Dear Parent,

Before the next appointment you have scheduled to discuss your concerns about your child's attention/school issues, we ask that you complete several items that will help guide our evaluation and discussion:

- Vanderbilt Scale (Parent and Teacher Assessment)
- Co-Morbid Disorders Assessment
- Screen for Child Anxiety Related Disorders
- PHQ-9
- CRAFFT Screening

By utilizing these assessments we are able to be very accurate in our diagnosis. It helps us insure that we are not overlooking other problems that sometimes mimic, or occur along with, ADD/ADHD.

Please fill out your Vanderbilt Scale and have the teacher fill out theirs. We need both forms returned to us before the next appointment. If we don't have them by the next appointment, we may have to reschedule your appointment for a later date. Please be aware there will be a charge for scoring and evaluating these surveys. If a diagnosis of ADD/ADHD is made, we will also continue to require a shorter version of the Vanderbilt Scale from both you and your child's teacher to monitor your child's progress annually.

The remainder of the packet is information provided by the American Academy of Pediatrics about ADD/ADHD, related medical conditions, medications, educational concerns, and frequently asked questions that we hope will assist you.

Sincerely,

Growing Together Pediatrics

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common chronic childhood disorders. Current estimates indicate that 4% to 12% of all school-aged children may be affected. ADHD is a neurobehavioral disorder that usually appears in children before the age of 7.

Children with ADHD may have difficulty controlling their behavior in school and social settings and often fail to achieve their full academic potential. Clinically, the child may present with varying symptoms of hyperactivity, impulsivity, and/or inattention. The child may be easily distracted, be unable to pay attention and follow directions, be overactive, and/or have poor self-control.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),* characterizes the following 3 subtypes of ADHD:

• **Inattentive only (ADHD-IA)** (formerly known as attention-deficit disorder [ADD])—Children with this form of ADHD are not overly active. Because they do not disrupt the classroom or other activities, their symptoms may not be noticed. Among girls with ADHD, this form is most common. Approximately 30% to 40% of children with ADHD have this subtype.

• **Hyperactive/Impulsive (ADHD-H/I)**—Children with this type of ADHD show hyperactive and impulsive behavior but can pay attention. This subtype accounts for a small percentage, approximately 10%, of children with ADHD.

• **Combined Inattentive/Hyperactive/Impulsive**—Children with this type of ADHD show all 3 symptoms. This is the most commontype of ADHD. The majority of children with ADHD have this subtype, approximately 50% to 60%.

The diagnosis of ADHD relies on the documentation of symptoms that are associated with functional impairment from multiple environments. Because of this, school personnel, families, and primary care clinicians need to work collaboratively to document specific symptoms and their effect on a child's functioning. School personnel and families also need to be aware that there currently are no biological markers or computerized tests that allow for diagnostic specificity.

Once a diagnosis of ADHD has been made with confidence, the primary care clinician can approach the issue of treatment of the child with ADHD. This involves developing a management plan that incorporates the appropriate medication and/or behavior therapy to meet target outcomes. The care of most children with ADHD can be managed in a primary care setting.

The role of the primary care clinician is to:
• Synthesize and interpret information about a child's behavior.
• Identify other medical or psychosocial problems that might be causing and/or exacerbating the child's symptoms.
• Refer for further evaluation where needed.
• Arrange other treatment (eg, educational, psychological) as needed.
• Provide appropriate medical treatment.
• Monitor progress.
• Support parents in their role as advocates for the child.

NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Name: _____

Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child

☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often	
1. Does not pay attention to details or makes careless mistakes with, for example, homework	☐ 0	☐ 1	☐ 2	☐ 3	
2. Has difficulty keeping attention to what needs to be done	☐ 0	☐ 1	☐ 2	☐ 3	
3. Does not seem to listen when spoken to directly	☐ 0	☐ 1	☐ 2	☐ 3	
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	☐ 0	☐ 1	☐ 2	☐ 3	
5. Has difficulty organizing tasks and activities	☐ 0	☐ 1	☐ 2	☐ 3	
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	☐ 0	☐ 1	☐ 2	☐ 3	
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)	☐ 0	☐ 1	☐ 2	☐ 3	
8. Is easily distracted by noises or other stimuli	☐ 0	☐ 1	☐ 2	☐ 3	
9. Is forgetful in daily activities	☐ 0	☐ 1	☐ 2	☐ 3	For Office Use Only _____/9
10. Fidgets with hands or feet or squirms in seat	☐ 0	☐ 1	☐ 2	☐ 3	
11. Leaves seat when remaining seated is expected	☐ 0	☐ 1	☐ 2	☐ 3	
12. Runs about or climbs too much when remaining seated is expected	☐ 0	☐ 1	☐ 2	☐ 3	
13. Has difficulty playing or beginning quiet play activities	☐ 0	☐ 1	☐ 2	☐ 3	
14. Is "on the go" or often acts as if "driven by a motor"	☐ 0	☐ 1	☐ 2	☐ 3	
15. Talks too much	☐ 0	☐ 1	☐ 2	☐ 3	
16. Blurts out answers before questions have been completed	☐ 0	☐ 1	☐ 2	☐ 3	
17. Has difficulty waiting his or her turn	☐ 0	☐ 1	☐ 2	☐ 3	
18. Interrupts or intrudes in on others' conversations and/or activities	☐ 0	☐ 1	☐ 2	☐ 3	For Office Use Only _____/9

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	☐ 0	☐ 1	☐ 2	☐ 3	
20. Loses temper	☐ 0	☐ 1	☐ 2	☐ 3	
21. Actively defies or refuses to go along with adults' requests or rules	☐ 0	☐ 1	☐ 2	☐ 3	
22. Deliberately annoys people	☐ 0	☐ 1	☐ 2	☐ 3	
23. Blames others for his or her mistakes or misbehaviors	☐ 0	☐ 1	☐ 2	☐ 3	
24. Is touchy or easily annoyed by others	☐ 0	☐ 1	☐ 2	☐ 3	
25. Is angry or resentful	☐ 0	☐ 1	☐ 2	☐ 3	
26. Is spiteful and wants to get even	☐ 0	☐ 1	☐ 2	☐ 3	For Office Use Only _____/8
27. Bullies, threatens, or intimidates others	☐ 0	☐ 1	☐ 2	☐ 3	
28. Starts physical fights	☐ 0	☐ 1	☐ 2	☐ 3	
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	☐ 0	☐ 1	☐ 2	☐ 3	
30. Is truant from school (skips school) without permission	☐ 0	☐ 1	☐ 2	☐ 3	
31. Is physically cruel to people	☐ 0	☐ 1	☐ 2	☐ 3	
32. Has stolen things that have value	☐ 0	☐ 1	☐ 2	☐ 3	
33. Deliberately destroys others' property	☐ 0	☐ 1	☐ 2	☐ 3	
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	☐ 0	☐ 1	☐ 2	☐ 3	
35. Is physically cruel to animals	☐ 0	☐ 1	☐ 2	☐ 3	
36. Has deliberately set fires to cause damage	☐ 0	☐ 1	☐ 2	☐ 3	
37. Has broken into someone else's home, business, or car	☐ 0	☐ 1	☐ 2	☐ 3	
38. Has stayed out at night without permission	☐ 0	☐ 1	☐ 2	☐ 3	
39. Has run away from home overnight	☐ 0	☐ 1	☐ 2	☐ 3	
40. Has forced someone into sexual activity	☐ 0	☐ 1	☐ 2	☐ 3	For Office Use Only _____/14
41. Is fearful, anxious, or worried	☐ 0	☐ 1	☐ 2	☐ 3	
42. Is afraid to try new things for fear of making mistakes	☐ 0	☐ 1	☐ 2	☐ 3	
43. Feels worthless or inferior	☐ 0	☐ 1	☐ 2	☐ 3	
44. Blames self for problems, feels guilty	☐ 0	☐ 1	☐ 2	☐ 3	
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	☐ 0	☐ 1	☐ 2	☐ 3	
46. Is sad, unhappy, or depressed	☐ 0	☐ 1	☐ 2	☐ 3	
47. Is self-conscious or easily embarrassed	☐ 0	☐ 1	☐ 2	☐ 3	For Office Use Only _____/7

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
49. Writing	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	For Office Use Only 4s:_____/3
50. Mathematics	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	For Office Use Only 5s:_____/3
51. Relationship with parents	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
52. Relationship with siblings	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
53. Relationship with peers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	For Office Use Only 4s:_____/4
54. Participation in organized activities (eg, teams)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	For Office Use Only 5s:_____/4

Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1. **Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, or repetition of words or short phrases.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

3. If **YES** to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? ☐ No ☐ Yes

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

1.	Has your child been diagnosed with a tic disorder or Tourette syndrome?	☐ No	☐ Yes
2.	Is your child on medication for a tic disorder or Tourette syndrome?	☐ No	☐ Yes
3.	Has your child been diagnosed with depression?	☐ No	☐ Yes
4.	Is your child on medication for depression?	☐ No	☐ Yes
5.	Has your child been diagnosed with an anxiety disorder?	☐ No	☐ Yes
6.	Is your child on medication for an anxiety disorder?	☐ No	☐ Yes
7.	Has your child been diagnosed with a learning or language disorder?	☐ No	☐ Yes

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 in questions 48–50: _____

Total number of questions scored 5 in questions 48–50: _____

Total number of questions scored 4 in questions 51–54: _____

Total number of questions scored 5 in questions 51–54: _____

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	○	○	○
2. I get headaches when I am at school.	○	○	○
3. I don't like to be with people I don't know well.	○	○	○
4. I get scared if I sleep away from home.	○	○	○
5. I worry about other people liking me.	○	○	○
6. When I get frightened, I feel like passing out.	○	○	○
7. I am nervous.	○	○	○
8. I follow my mother or father wherever they go.	○	○	○
9. People tell me that I look nervous.	○	○	○
10. I feel nervous with people I don't know well.	○	○	○
11. I get stomachaches at school.	○	○	○
12. When I get frightened, I feel like I am going crazy.	○	○	○
13. I worry about sleeping alone.	○	○	○
14. I worry about being as good as other kids.	○	○	○
15. When I get frightened, I feel like things are not real.	○	○	○
16. I have nightmares about something bad happening to my parents.	○	○	○
17. I worry about going to school.	○	○	○
18. When I get frightened, my heart beats fast.	○	○	○
19. I get shaky.	○	○	○
20. I have nightmares about something bad happening to me.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
23. I am a worrier.	○	○	○
24. I get really frightened for no reason at all.	○	○	○
25. I am afraid to be alone in the house.	○	○	○
26. It is hard for me to talk with people I don't know well.	○	○	○
27. When I get frightened, I feel like I am choking.	○	○	○
28. People tell me that I worry too much.	○	○	○
29. I don't like to be away from my family.	○	○	○
30. I am afraid of having anxiety (or panic) attacks.	○	○	○
31. I worry that something bad might happen to my parents.	○	○	○
32. I feel shy with people I don't know well.	○	○	○
33. I worry about what is going to happen in the future.	○	○	○
34. When I get frightened, I feel like throwing up.	○	○	○
35. I worry about how well I do things.	○	○	○
36. I am scared to go to school.	○	○	○
37. I worry about things that have already happened.	○	○	○
38. When I get frightened, I feel dizzy.	○	○	○
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	○	○	○
41. I am shy.	○	○	○

SCORING: 0

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

CO-MORBID DISORDERS ASSESSMENT SCALE

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Symptoms	Never	Occasionally	Often	Very Often
Intermittent Explosive Behavior				
Demonstrates mood swings	☐ 0	☐ 1	☐ 2	☐ 3
Has frequent tantrums	☐ 0	☐ 1	☐ 2	☐ 3
Reacts explosively to "NO"	☐ 0	☐ 1	☐ 2	☐ 3
Has night terrors	☐ 0	☐ 1	☐ 2	☐ 3
Is pleasant then explosive	☐ 0	☐ 1	☐ 2	☐ 3
Is Physically aggressive	☐ 0	☐ 1	☐ 2	☐ 3
Has punched or kicked people	☐ 0	☐ 1	☐ 2	☐ 3
Has punched or kicked walls, doors, etc.	☐ 0	☐ 1	☐ 2	☐ 3
Screams and cries during tantrum	☐ 0	☐ 1	☐ 2	☐ 3
Is uncontrollable during tantrum	☐ 0	☐ 1	☐ 2	☐ 3
Bangs head during tantrum	☐ 0	☐ 1	☐ 2	☐ 3
Controls others with outbursts	☐ 0	☐ 1	☐ 2	☐ 3

How long do tantrums last? _____
How frequent are tantrums? _____
Age of onset of tantrums? _____
What have you tried to control tantrums?_____
_____

