NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

RE: IPRA Records Request of May 19, 2026, Reference # R000160-051926.

Dear Sarah Smith,

The NM DOH received a public information request from you on May 19, 2026. Your request mentioned:

> **This is an IPRA request for the health risk screening survey that is used for students by School Based Health Centers in New Mexico.**
>
> **• I am requesting the survey in full for both children and adolescents.**
> **• I understand that the survey may have questions which are only seen depending on how the prior questions are answered.**
> **• For clarity, I am requesting to see all the possible questions and answers to the survey.**

The New Mexico Department of Health has identified documents that are responsive to your request. Please log in to the IPRA Request Center at the following link to retrieve the appropriate responsive documents.

IPRA Records Request - R000160-051926

Our office has completed this search and this IPRA request is closed. The individual responsible for the information being disclosed is [redacted], Records Custodian.

If you have any questions or need additional information, please reply to this email.

Sincerely,

[redacted]
Chief Records Custodian
OGC (Office of General Counsel)

Just Health Adolescent Version v.1358

Welcome to the School-Based Health Center!

We are really glad you are here.

We want you to do and be your best in school and at home, with friends and others, and/or in sports. **One way we can help you do and be your best is to ask you some questions about many parts of your life.** This helps us take better care of you. We will also assist you in getting the help that you need.

Please tell us if you don't understand some questions, or if this makes you feel uncomfortable in any way. The provider will review your answers and talk them over with you. This information is confidential (private) and will not be shared with anyone else unless there is a concern about safety, (yours, or someone else's).

Thank you for helping us to know you a bit better!

If you have parent / guardian permission to be seen at this clinic, **questions about your physical health will go into your health record**, which your parent / guardian may see if they request your chart or the information is important to take care of you.

This includes questions like how many fruits and vegetables you eat, or if you have any tooth pain.

Young people like you can be seen for their sexual and mental health without permission from their parent or guardian.

Your responses to questions about your feelings, sexual practices, and use of drugs or alcohol are completely confidential (private) and will not be shared with anyone else unless there is a concern about safety (yours, or someone else's).

Grade Level (if in school)

- [ ] ---- N/A ----
- [ ] 4 - Fourth
- [ ] 5 - Fifth
- [ ] 6 - Sixth
- [ ] 7 - Seventh
- [ ] 8 - Eighth
- [ ] 9 - Ninth
- [ ] 10 - Tenth
- [ ] 11 - Eleventh
- [ ] 12 - Twelfth
- [ ] College

Are you Hispanic or Latino/a?

- [ ] Yes
- [ ] No

What is your race? (Check all that apply)

- [ ] American Indian or Alaskan Native
- [ ] Black or African American
- [ ] White
- [ ] Asian
- [ ] Native Hawaiian or Other Pacific Islander

When you were born, what sex was put on your birth certificate?

- [ ] Male
- [ ] Female

Which of the following best describes you? (Check all that apply)

- [ ] Male
- [ ] Female
- [ ] Transgender
- [ ] Self-Identify

Self-Identify

Which pronouns do you prefer?

- [ ] He/Him/His
- [ ] She/Her/Hers
- [ ] They/Them/Their
- [ ] Ze/Hir/Hirs
- [ ] No pronouns, just my name
- [ ] Other

Other

Which of the following best describes you?

- [ ] Heterosexual (Straight)
- [ ] Gay or Lesbian
- [ ] Bisexual
- [ ] Not Sure
- [ ] Not Listed

Please explain/identify:

How can we contact you if we need to talk to you privately (for test results, etc.) besides through school?

Email

Cell Phone

Friend's Number

Is the school health center (SBHC) the main place you go to get the physical health care that you need/want? Physical health care is when you get support for things like a checkup, sports physical, a shot, or when you feel sick or are hurt. You might see a doctor or nurse.

- [ ] Yes
- [ ] No

In the past year, where have you gone to get health care? Check all that apply to you.

- [ ] Nowhere
- [ ] At the SBHC (this can include in-person or telehealth visits)
- [ ] Emergency room or hospital
- [ ] Urgent care center
- [ ] Doctor's office, clinic, or telehealth (not the SBHC)
- [ ] Other (Please write where else you've gotten care):

Other (Please write where else you've gotten care):

Is the school health center (SBHC) the main place you would go to get the mental health care that you need/want? Mental health care is when you get support for how you're feeling—like if you're feeling really down, anxious, overwhelmed, or having a hard time with things like school, friends, or sleep. You might talk to a counselor or therapist.

