Name_____ Today's Date_____
Date of Birth _____

TB Screening Questionnaire (administer at 2 months, 6 months, 12 months, 18 months, 24 months, then yearly)

	YES	NO	UNSURE
Has your child been in close contact with a person with infectious Tuberculosis?			
Does your child have HIV infection or is considered at risk for HIV infection?			
Is your child foreign born (especially if born in Asia, Africa, or Latin America), a refugee, or an immigrant?			
Is your child in contact with the following individuals: HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does your child have a depressed immune system, either because of disease or treatment for disease?			
Does your child live in an established "high risk for tuberculosis" community or area?			

Cholesterol Risk Assessment Questionnaire (administer yearly from 2 to 18 years)

	YES	NO	UNSURE
Does your child have risk factors for future heart disease such as physically inactivity, diabetes, or obesity?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease (like heart attack or stroke) below age 55?			
Is there a family history (parents and grandparents) of elevated cholesterol?			

Hunger Vital Sign Questionnaire: (NB then yearly)
For each statement, please tell me whether the statement was Often True, Sometimes True, or Never True for your household in the past 12 months.

	Often True	**Sometimes True**	**Never True**
Within the past 12 months, we worried whether our food would run out before we got money to buy more.			
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.			

Patient Health Questionnaire:
modified

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: _____

Name: _____ Date: _____

Date of Birth: _____

The CRAFFT Screening Questions

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 the patient answered NO to ALL of the questions in Part A, ask the CAR question only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

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?	☐	☐