Adolescent Confidential Questionnaire

Name:_____ Date:_____

Pronouns:_____

Directions: Please answer the following questions to the best of your ability. This is a confidential assessment and will only be seen by the medical staff at the office.

Question	Yes	No
1. In the past year, have you consumed alcohol?		
2. In the past year, have you used any drugs or substances, including marijuana, that have not been prescribed to you?		
3. In the past year, have you used a cigarette, e-cig, or other vaping device?		
4. Would you like to talk about gender or sexual identity?		
5. Do you feel safe at home?		
6. Do you feel safe at school and with your peers?		
7. Is there anything you would like to discuss privately between you and your doctor? If comfortable, feel free to write what you would like to discuss below.		

Over the last **two weeks** have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things.				
Feeling down, depressed, or hopeless.				