COMPASS

HEADSS Assessment (ages 11-21 years)

HOME

Who lives in your home?

Are there any problems at your home?

Do you get along with the people in your home?

EDUCATION/EMPLOYMENT

What school do you go to?

What grade are you in?

How are your grades?

Do you work?

Do you have any problems at school?

What are your plans after high school?

ACTIVITIES

Who do you hang out with?

Are you in sports or other activities?

Do you wear a seatbelt?

Do you drive?

DRUGS

Do you or your friends use tobacco, alcohol or drugs?

Where do you and your friends mostly hang out?

SEXUALITY

Are you in a relationship?

Have you had sex?

How many partners?

What type of protection was used, if any?

Females: When was your last period (LMP)?

Do you perform breast self-exams (BSE)?

Males: Do you perform testicular self-exams (TSE)?

SUICIDE/DEPRESSION

Do you have trouble sleeping?

Do you have feelings of hopelessness?

Do you have a history of suicide attempt(s)?

Have you been treated for depression?

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	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. Trouble falling or staying asleep, or sleeping too much	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 figety 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
add columns			+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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