- [ ] Yes
- [ ] No

In the past year, where have you gone to get mental health care? Check all that apply to you.

- [ ] Nowhere
- [ ] At the SBHC (this can include in-person or telehealth visits)
- [ ] Emergency room or hospital
- [ ] Urgent care center
- [ ] Doctor's office or clinic (not the SBHC)
- [ ] Counselor or therapist office or telehealth (not the SBHC)
- [ ] Other (Please write where else you've gotten care):

Other (Please write where else you've gotten care):

Where are you currently living? (Check all that apply)

- [ ] In a house with just my family
- [ ] In an apartment
- [ ] In a trailer
- [ ] In a motel/hotel
- [ ] In a shelter
- [ ] Transitional housing
- [ ] Group home
- [ ] Temporary/Emergency foster home
- [ ] With more than one family in a house or apartment
- [ ] Moving from place to place
- [ ] In a location not designed for sleeping such as a car, park, or campsite
- [ ] Couch surfing

Who do you live with? (Check all that apply)

- [ ] Mother
- [ ] Father
- [ ] Step-Mother
- [ ] Step-Father
- [ ] Friend/Roommate
- [ ] Significant Other/Spouse
- [ ] Brother/Sister
- [ ] By Yourself
- [ ] Aunt
- [ ] Uncle
- [ ] Grandparent(s)
- [ ] Foster Parent
- [ ] Other

Other:

What is your current relationship status?

- [ ] In a relationship
- [ ] In an open relationship
- [ ] It's complicated
- [ ] Single
- [ ] Engaged
- [ ] Married
- [ ] Separated
- [ ] Divorced

Do you have someone who you feel you can really talk to?

- [ ] Yes
- [ ] No

Who do you feel you can really talk to (check all that apply)?

- [ ] Friend
- [ ] Significant Other/Spouse
- [ ] Parent
- [ ] Brother/Sister
- [ ] Teacher
- [ ] Online Friend
- [ ] Other
- [ ] Other Adult
- [ ] Other Relative
- [ ] No One

Other

Other Adult

Other Relative

Are you having any problems at home?

- [ ] Yes
- [ ] No

Which problems are you having at home (check all that apply)?

- [ ] Physical Violence
- [ ] Arguing or Yelling
- [ ] Concerns With a Family Member
- [ ] Concerns With Roommates
- [ ] Family Member Out of Work
- [ ] Other

Other

Are you having any problems at school?

- [ ] Yes
- [ ] No

Which problems are you having at school (check all that apply)?

- [ ] Missing School
- [ ] Suspension
- [ ] Grades
- [ ] Bullying (in person or through social media)
- [ ] Other

Other

At my school, there is a teacher or some other adult who listens when I have something to say.

- [ ] Not at all true
- [ ] A little true
- [ ] Pretty much true
- [ ] Very much true

I have a friend about my own age who I can talk to about any concerns or problems.

- [ ] Not at all true
- [ ] A little true
- [ ] Pretty much true
- [ ] Very much true

For each statement, please tell me whether the statement was Often True, Sometimes True or Never True based on your experiences in the past 12 months:

I worried about not having enough to eat.

- [ ] Often True
- [ ] Sometimes True
- [ ] Never True

I tried not to eat a lot so that our food would last.

- [ ] Often True
- [ ] Sometimes True
- [ ] Never True

Do you usually participate in physical activities such as walking, skateboarding, dancing, swimming or playing basketball for a total of 1 hour every day?

- [ ] Yes
- [ ] No

Do you usually watch TV, play video games or spend time on a computer, tablet or smart phone for more than 2 hours per day (not including computer time for school or work)?

- [ ] Yes
- [ ] No

Do you usually eat 5 or more servings of vegetables and fruits every day?

- [ ] Yes
- [ ] No

Do you usually get 8 or more hours of sleep every night?

- [ ] Yes
- [ ] No

In the last 6 months, have you seen a dentist or gone to a dental clinic?

- [ ] Yes
- [ ] No

Do you have any tooth pain right now?

- [ ] Yes
- [ ] No

Do you always wear a seatbelt when driving or riding in a car, truck or van?

