ISI

ISI

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Difficulty falling asleep

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

Difficulty staying asleep

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

Problems waking up too early

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?

☐ Very Satisfied ☐ Satisfied ☐ Moderately Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

☐ Not at all Noticeable ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Noticeable

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

How WORRIED / DISTRESSED are you about your current sleep problem?

☐ Not at all Worried ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Worried

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work / daily chores, concentration, memory, mood, etc.) CURRENTLY?

☐ Not at all Interfering ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Interfering

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

ISI Total

Mood Disorder Screening

MOOD DISORDER SCREENING

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...

	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

☐ Yes ☐ No

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

☐ Yes ☐ No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ Yes ☐ No

Score (based on algorithm):

GAD-7

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following problems?

Rating Scale

	(0) Not at all	(1) Several Days	(2) More than Half the Days	(3) Nearly Everyday
1. Feeling nervous, anxious or on edge?	○	○	○	○
2. Not being able to stop or control worrying?	○	○	○	○
3. Worrying too much about different things?	○	○	○	○
4. Trouble relaxing?	○	○	○	○
5. Being so restless that it is hard to sit still?	○	○	○	○
6. Becoming easily annoyed or irritable?	○	○	○	○
7. Feeling afraid as if something awful might happen?	○	○	○	○

Score

PHQ-9

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	0 - Not at all	1 - Several days	2 - More than half the days	3 - Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overreacting	○	○	○	○
6. Feeling bad about yourself... or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself	○	○	○	○

Score

SHA 9 -11 YEARS

Only complete this form on behalf of a patient who is 9-11 years of age

Person Completing Form

☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Self ☐

Other

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Does your child drink or eat 3 servings of calcium-rich foods 1 daily, such as milk, cheese, yogurt, soy milk, or tofu?

▢ Yes ▢ No ▢ Skip

2. Does your child eat fruits and vegetables at least two times per day?

▢ Yes ▢ No ▢ Skip

3. Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?

▢ Yes ▢ No ▢ Skip

4. Does your child drink more than one cup (8 oz.) of juice per day?

▢ Yes ▢ No ▢ Skip

5. Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?

▢ Yes ▢ No ▢ Skip

6. Does your child exercise or play sports most days of the week?

▢ Yes ▢ No ▢ Skip

7. Are you concerned about your child's weight?

▢ Yes ▢ No ▢ Skip

8. Does your child watch TV or play video games less than 2 hours per day?

▢ Yes ▢ No ▢ Skip

9. Does your home have a working smoke detector?

▢ Yes ▢ No ▢ Skip

10. Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?

▢ Yes ▢ No ▢ Skip

11. Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?

▢ Yes ▢ No ▢ Skip

12. Does your child spend time near a swimming pool, river, or lake?

▢ Yes ▢ No ▢ Skip

13. Does your child spend time in a home where a gun is kept?

▢ Yes ▢ No ▢ Skip

14. Does your child spend time with anyone who carries a gun, knife, or other weapon?

▢ Yes ▢ No ▢ Skip

15. Does your child always wear a helmet when riding a bike, skateboard, or scooter?

▢ Yes ▢ No ▢ Skip

16. Has your child ever witnessed or been a victim of abuse or violence?

▢ Yes ▢ No ▢ Skip

17. Has your child been hit or has your child hit someone in the past year?

▢ Yes ▢ No ▢ Skip

18. Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?

▢ Yes ▢ No ▢ Skip

19. Does your child brush and floss her/his teeth daily?

▢ Yes ▢ No ▢ Skip

20. Does your child often seem sad or depressed?

▢ Yes ▢ No ▢ Skip

21. Does your child spend time with anyone who smokes?

▢ Yes ▢ No ▢ Skip

22. Has your child ever smoked cigarettes or chewed tobacco?

▢ Yes ▢ No ▢ Skip

23. Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?

▢ Yes ▢ No ▢ Skip

24. Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?

▢ Yes ▢ No ▢ Skip

25. Does your child have friends or family members who have a problem with drugs or alcohol?

▢ Yes ▢ No ▢ Skip

26. Has your child started dating or "going out" with boyfriends or girlfriends?

▢ Yes ▢ No ▢ Skip

27. Do you think your child might be sexually active?

☐ Yes ☐ No ☐ Skip

28. Do you have any other questions or concerns about your child's health or behavior?

☐ Yes ☐ No ☐ Skip

Clinic Use Only

Nutrition

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Physical Activity

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Safety

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Dental Health

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Tobacco Exposure

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

☐ **Patient Declined the SHA**

Comments:

SHA 12 - 17 YEARS

Only complete this form if you are between 12-17 years of age

Person Completing Form

☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Self ☐

Other

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?

