FIFTH AVENUE PEDIATRICS
2855 5th Avenue North
St. Petersburg, Florida 33713
(727)323-2727

Screening For Adolescents

Name______________________________ Date____________________

Carefully read each question and answer "YES" or "NO" by checking the appropriate box. By "drugs" I mean street drugs, like Ecstasy or Cocaine; inhalants like glue or paint thinner, over the counter drugs like DXM (cough medicine); or prescription drugs like OxyContin, Klonopin, ADD meds like Ritalin, Concerta, Adderall, Vyvanse that were not prescribed for you or that you did not take as prescribed.

During the past year (or since I saw you last) have you:

	YES	NO
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 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?		
7. Have you in the past smoked cigarettes, used e-cigarettes (vaping), or used marijuana or other inhaled substances?		
8. Do you currently smoke cigarettes, e-cigarettes, marijuana, or other inhaled substances?		
9. Would you like to talk about sexuality or do you have questions about gender identity?		
10. Have you been or do you feel physically harmed or sexually harmed by another person?		