Well Child Packet
(11 – 21 Years of Age)

Patient Name: _____ **DOB**: _____ **Date**: _____

Please have the patient answer the following questions.

PHQ-9 modified for Adolescents (PHQ-A)

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 the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
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 school work, 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?				

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.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Patient Name: _____ DOB: _____ Date: _____

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
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")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

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?	☐	☐

Patient Name: _____ **DOB:** _____ **Date:** _____

Lead Risk Assessment

Circle Yes or No.

1. Does your child live in or regularly visit a house/apt. that was built before 1978? ***Yes / No***

2. Does your child live in or often visit a house/apt. that is being remodeled or having paint removed? ***Yes / No***

3. Does your child live with or often visit with a child that had an elevated Blood Lead Level? ***Yes / No***

4. Does your child live with an adult whose job or hobby involves exposure to lead? ***Yes / No***

5. Does your child chew on or eat non-food items such as paint chips or dirt? ***Yes / No***

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? ***Yes / No***

7. Does your child receive medicines such as Greta, Azarcon, Kohl or Pay-loo-ay? ***Yes / No***

Tuberculosis (TB) Risk Assessment

Circle Yes or No.

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray? ***Yes / No***

2. Has the child been in close contact to a person sick with active TB disease? ***Yes / No***

3. Was the child born outside the United States or has the child traveled outside the United States? ***Yes / No***

4. Does the child have a household member who was born outside the United States or who has traveled outside the United States? ***Yes / No***

5. Is the child exposed to a person who ***Yes / No***
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker?

6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? ***Yes / No***

7. Is the child/teen in jail or ever been in jail? ***Yes / No***

Hemoglobin Assessment

1. Does the child have history of prematurity or low birth weight? ***Yes / No***

2. Does the child have any feeding problems and/or sudden weight gain or loss? ***Yes / No***

3. Does the child have any chronic disease or major blood loss? ***Yes / No***