Columbia University
TeenScreen Program

ID# ____________

THE COLUMBIA UNIVERSITY TEENSCREEN® PROGRAM

1. TODAY'S DATE ___ / ___ / ___

2. AGE
○ *11* ○ *12* ○ *13*
○ *14* ○ *15* ○ *16*
○ *17* ○ *18* ○ *19*
○ *20* ○ *21*

3. YOUR SEX ○ *Male* ○ *Female*

4. ARE YOU LATINO/A? ○ *Yes* ○ *No*

5. CHOOSE THE CATEGORY THAT BEST DESCRIBES YOUR RACE
CHECK ONE
○ *White/Caucasian*
○ *Black/African American*
○ *American Indian/Alaska Native*
○ *Native Hawaiian/Other Pacific Islander*
○ *Asian*
○ *Mixed – more than one race*
○ *Other*

6. YOUR GRADE
○ *5th* ○ *6th* ○ *7th*
○ *8th* ○ *9th* ○ *10th*
○ *11th* ○ *12th* ○ *Not in School*

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INSTRUCTIONS

Please check Yes or No for the following questions. Then, follow the arrow by your answer to go to the next question.

1 **During the past 3 months, have you had trouble seeing (even with glasses)?**

○ YES ▶ **1a** Have you seen a doctor about this?
- ○ YES
- ○ NO

○ NO ▼

2 **During the past 3 months, have you had trouble hearing?**

○ YES ▶ **2a** Have you seen a doctor about this?
- ○ YES
- ○ NO

○ NO ▼

3 **During the past 3 months, have you had trouble with your teeth or gums?**

○ YES ▶ **3a** Have you seen a dentist about this?
- ○ YES
- ○ NO

○ NO ▼

GO ON
TO THE NEXT PAGE

INSTRUCTIONS

Please answer the following questions using the rating scale provided. Check the circle that best describes your answer. Then, follow the arrow next to your answer to go to the next question.

4 **During the past 3 months, how much of a problem have you had with feeling nervous or afraid?**

- 1 NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- 2 SLIGHT PROBLEM ○
- 3 MEDIUM PROBLEM ○
- 4 BAD PROBLEM ○
- 5 VERY BAD PROBLEM ○

Please answer questions 4a through 4c.

4a Are you so concerned about this that you think you should get help?
○ YES
○ NO

4b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?
○ YES
○ NO

4c Do you have an appointment scheduled to see a professional about this?
○ YES
○ NO

GO ON TO THE NEXT PAGE ▶

5 <u>**During the past 3 months**</u>**, how much of a problem have you had with doing less with other people and withdrawing more and more into yourself?**

- **1** NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- **2** SLIGHT PROBLEM ○
- **3** MEDIUM PROBLEM ○
- **4** BAD PROBLEM ○
- **5** VERY BAD PROBLEM ○

Please answer questions 5a through 5c.

5a Are you so concerned about this that you think you should get help?

○ YES

○ NO

5b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?

○ YES

○ NO

5c Do you have an appointment scheduled to see a professional about this?

○ YES

○ NO

GO ON TO THE NEXT PAGE ▶

6 **During the past 3 months, how much of a problem have you had with feeling unhappy or sad?**

- **1** NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- **2** SLIGHT PROBLEM ○
- **3** MEDIUM PROBLEM ○
- **4** BAD PROBLEM ○
- **5** VERY BAD PROBLEM ○

Please answer questions 6a through 6c.

6a Are you so concerned about this that you think you should get help?

○ YES

○ NO

6b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?

○ YES

○ NO

6c Do you have an appointment scheduled to see a professional about this?

○ YES

○ NO

GO ON TO THE NEXT PAGE ▶

7 <u>During the past 3 months</u>, how much of a problem have you had with losing your temper, being in a bad mood, or having little things make you mad or upset?

- **1** NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- **2** SLIGHT PROBLEM ○
- **3** MEDIUM PROBLEM ○
- **4** BAD PROBLEM ○
- **5** VERY BAD PROBLEM ○

Please answer questions 7a through 7c.

7a Are you so concerned about this that you think you should get help?

○ YES

○ NO

7b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?

○ YES

○ NO

7c Do you have an appointment scheduled to see a professional about this?

