

Alabama Department of Mental Health  
Substance Abuse Division  
**CRAFT SCREENING – Electronic Version**  
**(UNDER AGE 18)**

Completed By: \_\_\_\_\_  
Date of Screening: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_

ASAIS ID: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Maiden

Alias 1: \_\_\_\_\_ Alias 2: \_\_\_\_\_

What is the most important thing you want that made you decide to call for help:

**Presenting Problems:** (check all that apply)

- |                                           |                                                   |                                           |                                           |
|-------------------------------------------|---------------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Abuse Victim     | <input type="checkbox"/> Depressive/Mood Disorder | <input type="checkbox"/> Marital          | <input type="checkbox"/> Somatic          |
| <input type="checkbox"/> Alcohol          | <input type="checkbox"/> Drug                     | <input type="checkbox"/> Medical          | <input type="checkbox"/> Suicidal         |
| <input type="checkbox"/> Assault Victim   | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Rape Victim      | <input type="checkbox"/> Thought Disorder |
| <input type="checkbox"/> Criminal Justice | <input type="checkbox"/> Family                   | <input type="checkbox"/> Runaway Behavior | <input type="checkbox"/> None             |
| <input type="checkbox"/> Daily Coping     | <input type="checkbox"/> Interpersonal            | <input type="checkbox"/> Social           | <input type="checkbox"/> Other: _____     |

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SSN#: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

- |                                     |                                                             |                                                                 |                                              |
|-------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------|
| <b>Sex:</b>                         | <b>Race:</b> (Check one box)                                | <b>Ethnicity:</b> (Check one box)                               | <b>Marital Status:</b> ____ yr(s) ____ mo(s) |
| <input type="checkbox"/> Female – F | <input type="checkbox"/> Alaskan Native                     | <input type="checkbox"/> Cuban                                  | <input type="checkbox"/> Common Law          |
| <input type="checkbox"/> Male – M   | <input type="checkbox"/> American Indian                    | <input type="checkbox"/> Hispanic-Specific Origin not Specified | <input type="checkbox"/> Divorced            |
|                                     | <input type="checkbox"/> Asian                              | <input type="checkbox"/> Mexican                                | <input type="checkbox"/> Married             |
|                                     | <input type="checkbox"/> Black / African American           | <input type="checkbox"/> Not of Hispanic Origin                 | <input type="checkbox"/> Never Married       |
|                                     | <input type="checkbox"/> Caucasian / White                  | <input type="checkbox"/> Other Specific Hispanic                | <input type="checkbox"/> Separated           |
|                                     | <input type="checkbox"/> Multi-Racial                       | <input type="checkbox"/> Puerto Rican                           | <input type="checkbox"/> Divorced            |
|                                     | <input type="checkbox"/> Native Hawaiian / Other Pac Island | <input type="checkbox"/> Unknown                                | Number of Marriages: _____                   |
|                                     | <input type="checkbox"/> Other _____                        |                                                                 |                                              |

**Language Preference:** If other than English, please specify: \_\_\_\_\_

- Linguistic Status:**
- |                                                      |                                                  |
|------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Cognitive Disability        | <input type="checkbox"/> Low Literacy Level      |
| <input type="checkbox"/> English Proficiency         | <input type="checkbox"/> Not Literate            |
| <input type="checkbox"/> Limited English Proficiency | <input type="checkbox"/> Other Disability: _____ |

