



Adolescent Patient Screeners Booklet



Dear Provider Partner,

As we work together to serve our community with best practices in whole-person health, we know the magnitude of mental health needs that many of your patients present to you with as a busy primary care provider. We understand that given the volume of patients you see, mental health resources may be limited in your practice setting. I am sharing a few publicly available brief screening tools that can aid you in quickly assessing your patient's needs.

When screeners indicate symptoms acute enough to warrant referral for specialty assessments and intervention, SunCloud Health is here to help. We have a large team of psychiatrists, therapists and intake clinicians dedicated to serving our community's mental health needs and partnering with local primary care providers to offload some of the excessive workload that first lands at your door.

Our staff can conduct the comprehensive bio/psycho/social assessment to determine diagnosis and appropriate needed level of care to treat one or more mental health diagnoses, including depression, trauma, anxiety, addiction, eating disorders and other behavioral concerns.

When screening tool indicates need for referral for full assessment, we are here to help.
(Include access number and website here: could also include an access code)

Thank you for your continued partnership. We are committed to supporting you and your patients.

With Gratitude,



Kim Dennis, M.D.
Chief Medical Officer
SunCloud Health

Table of Contents

Item	Page #
Assessment Index	4
Alcohol Use Disorder Identification Test.....	5
Drug Abuse Screening Test.....	7
Modified Yale Food Addiction Scale 2.0 for Children.....	9
SCOFF Assessment.....	11
Patient Health Questionnaire 9.....	12
Screeners for Child Anxiety Related Disorders.....	14
References.....	17

Assessment Index

Addiction Screeners

1. Alcohol Use Disorder Identification Test (AUDIT-SR)
 - a. Assesses alcohol consumption, drinking behaviors, and alcohol related problems
2. Drug Abuse Screening Test (DAST-10)
 - a. Assesses drug use over the past year
3. Modified Yale Food Addiction Scale (mYFAS 2.0 C)
 - a. Assesses signs of addictive-like eating behaviors

Eating Disorder Screener

1. National Eating Disorders Association Eating Disorder Screening Tool
 - a. Assessing shape, weight, and restriction and eating concerns

Mood and Anxiety Disorder Assessments

1. Patient Health Questionnaire (PHQ-9)
 - a. Assesses degree of depression severity
2. Screener for Child Anxiety Related Disorders (SCARED)
 - a. Assesses the frequency of anxiety symptomology

Alcohol Use Disorder Identification Test (AUDIT – SR)

1. How often do you have a drink containing alcohol?

- 1) Never
- 2) Monthly or less
- 3) 2-4 times a month
- 4) 2-3 times a week
- 5) 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 1) 1 or 2
- 2) 3 or 4
- 3) 5 or 6
- 4) 7 to 9
- 5) 10 or more

3. How often do you have six or more drinks on one occasion?

- 1) Never
- 2) Less than monthly
- 3) Monthly
- 4) Weekly
- 5) Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- 1) Never
- 2) Less than monthly
- 3) Monthly
- 4) Weekly
- 5) Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- 1) Never
- 2) Less than monthly
- 3) Monthly
- 4) Weekly
- 5) Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- 1) Never
- 2) Less than monthly
- 3) Monthly
- 4) Weekly
- 5) Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

1) Never
2) Less than monthly
3) Monthly
4) Weekly
5) Daily or almost daily
8. During the past year, how often have you been unable to remember what happened the night before because you had been drinking?

1) Never
2) Less than monthly
3) Monthly
4) Weekly
5) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?

1) No
2) Yes, but not in the past year
3) Yes, during the past year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

1) No
2) Yes, but not in the past year
3) Yes, during the past year

Scoring Guide

The AUDIT has 10 questions and the possible responses to each question are scored 0, 1, 2, 3 or 4, with the exception of questions 9 and 10 which have possible responses of 0, 2 and 4.

A score of 15 or higher is an indication of moderate to severe alcohol use disorder. Please contact SunCloud Health for a more intensive assessment.

Risk Category	AUDIT SR – Scoring
Low Risk Consumption:	1 – 7
Hazardous or Harmful Consumption:	8-14
Alcohol Dependence:	15+

Assessment link: <https://auditscreen.org/>

Drug Abuse Screening Test (DAST-10)

In the past 12 months		Circle	
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you use more than one drug at a time?	Yes	No
3	Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use? (If never use drugs, answer "No")	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Scoring Guide

Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point

A score of 6 or higher is an indication of a probable substance use disorder. Please contact SunCloud health for a more intensive assessment.

