Adolescent Medicine & Student Health Services
Patient Questionnaire

Please complete both sides of this form.

Please Check Below

Tobacco Use

Does the patient smoke cigarettes? ☐ Never ☐ Yes ☐ Sometimes If yes, how much? _____

Is the patient exposed to cigarette smoke? ☐ Yes ☐ No

Does the patient use other tobacco products? ☐ JUUL ☐ Cigar ☐ E-Cigs ☐ Chew ☐ Vape

Interested in help with quitting? ☐ Yes ☐ No

Alcohol Use

Does the patient drink alcohol? ☐ Never ☐ Yes ☐ No If yes, number of drinks per week? _____

Drug Use

Does the patient use recreational drugs? ☐ Yes ☐ No If yes, what? _____

Dietary Intake

Does the patient drink caffeinated beverages? ☐ Yes ☐ No If yes, how much per day? _____

How much water does the patient drink per day? _____

Does the patient skip meals? ☐ Yes ☐ No If yes, which ones & how often? _____

Sleep

How many hours of sleep does the patient get? _____

Does the patient have trouble sleeping? ☐ Yes ☐ No

Sexual History

Is the patient sexually active? ☐ Yes ☐ No ☐ Not Currently

Sexual Partners? ☐ Male ☐ Female ☐ Both

Birth Control Methods used? ☐ Condoms ☐ Pill, Patch, Ring ☐ Injection ☐ Implant ☐ IUD ☐ None

Other: _____

Other

Any other problems or concerns that you want to discuss? _____

_____

_____

_____

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NAME: _____ DATE: _____

DOB: _____

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	0	1	2	3

add columns _____ + _____ + _____

(Health care professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. 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 _____

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CAR-PEDS-ALL-PHQ9

CARILION Children's

PATIENT IDENTIFICATION

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CHART-5032