Pediatric Wizards

The Magic of Caring

To our Pediatric Wizards Families,

We have been given the opportunity to become a Patient Centered Medical Home (PCMH). A PCMH is a model standard that enables providers to more effectively deliver better care and achieve improved outcomes for your child's health and well-being.

Attached are two forms that will need to be completed by your child at every well check beginning at age 12. While we understand these are sensitive topics, it has become a standard requirement in order to provide the best care for your child.

Please have your child fill in both forms and hand in to the Medical Assistant.

We thank you for your help and participation.

Sincerely,

The Staff at Pediatric Wizards

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PHQ-9 modified for Adolescents (PHQ-A)

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

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. Trouble falling asleep, staying 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 feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, 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 were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐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?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

CRAFFT Screening Tool for Adolescent Substance Abuse

The following questions concern information about your potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Then mark in the appropriate box beside the question. Please answer every question. If you cannot decide, then choose the response that is mostly right.

When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used in excess of the directions and any non-medical use of drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc...), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).

	Part A: During the PAST 12 MONTHS, did you:	No	Yes
1.	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2.	Smoke any marijuana or hashish?		
3.	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
	Part B: CRAFFT	No	Yes
1.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?		
4.	Do you ever **FORGET** things you did while using alcohol or drugs?		
5.	Do your **FAMILY or FRIENDS** ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?		