Oppositional Behavior				
Looses temper	☐ 0	☐ 1	☐ 2	☐ 3
Refuses to follow rules	☐ 0	☐ 1	☐ 2	☐ 3
Defiant to authority	☐ 0	☐ 1	☐ 2	☐ 3
Deliberately annoys others	☐ 0	☐ 1	☐ 2	☐ 3
Blames others for mistakes	☐ 0	☐ 1	☐ 2	☐ 3
Is angry or resentful	☐ 0	☐ 1	☐ 2	☐ 3
Carries grudges	☐ 0	☐ 1	☐ 2	☐ 3
Swears, cusses	☐ 0	☐ 1	☐ 2	☐ 3
Is mean or spiteful	☐ 0	☐ 1	☐ 2	☐ 3
Annoyed by others	☐ 0	☐ 1	☐ 2	☐ 3
Argumentative	☐ 0	☐ 1	☐ 2	☐ 3

Age of onset? _____

Symptoms of Depression				
Sad or unhappy	☐ 0	☐ 1	☐ 2	☐ 3
Low self-esteem	☐ 0	☐ 1	☐ 2	☐ 3

Lost interest in fun activities	☐ 0	☐ 1	☐ 2	☐ 3
Irritable	☐ 0	☐ 1	☐ 2	☐ 3
Moody	☐ 0	☐ 1	☐ 2	☐ 3
Plays alone	☐ 0	☐ 1	☐ 2	☐ 3
Cries easily	☐ 0	☐ 1	☐ 2	☐ 3
Seems tired lacks energy	☐ 0	☐ 1	☐ 2	☐ 3
Ideas of suicide	☐ 0	☐ 1	☐ 2	☐ 3
Plan for suicide	☐ 0	☐ 1	☐ 2	☐ 3
Suicide attempt	☐ 0	☐ 1	☐ 2	☐ 3
History of self harm	☐ 0	☐ 1	☐ 2	☐ 3

Age of onset? _____

Sleep Problems

Trouble falling asleep	☐ 0	☐ 1	☐ 2	☐ 3
Frequent awakening	☐ 0	☐ 1	☐ 2	☐ 3
Early a.m. awakening	☐ 0	☐ 1	☐ 2	☐ 3
Nightmares	☐ 0	☐ 1	☐ 2	☐ 3
Sleep walking	☐ 0	☐ 1	☐ 2	☐ 3
Bed wetting	☐ 0	☐ 1	☐ 2	☐ 3
Refuses to sleep in own bed	☐ 0	☐ 1	☐ 2	☐ 3
Snoring	☐ 0	☐ 1	☐ 2	☐ 3

Age of onset? _____

Appetite Problems

Loss of appetite	☐ 0	☐ 1	☐ 2	☐ 3
Eating too much	☐ 0	☐ 1	☐ 2	☐ 3
Change in weight	☐ 0	☐ 1	☐ 2	☐ 3
Picky eater	☐ 0	☐ 1	☐ 2	☐ 3

Age of onset? _____

Conduct Problems

Steals	☐ 0	☐ 1	☐ 2	☐ 3
Runs away	☐ 0	☐ 1	☐ 2	☐ 3
Lies	☐ 0	☐ 1	☐ 2	☐ 3
Cuts school	☐ 0	☐ 1	☐ 2	☐ 3
Cruel to animals	☐ 0	☐ 1	☐ 2	☐ 3
Destroys property	☐ 0	☐ 1	☐ 2	☐ 3
Gets into fights	☐ 0	☐ 1	☐ 2	☐ 3
Cruel to people	☐ 0	☐ 1	☐ 2	☐ 3
Not sorry	☐ 0	☐ 1	☐ 2	☐ 3
Sets fires	☐ 0	☐ 1	☐ 2	☐ 3
Broken into house or car	☐ 0	☐ 1	☐ 2	☐ 3
Bullies or threatens	☐ 0	☐ 1	☐ 2	☐ 3

Age of onset? _____

PHQ9P

PATIENT HEALTH QUESTIONNAIRE-9

72883

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

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 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 overeating	☐ 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 usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

SCORING FOR USE BY STUDY PERSONNEL ONLY

0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

EPI0905.PHQ9P

I confirm this information is accurate.	Patient's/Subject's initials:	Date:

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____

Medical Record or ID Number _____ Date _____

The CRAFFT Screening Questionnaire

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1, A2, A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.