SOS Signs of Suicide® Prevention Program

Name: ____________________

Student Screening Form

- Age: ______
- Grade: ______
- Gender:

□ Female □ Male □ Transgender

- Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
- Race: *(Check all that apply)*

□ American Indian/Alaska Native □ Black/African American □ White

□ Native Hawaiian/Other Pacific Islander □ Other/Multicultural □ Asian

- Are you currently being treated for depression? □ Yes □ No

Brief Screen for Adolescent Depression (BSAD)*

Please answer the following questions as honestly as possible by circling the "Yes" or "No" response.

In the last four weeks...

1. Have you felt like nothing is fun for you and you just aren't interested in anything? **Yes No**

2. Have you had less energy than you usually do? Yes No

3. Have you felt you couldn't do anything well or that you weren't as good-looking or as smart as most other people? Yes No

4. Have you thought seriously about killing yourself? Yes No

5. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? **Yes No**

6. Has doing even little things made you feel really tired? Yes No

6. Has it seemed like you couldn't think as clearly or as fast as usual? Yes No

Alcohol Use

a. In the past year, has there been a time when you had five or more alcoholic drinks in a row? (By "drinks" we mean any kind of beer, wine, or liquor) Yes No

b. In the past year, have you used alcohol because you were feeling down? Yes No