- [ ] Yes
- [ ] No

Do you always wear a helmet when rollerblading, biking, motorcycling, skateboarding, ATV, skiing or snowboarding?

- [ ] Yes
- [ ] No
- [ ] N/A

Do you drive?

- [ ] Yes
- [ ] No

Do you text, talk or surf the internet on your cell phone while you are driving?

- [ ] Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Always

How often are you using your bluetooth/hands-free device to talk while driving?

- [ ] Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Always

Is there someone at home, school or anywhere else who has made you feel afraid, threatened you or hurt you?

- [ ] Yes
- [ ] No

Have you ever been physically, sexually or emotionally abused?

- [ ] Yes
- [ ] No

In the past 12 months did your significant other/spouse ever hit, slap or hurt you on purpose?

- [ ] Yes
- [ ] No

Have you ever carried a weapon (gun, knife, club, etc.) to protect yourself?

- [ ] Yes
- [ ] No

Have you ever been in foster care, a group home or homeless?

- [ ] Yes
- [ ] No

Have you ever been in jail or in a detention center?

- [ ] Yes
- [ ] No

Instructions: How often have you been bothered by each of the following symptoms during the PAST TWO WEEKS? For each symptom select the answer that best describes how you have been feeling.

Feeling nervous, anxious, or on edge

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Not being able to stop or control worrying

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Instructions: How often have you been bothered by each of the following symptoms during the PAST TWO WEEKS? For each symptom select the answer that best describes how you have been feeling.

Worrying too much about different things

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Trouble relaxing

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Being so restless that it's hard to sit still

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Becoming easily annoyed or irritable

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

Feeling afraid as if something awful might happen

- [ ] Not At All
- [ ] Several Days
- [ ] Over Half The Days
- [ ] Nearly Everyday

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

Have you ever purposefully hurt yourself without wanting to die, such as cutting or burning yourself?

- [ ] Yes
- [ ] No

Instructions: How often have you been bothered by each of the following symptoms during the PAST TWO WEEKS? For each symptom select the answer that best describes how you have been feeling.

Feeling down, depressed, irritable, hopeless?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Little interest or pleasure in doing things (that you usually like to do)?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Instructions: How often have you been bothered by each of the following symptoms during the PAST TWO WEEKS? For each symptom select the answer that best describes how you have been feeling.

Trouble falling or staying asleep or sleeping too much?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Poor appetite, weight loss, or overeating?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Feeling tired or having little energy?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Feeling bad about yourself or feeling that you are a failure, or have let yourself or your family down?

- [ ] Not At All
- [ ] Several Days
- [ ] More Than Half The Days
- [ ] Nearly Everyday

Instructions: How often have you been bothered by each of the following symptoms during the PAST TWO WEEKS? For each symptom select the answer that best describes how you have been feeling.

Trouble concentrating on things, like school work, reading or watching TV?

- ☐ Not At All
- ☐ Several Days
- ☐ More Than Half The Days
- ☐ Nearly Everyday

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?

- ☐ Not At All
- ☐ Several Days
- ☐ More Than Half The Days
- ☐ Nearly Everyday

Thoughts that you would be better off dead, or of hurting yourself in some way?

- ☐ Not At All
- ☐ Several Days
- ☐ More Than Half The Days
- ☐ Nearly Everyday

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In the past year have you felt depressed or sad most days, even if you felt OK sometimes?

- ☐ Yes
- ☐ No

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

Have you wished you were dead or wished you could go to sleep and not wake up in the past month?

- ☐ Yes
- ☐ No

Have you actually had any thoughts about killing yourself in the past month?

- ☐ Yes
- ☐ No

Have you thought about how you might do this in the past month?

- [ ] Yes
- [ ] No

When you thought about killing yourself in the past month, did you think this was something you might actually do?

- [ ] Yes
- [ ] No

Have you started to work out or worked out the details of how to kill yourself in the past month?

- [ ] Yes
- [ ] No

Do you intend to carry out this plan?

- [ ] Yes
- [ ] No

Have you ever done anything, started to do anything, or prepared to do anything to end your life? (Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.)

- [ ] Yes
- [ ] No

Was this in the past 3 months?