Score	Risk Level	Intervention
0	Zone 1: No risk	Simple advice: Congratulations this means you are abstaining from excessive use of prescribed or over-the counter medications, illegal or non-medical drugs.
1 – 2	Zone 2: At Risk Use – “low level” of problem drug use	Brief Intervention (BI). You are at risk. Even though you may not be currently suffering or causing harm to yourself or others, you are at risk of chronic health or behavior problems because of using drugs or medications in excess.
3 – 5	Zone 3: “intermediate level”	Extended BI (EBI) and RT – your score indicates you are at an “intermediate level” of problem drug use. Talk with a professional and find out what services are available to help you to decide what approach is best to help you to effectively change this pattern of behavior.
6 – 10	Zone 4: Very High Risk, Probable Substance Use Disorder	EBI/RT- considered to be at a “substantial to severe level” of problem drug use. Refer to specialist for diagnostic evaluation and treatment.

Assessment link:

<https://www.oplc.nh.gov/sites/g/files/ehbemt441/files/inline-documents/sonh/dast-10risktool.pdf>

The Modified Yale Food Addiction Scale Version 2.0 for Children (mYFAS-C 2.0)

We want to know how kids feel about food and eating. There are no right or wrong answers. Every kid is different.

- We just want to know how you feel about “junk foods” like:
- Sweets like ice cream, chocolate, doughnuts, cookies, cake, candy
 - Salty snacks like chips, pretzels, and crackers
 - Fatty foods like steak, bacon, hamburgers, cheeseburgers, pizza, and French fries
 - Sugary drinks like soda pop, lemonade, sports drinks, and energy drinks

When we say “CERTAIN FOODS” we want you to think of ANY “junk food” like those above

In the past 12 months	Never	Rarely	Some- times	Very Often	Always
1. I ate until my stomach hurt or I felt sick.	0	1	2	3	4
2. I spent a lot of time feeling tired from eating too much.	0	1	2	3	4
3. If I was upset because I hadn't eaten certain foods, I would eat those foods to feel better.	0	1	2	3	4
4. The way I ate made me really unhappy.	0	1	2	3	4
5. The way I ate caused me problems. (ex. Problems at school, with parents, with friends)	0	1	2	3	4
6. I avoided places that had certain foods because I might eat too much. (ex. Parties, friends' houses)	0	1	2	3	4

In the past 12 months	Never	Rarely	Some- times	Very Often	Always
7. I ate so much that I did not do other important things. (ex. Homework, chores)	0	1	2	3	4
8. I kept eating too much even though it made me feel sad, nervous, or guilty.	0	1	2	3	4
9. When I ate the same amout of food, it didn't make me feel as good as it used to (ex. Feel happy, calm, relaxed)	0	1	2	3	4
10. I tried and failed to stop eating certain foods.	0	1	2	3	4
11. I was so distracted by eating that I could have been hurt. (ex. Crossing the street)	0	1	2	3	4
12. I had such strong urges to eat certain foods that I couldn't think of anything else.	0	1	2	3	4
13. My friends or family were worried that I ate too much.	0	1	2	3	4

MYFAS 2.0 C Scoring Guide

Scoring: Each question is scored as a 0 or 1 depending on if the patient’s answer meets threshold. Each question has a different threshold: 0 =threshold not met, 1=threshold is met and shown in gray.

- A score of 2 or higher (sometimes) must be met for questions
 - 1, 3, 6, 7, 8, 11, 12, 13
- A score of 3 or higher (Often) must be met for questions
 - 2, 4, 5, 9, 10

To calculate a patient’s symptom score, please count the number of questions that have met threshold (boxes that are gray) questions 1-3 and 6-13 are counted. The range of scores is 0 – 11.

Please call SunCloud Health for a patient scoring a 2 or higher for a more comprehensive assessment.

Assessment link: <https://sites.lsa.umich.edu/fastlab/>

SCOFF Questionnaire

1. Do you make yourself sick because you feel uncomfortably full?

a. Yes or No

2. Do you worry you may have lost control over how much you eat?

a. Yes or No

3. Have you recently lost more than one stone (approximately 14 pounds) in a three-month period?

a. Yes or No

4. Do you believe yourself to be fat when others say you are too thin?

a. Yes or No

5. Would you say food dominates your life?

a. Yes or No

Scoring Guide

If a patient responds “yes”, to two or more questions, please contact SunCloud Health for a more comprehensive assessment.