☐ Yes ☐ No ☐ Skip

2. Do you eat fruits and vegetables at least 2 times per day?

☐ Yes ☐ No ☐ Skip

3. Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?

☐ Yes ☐ No ☐ Skip

4. Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy. drink, or sweetened coffee drink?

☐ Yes ☐ No ☐ Skip

5. Do you exercise or play sports most days of the week?

☐ Yes ☐ No ☐ Skip

6. Are you concerned about your weight?

☐ Yes ☐ No ☐ Skip

7. Do you watch TV or play video games less than 2 hours per day?

☐ Yes ☐ No ☐ Skip

8. Does your home have a working smoke detector?

☐ Yes ☐ No ☐ Skip

9. Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?

☐ Yes ☐ No ☐ Skip

10. Do you always wear a seatbelt when riding in a car?

☐ Yes ☐ No ☐ Skip

11. Do you spend time in a home where a gun is kept?

☐ Yes ☐ No ☐ Skip

12. Do you spend time with anyone who carries a gun, knife, or other weapon?

☐ Yes ☐ No ☐ Skip

13. Do you always wear a helmet when riding a bike, skateboard, or scooter?

☐ Yes ☐ No ☐ Skip

14. Have you ever witnessed abuse or violence?

☐ Yes ☐ No ☐ Skip

15. Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?

☐ Yes ☐ No ☐ Skip

16. Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?

☐ Yes ☐ No ☐ Skip

17. Do you brush and floss your teeth daily?

☐ Yes ☐ No ☐ Skip

18. Do you often feel sad, down, or hopeless?

☐ Yes ☐ No ☐ Skip

19. Do you spend time with anyone who smokes?

☐ Yes ☐ No ☐ Skip

20. Do you smoke cigarettes or chew tobacco?

☐ Yes ☐ No ☐ Skip

21. Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?

☐ Yes ☐ No ☐ Skip

22. Do you use medicines not prescribed for you?

☐ Yes ☐ No ☐ Skip

23. Do you drink alcohol once a week or more?

☐ Yes ☐ No ☐ Skip

24. If you drink alcohol, do you drink enough to get drunk or pass out?

☐ Yes ☐ No ☐ Skip

25. Do you have friends or family members who have a problem with drugs or alcohol?

☐ Yes ☐ No ☐ Skip

26. Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?

☐ Yes ☐ No ☐ Skip

27. Have you ever been forced or pressured to have sex?

☐ Yes ☐ No ☐ Skip

28. Have you ever had sex (oral, vaginal, or anal)? If no, skip to question 35.

☐ Yes ☐ No ☐ Skip

29. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?

☐ Yes ☐ No ☐ Skip

30. Have you or your partner(s) had sex with other people in the past year?

☐ Yes ☐ No ☐ Skip

31. Have you or your partner(s) had sex without using birth control in the past year?

☐ Yes ☐ No ☐ Skip

32. The last time you had sex, did you use birth control?

☐ Yes ☐ No ☐ Skip

33. Have you or your partner(s) had sex without a condom in the past year?

☐ Yes ☐ No ☐ Skip

34. Did you or your partner use a condom the last time you had sex?

☐ Yes ☐ No ☐ Skip

35. Do you have concerns about liking someone of the same sex?

☐ Yes ☐ No ☐ Skip

36. Do you have any other questions or concerns about your health?

☐ Yes ☐ No ☐ Skip

Clinic Use Only

Nutrition

- [ ] Counseled
- [ ] Referred
- [ ] Anticipatory Guidance
- [ ] Follow-up Ordered

Physical Activity

- [ ] Counseled
- [ ] Referred
- [ ] Anticipatory Guidance
- [ ] Follow-up Ordered

Safety

- [ ] Counseled
- [ ] Referred
- [ ] Anticipatory Guidance
- [ ] Follow-up Ordered

Dental Health

- [ ] Counseled
- [ ] Referred
- [ ] Anticipatory Guidance
- [ ] Follow-up Ordered

Tobacco Exposure

- [ ] Counseled
- [ ] Referred
- [ ] Anticipatory Guidance
- [ ] Follow-up Ordered

- [ ] **Patient Declined the SHA**

Comments:

SHA ADULT

Please complete this form if you are between 18-60 years of age

Person Completing Form

☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Self ☐

Other

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?