- [ ] Yes
- [ ] No

Have you ever had sex? (This includes oral, anal and vaginal sex)

- [ ] Yes
- [ ] No

Are you thinking about having sex in the next month? (This includes oral, anal and vaginal sex)

- [ ] Yes
- [ ] No
- [ ] Unsure

Do you want to talk about preventing pregnancy and STDs/STIs?

- [ ] Yes
- [ ] No

Do you think you are attracted to:

- [ ] Males
- [ ] Females
- [ ] Both
- [ ] Unsure

Please describe:

Have you ever sexted or has anyone sexted you (texted, emailed or posted online suggestive pictures)?

- [ ] Yes
- [ ] No

Have you ever had a sexual encounter you'd like to talk about?

- [ ] Yes
- [ ] No

How many sex partners have you had in the last year?

- [ ] None
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10+
- [ ] --- N/A ---

How long has it been since you started having sex?

- [ ] Less Than 6 Months
- [ ] 6 Months to a Year
- [ ] 1 to 3 Years
- [ ] 3 to 5 Years
- [ ] More Than 5 Years

Have you had sex with: (check all that apply)

- [ ] Men
- [ ] Women
- [ ] Transgender Men
- [ ] Transgender Women

What kinds of sex have you had in the past year? (select all that apply)

- [ ] Vaginal Sex (penis in vagina)
- [ ] Receptive Anal Sex (partner's penis in your anus)
- [ ] Insertive Anal Sex (your penis in partner's anus)
- [ ] Give Oral Sex (your mouth on partner's genitals)
- [ ] Receive Oral Sex (partner's mouth on your genitals)

Do you use condoms when having vaginal sex?

- [ ] Always
- [ ] Sometimes
- [ ] Never

Do you use condoms when having receptive anal sex?

- [ ] Always
- [ ] Sometimes
- [ ] Never

Do you use condoms when having insertive anal sex?

- [ ] Always
- [ ] Sometimes
- [ ] Never

Do you use condoms when giving oral sex?

- [ ] Always
- [ ] Sometimes
- [ ] Never

Do you use condoms when receiving oral sex?

- [ ] Always
- [ ] Sometimes
- [ ] Never

Do your sex partner(s) have sex with both men and women?

- [ ] Yes
- [ ] No
- [ ] Unsure

Do you know or think your partner may have had sex with someone other than you, while you were in a relationship with them?

- [ ] Yes
- [ ] No
- [ ] Unsure

Do you think you or your partner could have a sexually transmitted disease (STD) like gonorrhea, chlamydia, HIV, etc.?

- [ ] Yes
- [ ] No
- [ ] Unsure

Have you ever been pregnant or gotten someone pregnant?

- [ ] Yes
- [ ] No

Are you using a method to prevent pregnancy?

- [ ] Yes
- [ ] No
- [ ] Unsure

Which types? (check all that apply)

- [ ] Condoms
- [ ] Pills
- [ ] Shot (Depo-Provera)
- [ ] Patch (Ortho Evra)
- [ ] Arm Implant (Implanon/Nexplanon)
- [ ] Pulling Out
- [ ] Ring (Nuvaring)
- [ ] IUD
- [ ] Unsure

Have you been tested for gonorrhea or chlamydia in the past year?

- [ ] Yes
- [ ] No
- [ ] Unsure

Have you ever been tested for HIV?

- [ ] Yes
- [ ] No
- [ ] Unsure

Were you ever told you have a sexually transmitted disease (STD) like gonorrhea, chlamydia, HIV, etc.?

- [ ] Yes
- [ ] No
- [ ] Unsure

Which STDs were you told you had? (Check all that apply)

- [ ] Chlamydia
- [ ] Gonorrhea
- [ ] Syphilis
- [ ] HIV
- [ ] Herpes
- [ ] Genital Warts
- [ ] Trichomonas
- [ ] Unsure
- [ ] Other

Other

Do you discuss past sexual experiences with sex partner(s) (including HIV and STD testing or treatment)?

- [ ] Always
- [ ] More Than 1/2 The Time
- [ ] Less Than 1/2 The Time
- [ ] Never

Have you ever had sex with an HIV positive person?

- [ ] Yes
- [ ] No
- [ ] Unsure

Have you ever sexted or has anyone sexted you (texted, emailed or posted online suggestive pictures)?

- [ ] Yes
- [ ] No

Have you had sex with people you met online or through an app? (tinder, grindr, forums, dating websites, etc.)

