Marissa J. Burg, M.D.
Thomas F. Cozza, M.D.
Bonnie L. Cullen, P.N.P.
Charles J. Francemone, M.D.
Iris Kaushik, M.D. Nga
T.T. Le, M.D.

Nicole E. Mackey, P.N.P.
Maureen E. Montgomery, M.D.
Amanda Persaud, M.D.
Russell S. Vaughan, M.D.
Janine Artis, LMHC

Amherst Pediatric Associates

a practice dedicated to personalized child care from cradle to college

Patient Name _____ **DOB** _____

Date of Screening _____

Teen Health Screen

We ask all our teen patients about alcohol 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.

In the past year how many times have you used:	**Never**	**Once or Twice**	**Monthly**	**Weekly**
1.) Tobacco, nicotine, or vaping?.....	☐	☐	☐	☐
2.) Alcohol?.....	☐	☐	☐	☐
3.) Marijuana?.....	☐	☐	☐	☐
4.) Prescription drugs that were not prescribed for you; such as pain medication or Aderall, oxycontin, morphine, codeine, opana, percocet, valium, xanax?.....	☐	☐	☐	☐
5.) Illegal drugs; such as cocaine or Ecstasy, heroin, Molly, LSD, Acid, Mushrooms)?.....	☐	☐	☐	☐
6.) Inhalants; such as nitrous oxide or aerosol cans?.....	☐	☐	☐	☐
7.) Herbs or synthetic drugs; such as salvia, "K2", bath salts or synthetic marijuana?.....	☐	☐	☐	☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More than half the Days**	**Nearly Everyday**
1.) Little interest or pleasure in doing things….	☐	☐	☐	☐
2.) Feeling down, depressed, or hopeless……	☐	☐	☐	☐
3.) Trouble falling or staying asleep, or sleeping too much……..	☐	☐	☐	☐
4.) Feeling tired or having little energy……	☐	☐	☐	☐
5.) Poor appetite or overeating……..	☐	☐	☐	☐
6.) Feeling bad about yourself--or that you are a failure or have let yourself or your family down……	☐	☐	☐	☐
7.) Trouble concentrating on things, such as reading or watching television……	☐	☐	☐	☐
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……	☐	☐	☐	☐
9.) Thoughts that you would be better off dead, or of hurting yourself in some way……	☐	☐	☐	☐

	Not Difficult	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**
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?.....	☐	☐	☐	☐