PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

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

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Name:_____ **Date:** _____

Welcome to Omni Family Health!

Our healthcare providers are asking every patient the age of 12 and over to answer a few questions about his/her health habits. These questions are asked in order to provide you with the best and most complete care possible by allowing your doctor to get a better understanding of your health habits. This form is confidential and will not be released to anyone outside of Omni Family Health without your signed permission. If you have any questions, please feel free to ask the front office staff for clarification.

Patient Health Questionnaire- 2 (PHQ-2)

Over the last two weeks, how often 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

For office coding: __0__ + _____ +_____ + _____
= Total Score_____

If the total score is more than zero (0), please proceed to answer the next questionnaire PHQ-9.

Patient Health Questionnaire- 9 (PHQ-9)
To be completed every 6 months

Over the last two weeks, how often 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 asleep, 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 overeating	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or family down	0	1	2	3
7. Trouble concentration 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 being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thinking that you would be better off dead, or that you want to hurt yourself in someway	0	1	2	3
Add Columns				
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?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

PEARLS

Pediatric ACEs and Related Life Events Screener

CHILD

Many families experience stressful life events. Over time these experiences can affect your child's health and wellbeing. We would like to ask you questions about your child so we can help them be as healthy as possible.

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues?
   (for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver?
   (for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?

   Or has any adult in the household ever hit your child so hard that your child had marks or was injured?

   Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse?
   (for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)?
    (for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

Add up the "yes" answers for this first section: ☐

Please continue to the other side for the rest of questionnaire →

PART 2:

1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school?
   (for example, targeted bullying, assault or other violent actions, war or terrorism)

2. Has your child experienced discrimination?
   (for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)

3. Has your child ever had problems with housing?
   (for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)

4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?

5. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?

6. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?

7. Has your child ever lived with a parent or caregiver who died?

Add up the "yes" answers for the second section: ☐

Sudden Cardiac Death Risk Assessment Form

HEART & STROKE FOUNDATION

Is your child at risk? If unsure, talk to your child and/ or family members as you fill out this form.

If you or your child answer "Yes" to ANY of these specific questions, your child could have risk factors for cardiac arrest. Please review your results with your regular health care provider.

Risk Assessment for (Name of Child) _____	Yes	No
Has your child ever fainted or passed out DURING exercise, emotional stress or when startled?		
Has your child ever fainted or passed out AFTER exercise?		
Has your child ever said they had frequent trouble breathing, coughing or wheezing during exercise?		
Does your child tire more quickly than others when exercising?		
Has your child ever had tightness, discomfort, pain or pressure in his/her chest during or after exercise?		
Has your child ever had an unexplained seizure?		
Have you ever been told your child has high blood pressure?		
Have you ever been told your child has high cholesterol?		
Does your child have, or has your child ever told you they had racing of his/her heart or skipped beats?		
Have you ever been told your child has a heart arrhythmia (irregular heartbeat)?		
Does your child have any other history of heart problems?		
Has your child routinely taken any medications in the past two years?		

Continued on reverse...

Family History (Answer in reference to child's family - both paternal and maternal)	Yes	No
Are there any family members who had a sudden, unexpected, or unexplained death before age 50? (including SIDS, car accident, drowning, others)		
Are there any family members who died suddenly of "heart problems" before age 50?		
Are there any family members who have had unexplained fainting or seizures?		
Are there any relatives with certain conditions, such as:		
Enlarged Heart: Hypertrophic cardiomyopathy (HCM)		
Dilated cardiomyopathy (DCM) Heart		
Rhythm problems: Long QT syndrome (LQTS)		
Short QT syndrome		
Brugada syndrome		
Catecholaminergic ventricular tachycardia Arrhythmogenic		
right ventricular cardiomyopathy (ARVC)		
Marfan syndrome (aortic rupture)		
Wolff-Parkinson-White Syndrome		
Heart attack, age 50 or younger		
Pacemaker or implanted defibrillator		
Have any family members been treated for an irregular heart		
beat? Have any family members had heart transplantation?		
Have any family members had heart surgery?		
Are there any family members who were deaf at birth (congenital deafness)?		

Please explain any "Yes" answers here:

Please feel free to bring this form with you to your physician's or health care provider's office.

Revised: March 2013