**Hearing Status:**  Hearing  Hard of Hearing  Deaf

- Referral Source:**
- |                                                               |                                                           |                                                      |
|---------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> AOD Treatment, Inpatient/Residential | <input type="checkbox"/> Guardian                         | <input type="checkbox"/> Private Psychiatrist        |
| <input type="checkbox"/> AOD Treatment, Not Inpatient         | <input type="checkbox"/> ID 310 Program                   | <input type="checkbox"/> Probation/Parole            |
| <input type="checkbox"/> Clergy                               | <input type="checkbox"/> ID ARC                           | <input type="checkbox"/> Recognized Legal Entity     |
| <input type="checkbox"/> Court / Correctional Agency          | <input type="checkbox"/> ID Regional Office               | <input type="checkbox"/> School System               |
| <input type="checkbox"/> DHR                                  | <input type="checkbox"/> Multi-Service MH Agency          | <input type="checkbox"/> Self                        |
| <input type="checkbox"/> Diversionary Program/TASC            | <input type="checkbox"/> Outpatient Psych Services/Clinic | <input type="checkbox"/> Shelter for the Abused      |
| <input type="checkbox"/> DUI / DWI                            | <input type="checkbox"/> Nursing Home/Extended Care       | <input type="checkbox"/> Shelter for the Homeless    |
| <input type="checkbox"/> Educational Agency                   | <input type="checkbox"/> Parent                           | <input type="checkbox"/> Spouse                      |
| <input type="checkbox"/> Employer / EAP                       | <input type="checkbox"/> Partial Day Organization         | <input type="checkbox"/> State/County Psych Hospital |
| <input type="checkbox"/> Family                               | <input type="checkbox"/> Personal Care/Boarding Home      | <input type="checkbox"/> State/Federal Court         |
| <input type="checkbox"/> Formal Adjudication Process          | <input type="checkbox"/> Physician                        | <input type="checkbox"/> Voc Rehab Services          |
| <input type="checkbox"/> Friend                               | <input type="checkbox"/> Police                           | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> General / Psychiatric Hospital       | <input type="checkbox"/> Prison                           |                                                      |

Which is the primary referral source? \_\_\_\_\_ Secondary? \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

ASAS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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**Financial** I or my parents principal source of income is:

- Disability   
 Public Assistance   
 Retirement/Pension   
 Wages/Salary   
 None   
 Other: \_\_\_\_\_

Annual Income: \_\_\_\_\_

**Source of Payment:**

- Blue Cross/Blue Shield   
 Medicare   
 Personal Resources (Self/Family)  
 DMH   
 No Charge (free, charity, special research or   
 Service Contract (EAP, HMO, public mental  
teaching)   
health authority)  
 Health Insurance Companies (Not BCBS)   
 Other Government Payments: \_\_\_\_\_   
 Worker's Compensation  
 Medicaid

**Insurance** Do you have:

- Blue Cross/Blue Shield   
 Other (e.g. Tricare, Champus): \_\_\_\_\_  
 Health Maintenance Organization (HMO)   
 Private Insurance  
 Medicaid   
 Unknown  
 Medicare   
 None

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

- Special Population:**   
 IV Drug User   
 Pregnant Women   
 Women w/dependent child   
 Not applicable

**CRAFFT - Age Less Than 18**

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

**CRAFFT Score:** \_\_\_\_\_

(Two or more positive responses is highly predictive of an alcohol or drug-related disorder.)

SOURCE: Knight JR; Shrier LA; Bravender TD; Farrell M; Vander Bilt J; Shaffer HJ. (1999) A new brief screen for adolescent substance abuse. *Archives of Pediatrics and Adolescent Medicine Jun; 153(6)*. 591-6.