☐ Yes ☐ No ☐ Skip

2. Do you eat fruits and vegetables every day?

☐ Yes ☐ No ☐ Skip

3. Do you limit the amount of fried food or fast food that you eat?

☐ Yes ☐ No ☐ Skip

4. Are you easily able to get enough healthy food?

☐ Yes ☐ No ☐ Skip

5. Do you drink a soda, juice drink, sports or energy drink most days of the week?

☐ Yes ☐ No ☐ Skip

6. Do you often eat too much or too little food?

☐ Yes ☐ No ☐ Skip

7. Are you concerned about your weight?

☐ Yes ☐ No ☐ Skip

8. Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?

☐ Yes ☐ No ☐ Skip

9. Do you feel safe where you live?

☐ Yes ☐ No ☐ Skip

10. Have you had any car accidents lately?

☐ Yes ☐ No ☐ Skip

11. Have you been hit, slapped, kicked, or physically hurt by someone in the last year?

☐ Yes ☐ No ☐ Skip

12. Do you always wear a seat belt when driving or riding in a car?

☐ Yes ☐ No ☐ Skip

13. Do you keep a gun in your house or place where you live?

☐ Yes ☐ No ☐ Skip

14. Do you brush and floss your teeth daily?

☐ Yes ☐ No ☐ Skip

15. Do you often feel sad, hopeless, angry, or worried?

☐ Yes ☐ No ☐ Skip

16. Do you often ha e trouble sleeping?

☐ Yes ☐ No ☐ Skip

17. Do you smoke or chew tobacco?

☐ Yes ☐ No ☐ Skip

18. Do friends or family members smoke in your house or place were you live?

☐ Yes ☐ No ☐ Skip

19. In the past year, have you had: (men) 5 or more alcohol drinks in one day? or (women) 4 or more alcohol drinks in one day?

☐ Yes ☐ No ☐ Skip

20. Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?

☐ Yes ☐ No ☐ Skip

21. Do you think you or your partner could be pregnant?

☐ Yes ☐ No ☐ Skip

22. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?

☐ Yes ☐ No ☐ Skip

23. Have you or your partner(s) had sex without using birth control in the past year?

☐ Yes ☐ No ☐ Skip

24. Have you or your partner(s) had sex with other people in the past year?

☐ Yes ☐ No ☐ Skip

25. Have you or your partner(s) had sex without a condom in the past year?

☐ Yes ☐ No ☐ Skip

26. Have you ever been forced or pressured to have sex?

☐ Yes ☐ No ☐ Skip

27. Do you have other questions or concerns about your health?

☐ Yes ☐ No ☐ Skip

Clinic Use Only

Nutrition

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Physical Activity

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Safety

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Dental Health

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Tobacco Exposure

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

☐ **Patient Declined the SHA**

Comments:

SHA SENIOR

Please complete this form if you are 61 years of age or older

Person Completing Form

☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Self ☐

Other

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?

☐ Yes ☐ No ☐ Skip

2. Do you eat fruits and vegetables every day?

☐ Yes ☐ No ☐ Skip

3. Do you limit the amount of fried food or fast food that you eat?

☐ Yes ☐ No ☐ Skip

4. Are you easily able to get enough healthy food?

☐ Yes ☐ No ☐ Skip

5. Do you drink a soda, juice drink, sports or energy drink most days of the week?

☐ Yes ☐ No ☐ Skip

6. Do you often eat too much or too little food?

☐ Yes ☐ No ☐ Skip

7. Do you have difficulty chewing or swallowing?

☐ Yes ☐ No ☐ Skip

8. Are you concerned about your weight?

☐ Yes ☐ No ☐ Skip

9. Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?