- [ ] Yes
- [ ] No

Have you ever had a sexual encounter you'd like to talk about?

- [ ] Yes
- [ ] No

Do you use drugs or alcohol before, during, or after sex?

- [ ] Never
- [ ] Once
- [ ] Sometimes
- [ ] Often
- [ ] Always

Have you or your sex partner(s) ever injected (shot up) drugs (for example, morphine, heroin, cocaine, or meth)?

- [ ] Yes
- [ ] No

Do you live or spend time with anyone who uses tobacco or spend time where people smoke?

- [ ] Yes
- [ ] No

Do you live or spend time with anyone who vapes and/or use Juul or spend time in a place where people vape/use Juul.

- [ ] Yes
- [ ] No

The next two questions ask about vaping/tobacco/nicotine use. Do not include marijuana use. During the PAST 12 MONTHS:

On how many days did you use any tobacco or nicotine products (for example, cigarettes, or smokeless tobacco)?

- [ ] I Have Never Used This Drug
- [ ] Not This Past Year
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

On how many days did you vape (for example Juul, SMOK, Novo, Vuse, blu, e-cigarettes, vapes, vape pens, hookah pens, and mods.)?

- [ ] I Have Never Used This Drug
- [ ] Not This Past Year
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

During the PAST 12 MONTHS, how often did you:

Drink more than a few sips of beer, wine, or any drink containing alcohol?

- [ ] I Have Never Used This Drug
- [ ] Not This Past Year
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

Use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "synthetic marijuana" (like "K2, "Spice")?

- [ ] I Have Never Used This Drug
- [ ] Not This Past Year
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)?

- [ ] I Have Never Used This Drug
- [ ] Not This Past Year
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

- [ ] Yes
- [ ] No

Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

- [ ] Yes
- [ ] No

Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

- [ ] Yes
- [ ] No

Do you ever use alcohol or drugs while you are by yourself, or ALONE?

- [ ] Yes
- [ ] No

Do you ever FORGET things you did while using alcohol or drugs?

- [ ] Yes
- [ ] No

Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

- [ ] Yes
- [ ] No

Have you ever gotten into TROUBLE while you were using alcohol or drugs?

- [ ] Yes
- [ ] No

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Alcohol (beer, wine, liquors, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to drink Alcohol?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Amphetamines (meth, crystal, speed, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use amphetamines?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Cocaine or Crack (coke, coco, snow, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use cocaine?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Drugs used to treat ADD or ADHD (Ritalin, Adderall, ady, etc.) that aren't prescribed to you.

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use ADD/ADHD medication?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Pain-relieving drugs (Codeine, Oxycontin (oxy), Percocet (perc), etc.) that aren't prescribed to you.

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use pain relievers

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Tranquilizing drugs (Valium, Xanax, benzos, etc.) that aren't prescribed to you.

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use tranquilizers?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Heroin (H, Tar, smack, black)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use heroin?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Methadone (pills used to treat heroin addiction) that aren't prescribed to you.

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use methadone?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Suboxone (Street Bup, sub, etc.) that aren't prescribed to you.

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use street bup?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Marijuana (weed, hashish, Pot, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use marijuana?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Synthetic marijuana (Spice, K2, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use synthetic marijuana?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Drugs causing hallucinations (Acid (LSD), mushrooms (shrooms), etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use hallucinogens?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Club Drugs (Molly, ecstasy, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use club drugs?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Special K, Salvia, PCP

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to use special k?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Which of the substances listed below have you used anytime during the past 30 days? (Check all that apply to you)

Huffing, sniffing, bagging, dusting (glue, spray paint, markers, thinners, sharpies, white out, etc.)

- [ ] Never or Not This Month
- [ ] A Few Times
- [ ] Once or Twice a Week
- [ ] Almost Every Day
- [ ] Every Day

How harmful do you think it is to huff or sniff substances?

- [ ] No Risk
- [ ] Slight Risk
- [ ] Moderate Risk
- [ ] Great Risk

Do you have any concerns or questions about the size or shape of your body or your physical appearance?

- [ ] Yes
- [ ] No

Please describe:

On the whole, how much do you like yourself?

- [ ] 1 - Not Much
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5 - A Lot

What is your hope for yourself in the future?

