+_____: PCP - BHC - Smoke F/U date: ___

Youth & Young Adult Health & Safety Needs Questionnaire

Date: ____/____/____ Gender/Age: _____ Race: _____ Zip:_____Time: _____ - _____Staff:_____

Do you have a primary care doctor? Yes___ No___ When was your last physical?_____ Location?_____

Do you wear a helmet if you ride a bike or a motorcycle? Yes____ No____ N/A___

Do you wear a seat belt when you drive or ride in a car? Always___Sometimes___ Never___N/A__

In the past month, how often did you smoke cigarettes? Never__ Monthly or less__ 2-3x/week___Daily___

On a typical day when you smoke, how many cigarettes do you have?_____

Have you ever had sex? Yes___ No____ (**NO** skip to alcohol Q)Are you pregnant?Yes___No___ Unsure___ N/A___

Forms of birth control you use?_____How often do you use condoms? Always__Sometimes__ Most of_ Never__

Do you have any children? Yes____ No____ How many?___ The last time tested for **STI's**?_____ **HIV**?_____

How often do you drink **ALCOHOL**? Never__ Monthly/less__ 2-4x/month___2-3x/week___4>x/week___Daily___

On a typical **DAY,** when you drink, how many drinks do you have?:_____

How many times this month did you have **4 or > drinks (females) / 5 or > (males)** in a two-hour period? _____

Do you smoke any **MARIJUANA**? Yes____ No____ If **yes**, Monthly or less__ 2-4x/month___2-4x/week ___Daily___
If smoked daily, how many times per day? _____ **Do you use any DRUGS to get high**? Yes____ No____
Cocaine___ **Crack**___**Heroin**____ **Hallucinogens**(acid/lsd)___ **Ecstasy**___, **Amphetamines**(speed/crystal meth)___, **Inhalants** (paint/glue)___, **Prescription drugs:** ***Benzodiazepines*** (xanax,klonopin,valium)____, ***Stimulants***(ritalin/adderall)___ ***Painkillers*** **(**oxycodone/vicodin/percocet/)___,**O-T-C**___**Other**_____

CRAFFT (score=___ out of 6)	Yes	No
Have you ridden in a **CAR** driven by someone (Including yourself) who was "high" or had been using alcohol or drugs?		
Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?		
Do you ever use alcohol or drugs while you are by yourself, **ALONE**?		
Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?		
Do you ever **FORGET** things you did while using alcohol or drugs?		
Have you gotten into **TROUBLE** while you were using alcohol?		

*** > 2** positive CRAFFT recommend further assessment; ** **4** positive CRAFFT requires referral

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In the past month, how often have you felt really down, sad, or depressed?

Always___ Nearly Always___Sometimes___ Rarely___Never___

Have you thought that you would be better off dead or hurting yourself in some way? Yes___ No___

Have you witnessed violence that has interfered with your ability to go about your daily routine? Yes___ No___

Have you ever had someone **threaten you** with a weapon (e.g.gun,knife)?Yes___ No___ **Injure you**? Yes___ No___

Are you currently homeless? Yes____ No____ What is your **living situation**?_____

Are you currently in school? Yes___ No____ Interested in school related services (GED)? Yes___ No___

Do you currently have a job? Yes___ No____ Interested in job help? Yes___ No___

+_____: PCP - BHC - Smoke F/U date: ___

POSITIVE Alcohol & Drug Screen (ONLY)

BNI performed: Y N Change item #1:_____

Change item #2:_____

Change item #3:_____

ALCOHOL & DRUG REFERRAL (S):

Needed substance abuse/detox placement but NOT placed:

___ Refused
___ Detox bed unavailable today
___ Psych clearance pending
___ No social security
___ No insurance authorization
___ Lacks meds
___ Disciplinary reasons
___ No transportation
___ Admitted to hosp

Referrals made:

___ Inpatient detox/hosp
___ Outpatient alcohol/drug services
___ NA/AA/MA/Al-Anon/Al-Ateen
___ Room 5 (holding/transition)
___ Dual diagnosis (psych/sa))
___ Needle exchange
___ Suboxone
___ Methadone clinic
___ Acupuncture Clinic

OTHER REFERRAL (S):

___Primary care appt._____
___Behavioral health appt._____
___STD/HIV testing sites
___BPHC program_____
___VIAP
___Domestic Violence
___ Shelter
___Smoking cessation
___ Patient financial services
___ Community health clinic
___ Project HEALTH
___ ED HIV Testing
___ Condoms
___ Other_____

HEALTH EDUCATION BROCHURE (S):

___Alcohol/other drugs
___Mental Health/depression
___Primary care
___Domestic Violence
___Safe sex/contraception
___Smoking
___Violence/VIAP
___Seatbelt/Helmet
___HIV/STD/Hepatitis
___Employment
___Education
___ Other_____

FOLLOW-UP DATE:___/___/___ Name:_____Contact Information:_____

Notes:_____

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