



TEEN SCREEN
DO NOT COPY FOR MEDICAL RECORDS

Name: _____
DOB: _____

1. In the past 2 weeks, how often have you had LITTLE or NO interest or pleasure in doing things that you enjoy?	not at all (0)	several days (1)	> 1/2 of the days (2)	nearly every day (3)
2. In the past 2 weeks, how often have you felt down, depressed or hopeless	not at all (0)	several days (1)	> 1/2 of the days (2)	nearly every day (3)
3. In general, are you happy with the way things are going for you?	YES	Sometimes	NO	
4. Do you get along with your family?	YES	Sometimes	NO	
5. Do you have at least one adult you can really talk to?	YES	Sometimes	NO	
6. Do you wear a seat belt in a car/truck?	YES	Sometimes	NO	
7. Do you wear a helmet when you skateboard, bike, motorcycle, snowmobile or ATV?	YES	Sometimes	NO	
8. Do you feel you are about the right weight for your height?	YES	Sometimes	NO	
9. Do you get some exercise at least 3 times a week?	YES	Sometimes	NO	
10. Do you go to school regularly?	YES	Sometimes	NO	
11. Have your grades gotten worse than they used to be?	YES	Sometimes	NO	
12. Do you ever use laxatives or throw up on purpose after eating?	YES	Sometimes	NO	
13. Do you smoke cigarettes (including E cigarettes) or chew tobacco?	YES	Sometimes	NO	
14. Do you, or anyone you live with, have a gun or carry a gun around?	YES	Sometimes	NO	
15. Are you, or have you been, in a gang?	YES	Sometimes	NO	
16. Are you worried about money, a place to live, or having enough food to eat?	YES	Sometimes	NO	
17. Have you ever had sex (with women, men or both)?	YES	Sometimes	NO	
18. Have you ever been tested for or diagnosed with a sexually transmitted disease?	YES	Sometimes	NO	
19. Are you, or do you ever wonder if you are gay, lesbian, bisexual or transgender?	YES	Sometimes	NO	
20. Have you ever had thoughts about killing yourself or made a plan to kill yourself?	YES	Sometimes	NO	
21. Have you ever felt sad or down for more than 2 weeks or felt you had nothing to live for?	YES	Sometimes	NO	
22. Were you ever forced to have sex you did not want?	YES	Sometimes	NO	
23. Has someone touched you in a way that made you feel uncomfortable?	YES	Sometimes	NO	
24. Have you ever done something violent to yourself or others when you were angry?	YES	Sometimes	NO	
25. *Have you ever ridden in a CAR driven by someone else (or yourself) who was "high" or using drugs/alcohol?	YES	Sometimes	NO	
26. Have you tried any drugs (pot, crack, cocaine, heroin, acid, speed, etc.)?	YES	Sometimes	NO	
27. In the past 12 months, did you drink any alcohol (more than a few sips)?	YES	Sometimes	NO	
28. In the past 12 months, have you smoked any marijuana or hashish?	YES	Sometimes	NO	
29. In the past 12 months, have you used anything else to get high?	YES	Sometimes	NO	
IF YOU ANSWERED YES TO ANY OF THE LAST 3 QUESTIONS, PLEASE ANSWER THE FOLLOWING:				
*Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	YES	Sometimes	NO	
*Do you ever use alcohol or drugs while you are by yourself, or ALONE?	YES	Sometimes	NO	
*Do you FORGET things you did while using alcohol or drugs?	YES	Sometimes	NO	
*Do your FAMILY OR FRIENDS ever tell you that you should cut down on your drinking or drug use?	YES	Sometimes	NO	
*Have you ever gotten into TROUBLE while you were using alcohol or drugs?	YES	Sometimes	NO	

Provider Reviewed: _____

Date: _____