

Name: _____ DOB: ____ / ____ / ____ Date Completed: ____ / ____ / ____

Teen health screen (CRAFFT 2.1+N)

We ask clients about alcohol, drugs, and mood because these factors can affect your health. Please ask your provider if you have any questions.

During the PAST 12 months, on how many days did you:	Number of days
1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Put “0” if none.	
2. Use any marijuana (weed, oil, or hash by smoking, vaping, or in food) or “synthetic marijuana” (like “K2,” “Spice”)? Put “0” if none.	
3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put “0” if none.	
4. Use any tobacco or nicotine products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Say “0” if none.	

If you put “0” in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.

If you put “1” or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.

	No	Yes
5. Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

Send to submitdocs@Lifestance.com