○ YES

○ NO

GO ON TO THE NEXT PAGE ▶

8 <u>During the past 3 months</u>, how much of a problem have you had with drugs or alcohol or both?

- **1** NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- **2** SLIGHT PROBLEM ○
- **3** MEDIUM PROBLEM ○
- **4** BAD PROBLEM ○
- **5** VERY BAD PROBLEM ○

Please answer questions 8a through 8c.

8a Are you so concerned about this that you think you should get help?

○ YES

○ NO

8b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?

○ YES

○ NO

8c Do you have an appointment scheduled to see a professional about this?

○ YES

○ NO

GO ON TO THE NEXT PAGE ▶

9 <u>During the past 3 months</u>, how much of a problem have you had with getting along with your friends?

- **1** NO PROBLEM ○ ▶ GO ON TO THE NEXT PAGE
- **2** SLIGHT PROBLEM ○
- **3** MEDIUM PROBLEM ○
- **4** BAD PROBLEM ○
- **5** VERY BAD PROBLEM ○

Please answer questions 9a through 9c.

9a Are you so concerned about this that you think you should get help?

○ YES
○ NO

9b Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this problem during the past 3 months?

○ YES
○ NO

9c Do you have an appointment scheduled to see a professional about this?

○ YES
○ NO

GO ON TO THE NEXT PAGE ▶

INSTRUCTIONS

Please check Yes or No for the following questions. Then, follow the arrow next to your answer to go to the next question.

10 **During the past 3 months, have you thought of killing yourself?**

○ YES ▼ ○ NO ▶ GO ON TO THE NEXT PAGE

Please answer questions 10a through 10g.

10a Are you still thinking of killing yourself?

○ YES ○ NO

10b Have you often thought of killing yourself?

○ YES ○ NO

10c Have you thought seriously about killing yourself?

○ YES ○ NO

10d Have you been thinking about killing yourself for a long time?

○ YES ○ NO

10e Are you so concerned about these thoughts that you think you should get help?

○ YES ○ NO

10f Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with these thoughts during the past 3 months?

○ YES ○ NO

10g Do you have an appointment scheduled to see a professional for help with these thoughts?

○ YES ○ NO

GO ON TO THE NEXT PAGE ▶

11 Have you ever tried to kill yourself?

○ YES ○ NO ▶ GO ON TO THE NEXT PAGE

Please answer questions 11a through 11d.

11a Have you tried to do this in the last 3 months?

○ YES ○ NO

11b Are you so concerned about this that you think you should get help?

○ YES ○ NO

11c Have you seen a mental health professional like a counselor, social worker, psychologist, or psychiatrist for help with this during the past 3 months?

○ YES ○ NO

11d Do you have an appointment scheduled to see a professional for help with this?

○ YES ○ NO

GO ON TO THE NEXT PAGE ▶

INSTRUCTIONS

Thank you for completing the Columbia Health Screen. Please tell us what you thought of the screen by answering the following questions. Check the circle that best describes your answer.

12 Do you think this questionnaire is too long, too short, or just about right?

1 TOO LONG ○	2 JUST RIGHT ○	3 TOO SHORT ○

13 Do you think this questionnaire is interesting, boring, or neither one?

1 INTERESTING ○	2 NEITHER ○	3 BORING ○

14 Now that you finished this questionnaire, do you feel more comfortable, more upset, or about the same as you did before you started this questionnaire?

1 MORE COMFORTABLE ○	2 ABOUT THE SAME ○	3 MORE UPSET ○

STOP
YOU'RE DONE!

Section V: Clinical Interview & Referral

Date of Interview: __ __/ __ __/ __ __

Reason For Clinical Interview:

- ❑ Positive CHS Screen
- ❑ Youth request
- ❑ Referred as a result of debriefing interview
- ❑ Other ______________________________

Instructions for Clinician

- ❑ **Assess depression and suicidality for every youth**
- ❑ **Follow-up screening results using Symptom Checklist(s) as guides to explore whether youth needs further evaluation and/or treatment**

Depression: Ask about duration, persistence, and severity of symptoms

Low Mood:	Guilt / Worthlessness:
Irritability:	Hopelessness:
Lack of pleasure / Interest:	Fatigue / Loss of energy:
Sleep Disturbance:	Decreased concentration / Indecisiveness:
Appetite / Weight change:	Agitation / Retardation:

