BIEN Être Psychiatry

Adolescent Screening Self Report(Ages 11–17)

Name: _____

Date of Birth: _____Age: _____

Date: _____

During the Past 2 Weeks, how often has each statement been true for you?

0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Almost Every Day

	0	1	2	3	4
I have felt sad or down.	☐	☐	☐	☐	☐
I have lost interest in things I usually enjoy.	☐	☐	☐	☐	☐
I have felt nervous, anxious, or worried.	☐	☐	☐	☐	☐
I could not stop worrying.	☐	☐	☐	☐	☐
I became angry or irritated easily.	☐	☐	☐	☐	☐
I had trouble paying attention in school or while doing homework.	☐	☐	☐	☐	☐
I had trouble falling asleep or staying asleep.	☐	☐	☐	☐	☐
I felt tired or had very little energy.	☐	☐	☐	☐	☐
I had stomachaches, headaches, or unexplained body aches.	☐	☐	☐	☐	☐
My thoughts kept repeating or I felt I had to check things over and over.	☐	☐	☐	☐	☐
I felt unusually energetic, needed less sleep, or acted impulsively.	☐	☐	☐	☐	☐
I heard or saw things that other people did not.	☐	☐	☐	☐	☐

Please answer Yes or No

	yes	No
Have you used alcohol, vaping products, marijuana, or other drugs?	☐	☐
Have you taken medication that was not prescribed for you?	☐	☐
Have you had thoughts about hurting yourself or ending your life?	☐	☐
Have you ever tried to hurt yourself or attempt suicide?	☐	☐

Right now, what are your biggest concerns? (Check all that apply)

☐ Anxiety

☐ Depression

☐ ADHD/Attention

☐ Mood Swings

☐ Anger

☐ OCD/Worries

☐ Sleep

☐ School Stress

☐ Friends

☐ Family

☐ Bullying

☐ Other: _____

What would you like help with the most? _____