

Patient Information for Those 18 Years and Older

Because of our respect for you, we would like to offer you time to discuss issues with your doctor without your parent's presence. Your parent/guardian has agreed to allow you this opportunity. We will make efforts as allowed by law to maintain the confidentiality of your information, but it is important for you to know that there are certain times when we may be required to share information contained in this form with others based on the laws that apply to us. In addition, if we become concerned that you are going to hurt yourself or someone else, these matters may be discussed with your parents/legal guardians. Let your doctor or nurse know if you have questions about the privacy of the information related to this form. We do encourage you to discuss most issues openly with your family and hope to help you think of ways to do this. Please note that we do urine testing for sexually transmitted diseases for all patients 16 years of age and older. We will do our best to inform you of positive results. If we cannot reach you we may need to inform your parent of the result.

	Yes	No
1. Do you now, or have you in the past smoked cigarettes, cigars, pipes, e-cigarettes or chewed tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you now, or have you in the past used illegal drugs (including marijuana)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you sniff anything to get "high"?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you attracted to boys, girls, both, or neither?	_____	
What is your gender identity?		
1. Male	2. Female	3. Unsure
5. Transgender male (female-to-male)	6. Transgender female (male-to-female)	4. Choose not to disclose
6. Are you having sex now or have you in the past had sex with anyone?	<input type="checkbox"/>	<input type="checkbox"/>
If so, was this with your consent, something you wanted?	<input type="checkbox"/>	<input type="checkbox"/>
Are you using any kind of birth control (condoms, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past month, have you...		
been bothered by feeling down, depressed, or hopeless? If yes, complete screening A on following page	<input type="checkbox"/>	<input type="checkbox"/>
often been bothered by little interest or pleasure in doing things? If yes, complete screening A on following page	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you ever have thoughts of suicide?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you feel anxious? If yes, complete screening B on following page	<input type="checkbox"/>	<input type="checkbox"/>
10. Is anyone harming you?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any concerns about your current weight?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have any issues you would like to discuss confidentially with your doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Which of the above are your parents aware of? _____

Is there a private number where you can be reached? _____

Name three things you like about yourself: _____

Your Signature: _____

Date: _____

Screening A

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom, circle the answer that best describes how you have been feeling.

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

Screening B

Instructions: Over the last 2 weeks, how often have you been bothered by the following problems? For each symptom, mark the answer that best describes how you have been feeling.

	0 Not at all	I Several days	II Over half the days	III Nearly every day
1. Feeling nervous, anxious, or on edge	0	I	II	III
2. Not being able to stop or control worrying	0	I	II	III
3. Worrying too much about different things	0	I	II	III
4. Trouble relaxing	0	I	II	III
5. Being so restless that it's hard to sit still	0	I	II	III
6. Becoming easily annoyed or irritable	0	I	II	III
7. Feeling afraid as if something awful might happen	0	I	II	III

***If you checked off any problems, how difficult have these 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