PEDIATRIC & ADOLESCENT
HEALTH PARTNERS

Adolescent Screen

Name: _____ **Clinician:** _____ **Date:** _____

Please circle one: Sick visit Well visit

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. Feeling nervous, anxious or on edge?				
4. Not being able to stop or control worrying?				

For the next set of questions, please answer yes or no with an X in the box	**YES**	**NO**
1. In the past few weeks, have you wished you were dead?		
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?		
3. In the past week, have you been having thoughts about killing yourself?		
4. Have you ever tried to kill yourself? If yes, how? _____ If yes, when? _____		
5. Are you having thoughts of killing yourself right now?		

Age: _____ **Gender:** _____ **Race/Ethnicity:** _____ **Other:** _____