ADOLESCENT AND YOUNG ADULT SCREENING QUESTIONNAIRE

Name: _____ Date of Birth: _____ Preferred Name: _____

Gender assigned at birth: (please circle) Female Male Other: _____ Prefer not to answer

Gender you identify with: Female Male Transgender Male Transgender Female

Non-binary Other: _____ Prefer not to answer

Preferred pronouns: she/her he/him they/them Other: _____

In the past 2 weeks, have you lost interest or pleasure in doing things you enjoy?	Yes	No	
In the past 2 weeks, have you been feeling down, depressed, or hopeless?	Yes	No	
In general, are you happy with the way things are going for you?	Yes	No	
Do you get along with your family?	Yes	No	
Do you have at least one adult or friend you can really talk to about any problems you have?	Yes	No	
Do you wear a seat belt when riding in a car/truck?	Yes	No	
Do you wear a helmet when you are on a skateboard/scooter, bike, motorcycle, snowmobile, or ATV?	Yes	No	
Do you get some exercise at least 3 times a week?	Yes	No	
Do you, or anyone you live with, have or carry a gun around?	Yes	No	
Are you having any difficulty at school?	Yes	No	
Are you having any trouble with fighting or bullying (this includes being insulted or threatened online)?	Yes	No	
Do you have any concerns about your weight or height?	Yes	No	
Do you ever skip meals, use laxative or diet pills, or throw up on purpose to lose weight or control your weight?	Yes	No	
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping devices)?	Yes	No	
In the past 12 months, did you drink any alcohol (more than a few sips)?	Yes	No	
In the past 12 months, have you used any marijuana (weed, pot)?	Yes	No	
In the past 12 months, have you used ANYTHING else to get high (illegal drugs, over-the-counter drugs, prescription drugs, things you sniff/huff)?	Yes	No	
Have you ever ridden in a car driven by someone (or yourself) who was "high" or had been using alcohol or drugs?	Yes	No	
Are you, or do you wonder if you are gay, lesbian, bisexual, pansexual, asexual, or other?	Yes	No	
Are you, or do you wonder if you are transgender, gender diverse, or a gender that is different from what you were called (boy or girl) at birth?	Yes	No	
Have you ever had any kind of sex (with anyone of any gender)?	Yes	No	
Have you ever had an infection that is spread by having sex (like herpes, gonorrhea, chlamydia, genital warts, pelvic inflammatory disease, HIV, syphilis)?	Yes	No	
Have you ever traded sex or sexual activity for money, food, a place to live or anything else?	Yes	No	
Has anyone ever hit or touched you in a way that made you feel uncomfortable or afraid?	Yes	No	
Have you ever hurt or cut yourself on purpose?	Yes	No	
In the past few weeks, have you wished you were dead?	Yes	No	
In the past few weeks, have you felt that you or your family would be better off if you were dead?	Yes	No	
In the past few weeks, have you been having thoughts about killing yourself?	Yes	No	
Have you ever, in your whole life, tried to kill yourself?	Yes	No	