. Have your child's parents or grandparents had a stroke or heart problem before age 55?			
8. Does your child have a parent with high cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?			
9. Does your child have any relatives who've experienced sudden unexplained death or early death (< age 50)?			
10. Does your child mainly eat a vegetarian or vegan diet?			
11. Do you have concerns that your child does NOT eat enough iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
12. Do you feel you have difficulties providing enough food to feed your family?			
13. Is your child ever around tobacco smoke?			

Development- Is your child doing any of the following:	Yes	No	Unsure
1. Having home or school disciplinary problems?			

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2. Getting at least 8 hours of sleep a night?			
3. Getting daily exercise for at least 30 minutes?			
4. Passing all of his classes at school?			

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Name_____ **Date**_____ **Boy 13 to 14 Year screening**

Patient Questions

	Yes	No	Unsure
1. Do you smoke cigarettes?			
2. Have you ever had low iron or anemia?			
3. Do you feel your diet lacks iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
4. Have you ever had sex (including intercourse or oral sex)?			
5. Do you have problems with any bullies?			

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6. Do you get along well with other kids at school?			
7. Do you have friends at school?			

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Name:_____ DOB:_____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half of the days	(3) Nearly every day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, irritable, or hopeless?				
If you answered "Not at all" on both question #1 AND #2, skip over #3-9.				
3. Trouble falling asleep, 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 feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like schoolwork, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

Complete the bottom sections and then complete the back side of this form.

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

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

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The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	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?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

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The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.