

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Have you ever been diagnosed as having iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For females: Does your period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you smoke cigarettes or use e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? IF NO, SKIP TO THE NEXT SECTION (HIV).	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you having unprotected sex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you having sex with multiple partners or anonymous partners?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Are you or any of your past or current sexual partners bisexual?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you ever been treated for a sexually transmitted infection?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you trade sex for money or drugs or have sex partners who do? For males: Have you ever had sex with other males?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
HIV	Do you now use or have you ever used injection drugs?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Tuberculosis	Are you infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Were you or was any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about your vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have you ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Do you feel safe at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you feel safe at school and getting to and from school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you been bullied in person, on the Internet, or through social media?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have ways that help you deal with feeling angry?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you been in a fight in the past 12 months?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

HOW YOU ARE DOING (CONTINUED)

Interpersonal Violence (Fighting and Bullying) (continued)			
Have you ever carried a weapon to school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you belong to a gang or know anyone in a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been touched in a sexual way that made you feel uncomfortable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been in a relationship with someone who threatened or hurt you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Food Security and Living Situation			
In the past 12 months, have you had trouble having enough food to eat or have concerns that you might not have enough?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Alcohol and Drugs			
Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Do you get along with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you follow your family rules and limits?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you get along with your friends and others at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Do you have interests outside of school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you do things you are good at or that you are proud of?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Have you missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you doing well in school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are you having any problems in school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have plans for what you will do after high school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Coping With Stress and Decision-making			
Do you have ways to deal with stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you worry or feel stressed out much of the time?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you floss once a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you chew gum or tobacco?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If you play contact sports, do you wear a mouth guard?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Body Image			
Do you have any concerns about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you currently doing anything to try to gain or lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been teased because of your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you have access to healthy food options?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you eat fruits and vegetables every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you drink juice, soda, sports drinks, or energy drinks?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

YOUR DAILY LIFE (CONTINUED)

Healthy Eating (continued)			
Do you ever skip meals?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Are you physically active at least 1 hour every day? This includes running, playing sports, or doing physically active things with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time every day do you spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours		
Do you get 8 or more hours of sleep each night?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble sleeping at night or waking up in the morning?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

YOUR EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Sexuality			
Have you talked with your parents about dating and sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have any questions about your gender identity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity				
If you have been in romantic relationships, have you always felt safe and respected?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you ever had sex, including oral, vaginal, or anal sex? <i>If no, skip to the next section.</i>	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Are you currently having sex, including oral sex, with anyone?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you had multiple partners in the past year?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Do you and your partner use condoms every time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you and your partner always use another form of birth control along with a condom?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Are you aware of emergency contraception?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs				
Have you ever smoked cigarettes or used e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you ever drunk alcohol?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you ever used drugs, including marijuana or street drugs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Have you ever taken prescription drugs that were not given to you for a medical condition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Acoustic Trauma				
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	

STAYING SAFE

Seat Belt and Helmet Use				
Do you always wear a lap and shoulder seat belt?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you always wear a life jacket when you do water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
If you have started driving, do you follow the safety rules for young drivers?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No	
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

15 THROUGH 17 YEAR VISITS FOR PATIENTS

STAYING SAFE (CONTINUED)

Sun Protection			
Do you use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you visit tanning parlors?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Gun Safety			
Have you ever carried a gun or knife (even for self-protection)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If there is a gun in your home, do you know how to get hold of it?	<input type="radio"/> NA	<input type="radio"/> No	<input type="radio"/> Sometimes <input type="radio"/> Yes

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition
 For more information, go to <https://brightfutures.aap.org>.



The CRAFFT+N Questionnaire

Please answer all questions **honestly**; your answers will be kept **confidential**. During the **PAST 12 MONTHS**, on **how many days did you**:

Patient Name

Date Of Birth

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.

of days

2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.

of days

3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.

of days

4. Use a **vaping device*** containing **nicotine and/or flavors**, or use any **tobacco products†**? Put "0" if none.

**Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*

of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in ALL of the boxes above, ANSWER QUESTION 5 BELOW, THEN STOP.
- If you put "1" or more for Questions 1, 2, or 3 above, ANSWER QUESTIONS 5-10 BELOW.
- If you put "1" or more for Question 4 above, ANSWER ALL QUESTIONS ON BACK PAGE.

Circle one

5. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

No Yes

6. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

No Yes

7. Do you ever use alcohol or drugs while you are by yourself, or ALONE?

No Yes

8. Do you ever FORGET things you did while using alcohol or drugs?

No Yes

9. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

No Yes

10. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

No Yes

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

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The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products***. Circle your answer for each question.

Circle one

1. Have you ever tried to quit using, but couldn't? **Yes No**

2. Do you vape or use tobacco now because it is really hard to quit? **Yes No**

3. Have you ever felt like you were addicted to vaping or tobacco? **Yes No**

4. Do you ever have strong cravings to vape or use tobacco? **Yes No**

5. Have you ever felt like you really needed to vape or use tobacco? **Yes No**

6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school? **Yes No**

7. When you haven't vaped or used tobacco in a while (or when you tried to stop using)...

a. did you find it hard to concentrate because you couldn't vape or use tobacco? **Yes No**

b. did you feel more irritable because you couldn't vape or use tobacco? **Yes No**

c. did you feel a strong need or urge to vape or use tobacco? **Yes No**

d. did you feel nervous, restless, or anxious because you couldn't vape or use tobacco? **Yes No**

**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health, 35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open, 1*(6), e183535.

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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 than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, 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