AS AIS ID: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

MI: \_\_\_\_\_

## MINI KID SCREEN

*If YES, go to the corresponding M.I.N.I. Kid module*

- |                                                                                                                                                                                                                                                                                                                            |                                                          |            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------|
| <p>➤ Have you felt sad or depressed, down or empty, or grouchy or annoyed, <b>most of the day, nearly every day</b> for the past two weeks? IF YES TO ANY, CODE YES</p>                                                                                                                                                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ A</p> |
| <p>➤ In the past two weeks, have you been bored a lot or much less interested in things (like playing your favorite games) for <b>most of the day, nearly every day</b>? Have felt that you couldn't enjoy things? IF YES TO ANY, CODE YES</p>                                                                             | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ A</p> |
| <p>➤ Have you <b>ever</b> felt so bad that you wished you were dead, or tried to hurt yourself, or tried to kill yourself? IF YES TO ANY, CODE YES</p>                                                                                                                                                                     | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ B</p> |
| <p>IF YOU SAID YES TO THE FIRST QUESTION, SKIP THIS QUESTION.</p>                                                                                                                                                                                                                                                          |                                                          |            |
| <p>➤ <b>In the past year</b> have you felt sad or depressed, down or empty, or grouchy or annoyed, <b>most of the time</b>? IF YES TO ANY, CODE YES</p>                                                                                                                                                                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ C</p> |
| <p>➤ Has there <b>ever</b> been a time when you were so happy that you felt really 'up' or 'high' or 'hyper'? By 'up' or 'high' I mean feeling really good; full of energy; needing less sleep; having racing thoughts or being full of ideas.</p>                                                                         | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ D</p> |
| <p>DO NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVERSTIMULATE AND MAKE CHILDREN VERY EXCITED, LIKE CHRISTMAS, BIRTHDAYS, ETC.</p>                                                                                                                                |                                                          | <p>→ D</p> |
| <p>➤ Are you <b>currently</b> feeling 'up' or 'high' or 'hyper' or full of energy?</p>                                                                                                                                                                                                                                     | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ D</p> |
| <p>➤ Has there <b>ever</b> been a time when you were so grouchy or annoyed, that you yelled or started fights; or yelled at people not counting your family? Have you or others noticed that you have been more grouchy than other kids, even when you thought you were right to act this way? IF YES TO ANY, CODE YES</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ D</p> |
| <p>DO NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVERSTIMULATE AND MAKE CHILDREN VERY GROUCHY OR ANNOYED.</p>                                                                                                                                                     |                                                          | <p>→ D</p> |
| <p>➤ Are you <b>currently</b> feeling grouchy or annoyed?</p>                                                                                                                                                                                                                                                              | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ E</p> |
| <p>➤ Have you <b>ever</b> been really frightened or nervous for no reason; or have you <b>ever</b> been really frightened or nervous in a situation where most kids would not feel that way? IF YES TO EITHER, CODE YES</p>                                                                                                | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ F</p> |
| <p>➤ Do you feel anxious, scared or uneasy in places or situations where you might become really frightened: like being in a crowd, standing in a line (queue), when you are all alone, or when crossing a bridge, traveling in a bus, train or car? IF YES TO ANY, CODE YES</p>                                           | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ F</p> |
- 
- |                                                                                                                                                                                                                                                                                                   |                                                          |            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------|
| <p>➤ <b>In the past month</b>, have you been really afraid about being away from someone close to you; or have you been really afraid that you would lose somebody you are close to? (Like getting lost from your parents or having something bad happen to them.) IF YES TO EITHER, CODE YES</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ G</p> |
| <p>➤ <b>In the past month</b>, were you afraid or embarrassed when others were watching you? Were you afraid of being teased? Like talking in front of the class? Or eating or writing in front of others? IF YES TO ANY, CODE YES</p>                                                            | <input type="checkbox"/> NO <input type="checkbox"/> YES | <p>→ H</p> |

ASAIS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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- **In the past month**, have you been really afraid of something like: snakes or bugs? Dogs or other animals? High places? Storms? The dark? Or seeing blood or needles?  
List the specific phobia : \_\_\_\_\_ NO YES → **I**
- **In the past month**, have you been bothered by bad things that come into your mind that you couldn't get rid of? Like bad thoughts or urges? Or nasty pictures? For example, did you think about hurting somebody even though you knew you didn't want to? Were you afraid you or someone would get hurt because of some little thing you did or didn't do? Did you worry a lot about having dirt or germs on you? Did you worry a lot that you would give someone else germs or make them sick somehow? Or were you afraid that you would do something really shocking? NO YES → **J**
- **IF YES TO ANY, CODE YES**  
DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL BEHAVIOR, OR ALCOHOL OR DRUG ABUSE BECAUSE YOU MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIS IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.
- **In the past month**, did you do something over and over without being able to stop doing it, like washing over and over? Straightening things up over and over? Counting something or checking on something over and over? Saying or doing something over and over? **IF YES TO ANY, CODE YES** NO YES → **J**
- Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad? Like being attacked by someone? NO YES → **K**
- Did you respond with intense fear, feel helpless or horrified or did you feel agitated or fall apart? NO YES → **K**
- **In the past month**, has this awful thing come back to you in some way? Like dreaming about it or having a strong memory of it? **IF YES TO ANY, CODE YES** NO YES → **K**
- In the past **year**, have you had 3 or more drinks of alcohol in a day? At those times, did you have 3 or more drinks in 3 hours? Did you do this 3 or more times in the past year? **IF YES TO ANY, CODE YES** NO YES → **L**
- **READ THE LIST BELOW** of street drugs or medicines.
- In the past year**, have you taken any of them more than one time to get high? To feel better or to change your mood? NO YES → **M**

amphetamines	speed	crystal meth	Dexedrine	Ritalin, diet pills
cocaine	crack	freebase	speedball	
heroin	morphine, methadone	opium	Demerol	codeine, Percodan, OxyContin, Vicodin
LSD	mescaline	PCP, angel dust	MDA,MDMA	ecstasy, ketamine
inhalants	glue	ether	GHB	steroids
THC, marijuana	cannabis, hashish	grass	weed, reefer	barbiturates, Valium, Xanax, Ativan

