

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Teen health screen (CRAFT 2.1+N)

We ask clients about alcohol, drugs, and mood because these factors can affect your health. Please ask your provider if you have any questions.

During the <b>PAST 12 months</b> , on how many days did you:	Number of days
1. Drink more than a few sips of beer, wine, or any drink containing <b>alcohol</b> ? Put "0" if none.	
2. Use any <b>marijuana</b> (weed, oil, or hash by smoking, vaping, or in food) or <b>"synthetic marijuana"</b> (like "K2," "Spice")? Put "0" if none.	
3. Use <b>anything else to get high</b> (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	
4. Use any <b>tobacco or nicotine</b> products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Say "0" if none.	

If you put "**0**" in **ALL** of the boxes above, ANSWER QUESTION 5, THEN STOP.

If you put "**1**" or **higher** in **ANY** of the boxes above, ANSWER QUESTIONS 5-10.

	No	Yes
5. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

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