Suicidal Ideation

Thoughts of killing self:	Onset, frequency, recency:
Suicide plan / Methods associated with thoughts:	Strength of intent / Wish to die:
Precipitants/ Triggers of suicidal ideation:	Deterrents to suicidal actions:
Thoughts of death (e.g., Wish were dead, never wake up):	Onset, frequency, recency:

Columbia University
Teen Screen® Program
Mental Health Check-ups for Youth

Screening Summary Form (CHS)

Section I: Youth Information

Youth ID: ______________

Age: ______________

Date: ____/____/____

Sex: ☐ Female ☐ Male

Grade: ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ Not in School

Section II: CHS Summary Report

☐ Vision problem / hasn't seen doctor	☐ Hearing problem / hasn't seen doctor	☐ Dental problem / hasn't seen dentist

Q. 4 Nervous ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	**Q. 9 Friends** ☐ Want Help (a)
Q. 5 Social Withdrawal ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 6 Unhappy ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 7 Irritable ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 8 Drugs / Alcohol ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	**Q. 14 Reaction** ☐ More upset

Q. 10 Suicidal Ideation ☐ Yes ☐ No

Q. 11 Suicide Attempt ever ☐ Yes ☐ No

Section III: Screening Results & Next Steps

Positive screen if any one of these is checked:

- ☐ Q. **10** or Q.11 = **YES** (Suicide Ideation or Attempt)
- ☐ Any Question Qs. 4a thru 9a = **Want Help** (a)
- ☐ **3 Qs.** from Qs. 4 thru 8 = **Bad** or **Very Bad**
- ☐ Q. **14 = More Upset**
- ☐ Youth requests / program staff recommends clinical interview
- ☐ Youth refuses to answer Q(s). ________

Screen Results/Next Steps:

☐ Positive screen: **Requires** clinical interview

☐ Negative screen: **Does not require** clinical interview

9/27//04

Suicidal Behavior

Number of attempts / self-injurious acts in Lifetime: _____

Most RECENT Suicide Attempt	Most SERIOUS Suicide Attempt
Date	Date
Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:	Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:

Summary of Suicide Risk Assessment: ____________________

____

Notes on Other Problem Areas: ____________________

____

____

____

Current Psychosocial Stressors: ____________________

____

Current Medical Conditions / Medications : ____________________

____

Psychiatric History / Significant Medical History: ____________________

____

Diagnostic Impressions: ____________________

____

____

Currently seeing a mental health professional? ❒ Yes ❒ No **Future appt. scheduled?** ❒ Yes ❒ No

If yes, for what? ____________________

Referral Recommended: ❒ Yes ❒ No **Emergency/Crisis:** ❒ Yes ❒ No

Reasons for Referral or Non-Referral: ____________________

____

____

Youth's Response to Referral: ❒ Accepted ❒ Denied ❒ Undecided ❒ Already In Treatment ❒ N/A

____

____

Clinician's Printed Name: ____________________

Clinician's Signature: ____________________ **Date:** __________

Section VI: Case Management & Follow-up

Date of Initial Contact with Youth: __/__/__ Date of Initial Contact with Parent: __/__/__

Parent's Response to Referral: ❒ Accepted ❒ Denied ❒ Undecided ❒ Youth Already In Treatment

Initial Appointment Scheduled? ❒ Yes ❒ No **Date Scheduled:** __/__/__

Youth Kept At Least One Appointment? ❒ Yes ❒ No **Date First Seen:** __/__/__

Initial Treatment Provider: ____________________

Services Received *Check all that apply:*

- ❒ School-Based Services
- ❒ Private Outpatient Care
- ❒ Emergency Room
- ❒ Partial Hospital Program
- ❒ Inpatient Unit
- ❒ Community Mental Health Center (CMHC) Outpatient Services
- ❒ Intensive Outpatient Program (IOP)
- ❒ Mobile Crisis
- ❒ Hospital-Based Psychiatric Clinic (outpatient)
- ❒ Other – Specify: ____________________

Date Case Closed: __/__/__ **Date Closing Letter Sent to Parents:** __/__/__

Reason for Closure: ____________________

Additional Case Management Notes: ____________________

____

____

Case Manager's Printed Name: ____________________

Case Manager's Signature: ____________________ Date: __________