Skagit Pediatrics ONLINE Well Adolescent Intake (12-21yrs)

This form is for adolescent patients to complete themselves before the check-up visit.

Today's Date: _____
Patients Name: _____
Birth Date: _____
Age: _____

We look forward to seeing you for your Well Checkup.

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. Information is not shared with other people without your permission unless we are concerned that someone might be in danger. We hope you will feel free to talk openly with us.

Please complete this form and click submit. We will receive it in a safe and confidential way.

What questions or concerns would you like to discuss at your visit?

Patient Health Questionnaire

Instructions: How often have you been bothered by each of the following symptoms <u>DURING THE PAST TWO WEEKS</u>? 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.Feeling down, depressed, or hopeless?				
2.Little interest or pleasure in doing things?				
3.Trouble falling 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 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 have been moving around a lot more that usual?				
9.Thoughts that you would be better off dead or hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes:	☐ Yes ☐ No
11. If you are experiencing any of the problems on this form, how difficult have the 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	

12. Has there been a time in the past month where you have Had serious thoughts about ending your life?	☐ Yes ☐ No
13. Have you ***ever,*** in your ***whole life***, tried to kill yourself or made a suicide attempt?	☐ Yes ☐ No

FOR OFFICE USE ONLY Score_____

Q. 12 and 13 = Y or TS = ≥ 11

Source: Patient Health Questionnaire Modified for Teens (PH-9) (Author: Drs. Robert L. Spritzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

GAD-7

Over the **last two weeks**, how often have you been bothered by the following problems? **For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling**.	Not at all	Several Days	More than half the days	Nearly every day
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				

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spritzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. 5-9 mild, 10-14 mod, >15 sev.

S2BI

In the PAST YEAR, how many times have you used

(Please mark one for each)

	Never	Once or Twice	Monthly	Weekly
Tobacco/Nicotine?	_____	_____	_____	_____
Alcohol?	_____	_____	_____	_____
Marijuana?	_____	_____	_____	_____

SUBMIT