☐ Yes ☐ No ☐ Skip

10. Do you feel safe where you live?

☐ Yes ☐ No ☐ Skip

11. Do you often have trouble keeping track of your medicines?

☐ Yes ☐ No ☐ Skip

12. Are family members or friends worried about your driving?

☐ Yes ☐ No ☐ Skip

13. Have you had any car accidents lately?

☐ Yes ☐ No ☐ Skip

14. Do you sometimes fall and hurt yourself, or is it hard to get up?

☐ Yes ☐ No ☐ Skip

15. Have you been hit, slapped, kicked, or physically hurt by someone in the past year?

☐ Yes ☐ No ☐ Skip

16. Do you keep a gun in your house or place where you live?

☐ Yes ☐ No ☐ Skip

17. Do you brush and floss your teeth daily?

☐ Yes ☐ No ☐ Skip

18. Do you often feel sad, hopeless, angry, or worried?

☐ Yes ☐ No ☐ Skip

19. Do you often have trouble sleeping?

☐ Yes ☐ No ☐ Skip

20. Do you or others think that you are having trouble remembering things?

☐ Yes ☐ No ☐ Skip

21. Do you smoke or chew tobacco?

☐ Yes ☐ No ☐ Skip

22. Do friends or family members smoke in your house or where you live?

☐ Yes ☐ No ☐ Skip

23. In the past year, have you had 4 or more alcohol drinks in one day?

☐ Yes ☐ No ☐ Skip

24. Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?

☐ Yes ☐ No ☐ Skip

25. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?

☐ Yes ☐ No ☐ Skip

26. Have you or your partner(s) had sex with other people in the past year?

☐ Yes ☐ No ☐ Skip

27. Have you or your partner(s) had sex without a condom in the past year?

☐ Yes ☐ No ☐ Skip

28. Have you ever been forced or pressured to have sex?

☐ Yes ☐ No ☐ Skip

29. Do you have someone to help you make decisions about your health and medical care?

☐ Yes ☐ No ☐ Skip

30. Do you need help bathing, eating, walking, dressing, or using the bathroom?

☐ Yes ☐ No ☐ Skip

31. Do you have someone to call when you need help in an emergency?

☐ Yes ☐ No ☐ Skip

32. Do you have other questions or concerns about your health?

☐ Yes ☐ No ☐ Skip

If yes, please describe

Clinic Use Only

Nutrition

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Physical Activity

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Safety

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Dental Health

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

Tobacco Exposure

☐ Counseled ☐ Referred ☐ Anticipatory Guidance ☐ Follow-up Ordered

☐ **Patient Declined the SHA**

Comments:

Pediatric Symptom Checklist

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child

Please mark under the heading that best describes your child:

Rating Scale

	Never	Sometimes	Often
1. Complains of aches and pains	○	○	○
2. Spends more time alone	○	○	○
3. Tires easily, has little energy	○	○	○
4. Fidgety, unable to sit still	○	○	○
5. Has trouble with teacher	○	○	○
6. Less interested in school	○	○	○
7. Acts as if driven by a motor	○	○	○
8. Daydreams too much	○	○	○
9. Distracted easily	○	○	○
10. Is afraid of new situations	○	○	○
11. Feels sad, unhappy	○	○	○
12. Is irritable, angry	○	○	○
13. Feels hopeless	○	○	○
14. Has trouble concentrating	○	○	○
15. Less interested in friends	○	○	○
16. Fights with other children	○	○	○
17. Absent from school	○	○	○
18. School grades dropping	○	○	○
19. Is down on him or herself	○	○	○
20. Visits the doctor with doctor finding nothing wrong	○	○	○
21. Has trouble sleeping	○	○	○
22. Worries a lot	○	○	○
23. Wants to be with you more than before	○	○	○
24. Feels he or she is bad	○	○	○
25. Takes unnecessary risks	○	○	○
26. Gets hurt frequently	○	○	○
27. Seems to be having less fun	○	○	○
28. Acts younger than children his or her age	○	○	○
29. Does not listen to rules	○	○	○
30. Does not show feelings	○	○	○
31. Does not understand other people's feeling	○	○	○
32. Teases others	○	○	○
33. Blames others for his or her troubles	○	○	○
34. Takes things that do not belong to him or her	○	○	○
35. Refuses to share	○	○	○

Total score

Does your child have any emotional or behavioral problems for which she/he needs help?

☐ Yes ☐ No

Are there any services that you would like your child to receive for these problems?

☐ Yes ☐ No

If yes, what services?

PHQ-9 Modified for Teens

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, choose 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 Everyday
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 to fidgety or restless that you were moving around a lot more than usual?	○	○	○	○
9. Thoughts that you would be better off dead, or or 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, have these problems made it difficult for you to do your work, take care of things at home, or get along with other people?

☐ Yes ☐ No

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

Total Score ____________