

## Teen health screen (CRAFT 2.1+N)

We ask all our teen patients about alcohol, drugs, and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

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During the PAST 12 months, on how many days did you:	Number of days
1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Put "0" if none.	
2. Use any marijuana (weed, oil, or hash by smoking, vaping, or in food) or "synthetic marijuana" (like "K2," "Spice")? Put "0" if none.	
3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	
4. Use any tobacco or nicotine products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Say "0" if none.	

If you put "0" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.

If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.

	No	Yes
5. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

### NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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For more information, contact [craftt@childrens.harvard.edu](mailto:craftt@childrens.harvard.edu)

**PHQ-9 Modified for Teens:**

How often have you been bothered by each of the following symptoms during the past <b>TWO WEEKS</b> ?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Not at all" to both questions above, you are finished answering questions. Otherwise, please continue answering all the questions below.

3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired, or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite, weight loss, or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things like school work, reading, or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3

In the <b>PAST YEAR</b> , have you felt depressed or sad most days, even if you felt okay sometimes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?		
<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult		
Has there been a time in the past month when you have had serious thoughts about ending your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you <b>EVER</b> , in your <b>WHOLE LIFE</b> , tried to kill yourself or made a suicide attempt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No