



MERCY CARE

Adolescent Behavioral Health Screen, Ages 12-17

Patient's Name: _____ DOB: _____ Date: _____

Directions: The information provided on this form will help us become aware of your behavioral health. If you have any questions or would like assistance in answering the following, please alert a Mercy Care staff member.

PHQ-2

Over the past 2 weeks, have you been bothered by:	No	Yes
Little interest or pleasure in doing things?	0	1
Feeling down, depressed, or hopeless?	0	1

CRAFT Part A and Part B

	No	Yes
Drink any alcohol (more than a few sips)?	0	1
Smoke any marijuana or hashish?	0	1
Use anything else to get high?	0	1
Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using Alcohol or drugs?	0	1

- *Have you ever had thoughts about committing suicide within the past two months? YES NO
- *Have you ever tried to commit suicide? YES NO
- *Have you ever been hospitalized for mental health/psychiatric reasons? YES NO
- *Have you ever heard voices no one else could or seen things which others could not see? YES NO
- *Have you ever had nightmares or flashbacks as a result of being involved in a traumatic/terrible event?
For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot/stabbed? YES NO
- *Have you ever spent a lot of time worrying? YES NO
- *Have you ever been in moods where you felt irritable or were full of energy and couldn't slow down? YES NO
- *Are you currently being seen by a behavioral health provider? YES NO

Comments:

Administering Provider's Signature:

Revised 4/14/2015



MERCY CARE

Behavioral Health Screen

Patient's Name: _____ DOB: _____ Date: _____

Directions: The information provided on this form will help us become aware of your behavioral health. If you have any questions or would like assistance in answering the following, please alert a Mercy Care staff member.

PHQ-2

Over the past 2 weeks, have you been bothered by:	No	Yes
Little interest or pleasure in doing things?	0	1
Feeling down, depressed, or hopeless?	0	1

SASQ

	0=none	1=1 or more
How many times in the past year have you had 5 or more drinks (men) or 4 or more drinks (women) in a day?	_____	_____
How many times in the past year have you used a recreational drug or used a prescription drug for non- medical reasons?	_____	_____

- *Have you ever had thoughts about committing suicide within the past two months? YES NO
- *Have you ever tried to commit suicide? YES NO
- *Have you ever been hospitalized for mental health/psychiatric reasons? YES NO
- *Have you ever heard voices no one else could or seen things which others could not see? YES NO
- *Have you ever had nightmares or flashbacks as a result of being involved in a traumatic/terrible event?
For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot/stabbed? YES NO
- *Have you ever spent a lot of time worrying YES NO
- *Have you ever been in moods where you felt irritable or were full of energy and couldn't slow down? YES NO
- *Are you currently being seen by a behavioral health provider? YES NO

Comments:

Administering Provider's Signature:

Revised 4/14/2015