ASAS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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- **In the past month**, did you have movements of your body called ‘tics’? Tics are quick movements of some part of your body that are hard to control. A tic might be blinking your eyes over and over, twitches of your face, jerking your head, making a movement with your hand over and over, or squatting, or shrugging your shoulders over and over. NO YES → N
- Have you **ever** had a tic that made you say something or make a sound over and over and it was hard to stop it? Like coughing or sniffing or clearing your throat over and over when you did not have a cold; or grunting or snorting or barking; having to say certain words over and over, having to say bad words, or having to repeat sounds you hear or words that other people say? IF YES TO ANY, CODE YES NO YES → N
- Has anyone (teacher, baby sitter, friend, parent) ever complained about your behavior or academic performance? NO YES → O,P, Q
- In the past 6 months:**
- Have you often not paid enough attention to details? Made careless mistakes in school? NO YES → O
- Have you often had trouble keeping your attention focused when playing or doing homework? NO YES → O
- Have you often been told that you do not listen when others talk directly to you? NO YES → O
- Have you often tried to avoid things that make you concentrate or think hard (like school work)? Do you hate or dislike things that make you concentrate or think hard? IF YES TO EITHER, CODE YES NO YES → O
- Have you often lost or forgotten things you needed? Like homework assignments, pencils or toys? NO YES → O
- Do you often get distracted easily by little things (like sounds or things outside the room)? NO YES → O
- In the past year :**
- Have you been in trouble repeatedly? NO YES → P
- Have you bullied or threatened other people? NO YES → P
- Have you hurt or threatened someone (physically) on purpose? NO YES → P
- Have you hurt animals on purpose? NO YES → P
- Have you stolen things? NO YES → P
- Have you started fires on purpose? NO YES → P
- Have you lied many times in order to get things from people? NO YES → P
- Have you skipped school often? NO YES → P
- In the past 6 months:**
- Have you often argued with adults and refused to do what they asked you to do? NO YES → Q
- Have you often annoyed people on purpose? NO YES → Q
- Have you ever heard things other people couldn’t hear, such as voices? NO YES → R
- Have your friends or family ever thought any of your beliefs were strange or weird? NO YES → R
- How tall are you? \_\_\_\_\_ | inches
- What was your lowest weight in the past 3 months? \_\_\_\_\_ | lbs

ASAS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? **HEIGHT/WEIGHT TABLE BELOW CORRESPONDS TO A BMI THRESHOLD OF 17.5 KG/M<sup>2</sup>**

NO  YES

→ S

Height ft/in	3'0	3'1	3'2	3'3	3'4	3'5	3'6	3'7	3'8	3'9	3'10
Weight (lbs)	32	34	36	38	40	42	44	46	48	50	53
Height (cm)	91	94	97	99	102	104	107	109	112	114	117
Weight (kgs)	15	15	16	17	18	19	20	21	22	23	24
Height ft/in	3'11	4'0	4'1	4'2	4'3	4'4	4'5	4'6	4'7	4'8	4'9
Weight (lbs)	102	104	107	110	108	110	111	113	115	115	118
Height (cm)	119	122	125	127	130	132	135	137	140	142	145
Weight (kgs)	25	26	27	28	29	31	32	33	34	35	37
Height ft/in	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8
Weight (lbs)	84	87	89	92	96	99	102	105	108	112	115
Height (cm)	147	150	152	155	158	160	163	165	168	170	173
Weight (kgs)	38	39	41	42	43	45	46	48	49	51	52
Height ft/in	5'9	5'10	5'11	6'0	6'1	6'2	6'3				
Weight (lbs)	118	122	125	129	132	136	140				
Height (cm)	175	178	180	183	185	188	191				
Weight (kgs)	54	55	57	59	60	62	64				

➤ Have you lost 5 lbs. or more in the last 3 months?

NO  YES

→ S

➤ If you are less than age 14, have you failed to gain any weight in the last 3 months?

NO  YES

→ S

➤ Has anyone thought that you lost too much weight in the last 3 months?

NO  YES

→ S

➤ In the past **three months**, did you have eating binges or times when you ate a very large amount of food within a **2-hour** period?

NO  YES

→ T

➤ In the last **3 months**, did you have eating binges as often as twice a week?

NO  YES

→ T

➤ Have you worried **excessively** or been anxious about several things over the past 6 months?

NO  YES

→ U

➤ Are you stressed out about something? Is this making you upset or making your behavior worse?

NO  YES

→ V