Patient's Name: _____ **Birth date:** ____/____/_____

PLEASE HAVE YOUR PARENT READ THIS PARAGRAPH before you begin this form:

We will submit an invoice to your insurance for this screen but we cannot guarantee your policy will pay for this screen even though it is recommended and extremely important. Both the AAP and the US Preventative Services Task Force recommend yearly screening for depression in adolescents ages 12-18.

Studies show **over 50% of the time, parents are not aware** of how severe their adolescent's mood disorder is.

Depressed youth are at an increased risk of suicide, **which is the 3rd leading cause of death** among those aged 15-24 years.

If your insurance does not cover this cost, the most you could be billed is $8.

If you do not want your child to complete this screening tool please tell your nurse and return the uncompleted form.

Today's Date: ____/____/_____ **PHQ-9 Score:** _____ **GAD-7 Score:** _____

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		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 over eating	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 normal	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you are experiencing any of the problems on this form, 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**

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at All	Several Days	More than half the days	Nearly every day
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it's hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

If you are experiencing any of the problems on this form, 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**