Provider Actions: (check all that apply)

- [ ] No concerns
- [ ] Home/school concerns addressed
- [ ] Health behaviors addressed
- [ ] Safety/injury concerns addressed
- [ ] Feelings and well-being addressed
- [ ] Sexual health addressed
- [ ] Tobacco/Vaping use discussed (MUST check if you are a part of the STEPP project)
- [ ] Substance use behaviors discussed (MUST check if you are a part of the SBIRT project)
- [ ] F/U scheduled for concerns (excluding tobacco, vaping and substance use concerns)
- [ ] Referral for medical care

When discussing the patient's feelings and wellbeing, what was the outcome?

- [ ] In-House Therapy Provided
- [ ] Already in Therapy
- [ ] Recommended Therapy but Refused
- [ ] Therapy not Needed

Would you like to add information regarding tobacco and/or vaping cessation counseling services you provided? (MUST fill out if participating in STEPP or SBIRT project)

- [ ] Yes
- [ ] No

Was tobacco/vaping cessation counseling needed?

- [ ] Yes
- [ ] No

Was health education provided for secondhand smoke and/or vape exposure?

- [ ] Yes
- [ ] No

Did you provide? (check all that apply)

- [ ] Tobacco/Nicotine Cessation Counseling
- [ ] Internal Referral for Tobacco Cessation Counseling
- [ ] External Referral (i.e. QuitLine, Not on Tobacco, Truth Initiative, Smokefree Teen, etc,)

How long was the cessation counseling session?

- [ ] Less than 3 minutes
- [ ] Greater than 3 up to 10 Minutes
- [ ] Greater than 10 Minutes

What type of internal referral for cessation counseling? (check all that apply)

- [ ] Primary Care Provider
- [ ] Behavioral Health Provider
- [ ] Health Educator
- [ ] Other

Other Internal Referral

What type of external referral? (check all that apply)

- [ ] QuitLine (available for ages 12 or older)
- [ ] Not on Tobacco (NOT) Program
- [ ] Smokefree Teen
- [ ] Truth Initiative E-cigarette and Vape Text Program
- [ ] My Life My Quit
- [ ] Other External Referral

Other External Referral

Would you like to add BIRT (Brief Intervention and Referral to Treatment) details to the substance abuse section? (MUST fill out if participating in the SBIRT project)

- [ ] Yes
- [ ] No

Brief intervention/advice needed?

- [ ] No: Negative Pre-Screen and Negative CAR
- [ ] Yes: Brief Advice (Positive Pre-Screen but Negative CRAFFT OR Negative Pre-Screen and Positive CAR)
- [ ] Yes: Brief Intervention (Positive CRAFFT)

Was positive reinforcement provided?

- [ ] Yes
- [ ] No

What is the status of the brief advice?

- [ ] Brief Advice Provided
- [ ] Brief Advice Postponed
- [ ] Brief Advice Not Provided

What is the status of brief intervention?

- [ ] Brief Intervention Provided
- [ ] Brief Intervention Postponed
- [ ] Brief Intervention Not Provided

What was the duration of the Brief Intervention?

- [ ] Under 15 Minutes
- [ ] 15-30 Minutes
- [ ] Greater Than 30 Minutes

Follow-Up Visit Status: Indicate if follow-up related to the CRAFFT screening results/substance use is scheduled. This includes scheduling follow-up for an additional brief intervention.

- [ ] No Follow-Up
- [ ] Follow-Up Scheduled/Set EHR Tickler
- [ ] Patient Refused Follow-Up
- [ ] Other

Other Follow-Up

Referral (check all that apply): For services and/or programs based on the CRAFFT screening and substance use assessment, incl mental health and social services.

- [ ] No Referral
- [ ] Patient Refused Referral
- [ ] Already in Treatment
- [ ] Internal Referral (within the SBHC, including warm handoff. Example: SBHC BHP)
- [ ] External (host school provider, medical sponsor, community clinic, or BHO office)
- [ ] Community Referral: For programs or services that are not treatment for substance use or mental health issue, ex. food bank, shelter, mentoring program, community resource center, etc.
- [ ] Other

Other Referral

Comments:

What type of provider signature would you like to add? (if a box is already checked, leave it checked so both signatures will appear)

- [ ] Primary Care
- [ ] Behavioral Health

Sign Here

Signature Date

Behavioral Health Signature

Behavioral Health Signature Date