Assessment link: <https://www.bmj.com/content/bmj/319/7223/1467.full.pdf>

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Day	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Feeling tired or having little energy	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total Score: _____

If you checked off any problems, 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 _____

Patient Health Questionnaire 9 Scoring Guide

If a patient scores a 10 or higher, please contact SunCloud Health for a more comprehensive assessment.

PHQ-9 Scoring Range

Total Score	Depression Severity
0-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Assessment link: <https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf>

Screen for Child Anxiety Related Emotional Disorders (SCARED)

Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide which answer is true for you. Then for each sentence, circle the response that describes the last 3 months.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1	When I feel frightened, it is hard for me to breathe	☐	☐	☐
2	I get headaches when I am at school	☐	☐	☐
3	I don't like to be with people I don't know well	☐	☐	☐
4	I get scared if I sleep away from home	☐	☐	☐
5	I worry about other people liking me	☐	☐	☐
6	When I get frightened, I feel like passing out	☐	☐	☐
7	I am nervous	☐	☐	☐
8	I follow my mother or father wherever they go	☐	☐	☐
9	People tell me that I look nervous	☐	☐	☐
10	I feel nervous with people I don't know well	☐	☐	☐
11	My I get stomachaches at school	☐	☐	☐
12	When I get frightened, I feel like I am going crazy	☐	☐	☐
13	I worry about being as good as other kids	☐	☐	☐
14	I worry about being as good as other kids	☐	☐	☐

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
15	When I feel frightened, I feel like things are not real	☐	☐	☐
16	I have nightmares about something bad happening to my parents	☐	☐	☐
17	I worry about going to school	☐	☐	☐
18	When I get frightened, my heart beats fast	☐	☐	☐
19	I get shaky	☐	☐	☐
20	I have nightmares about something bad happening to me	☐	☐	☐
21	I worry about things working out for me	☐	☐	☐
22	When I get frightened, I sweat a lot	☐	☐	☐
23	I am a worrier	☐	☐	☐
24	I get really frightened for no reason at all	☐	☐	☐
25	I am afraid to be alone in the house	☐	☐	☐
26	It is hard for me to talk with people I don't know well	☐	☐	☐
27	When I get frightened, I feel like I am choking	☐	☐	☐
28	People tell me that I worry too much	☐	☐	☐
29	I don't like to be away from my family	☐	☐	☐
30	My I get stomachaches at school	☐	☐	☐

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
31	I worry that something bad might happen to my parents	☐	☐	☐
32	I feel shy with people I don't know well	☐	☐	☐
33	I worry about what is going to happen in the future	☐	☐	☐
34	When I get frightened, i feel like throwing up	☐	☐	☐
35	I worry about how well I do things	☐	☐	☐
36	I am scared to go to school	☐	☐	☐
37	I worry about things that have already happened	☐	☐	☐
38	When I get frightened, I feel dizzy	☐	☐	☐
39	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	☐	☐	☐
40	I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	☐	☐	☐
41	I am shy	☐	☐	☐

Screeners for Child Anxiety Related Disorders Scoring Guide

Please contact SunCloud Health if a patient score is 25 or higher for a more comprehensive assessment.

- A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate panic disorder or Significant Somatic Symptoms.
- A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder.
- A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder.
- A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder.
- A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance.

Assessment link:

<https://www.ohsu.edu/sites/default/files/2019-06/SCARED-form-Parent-and-Child-version.pdf>

References

- Birmaher, B., Khetarpal, S., Brent, D., Cully, M., Balach, L., Kaufman, J., & Neer, S. M. (1997).** The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale Construction and Psychometric Characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(4), 545–553.
<https://doi.org/10.1097/00004583-199704000-00018>
- Horsager, C., & Gearhardt, A. N. (2024).** Development and validation of the modified Yale Food Addiction Scale for Children 2.0. *Eating Behaviors*, 55(101927), 101927–101927.
<https://doi.org/10.1016/j.eatbeh.2024.101927>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001).** The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613.
- Morgan, J. F., Reid, F., & Lacey, J. H. (1999).** The SCOFF questionnaire: Assessment of a New Screening Tool for Eating Disorders. *BMJ*, 319(7223), 1467–1468.
<https://doi.org/10.1136/bmj.319.7223.1467>
- Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M.** Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption--II. *Addiction*. 1993 Jun;88(6):791–804. doi: 10.1111/j.1360-0443.1993.tb02093.x. PMID: 8329970.
- Skinner, H. A. (1982).** The drug abuse screening test. *Addictive Behaviors*, 7(4), 363–371.
[https://doi.org/10.1016/0306-4603\(82\)90005-3](https://doi.org/10.1016/0306-4603(82)90005-3)