SOS Signs of Suicide® Prevention Program

Student Screening Form

- Age: _____
- Gender: □ Female □ Male
- Grade in School:
  □ 6 □ 7 □ 8 □ 9 □ 10
  □ 11 □ 12 □ GED Program
  □ Other:
- Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
- Race: *(Check all that apply)*
  □ American Indian/Alaska Native □ Asian
  □ Native Hawaiian/Other Pacific Islander □ White
  □ Black/African American □ Other/Multiracial
- Are you currently being treated for depression? □ Yes □ No

Brief Screen for Adolescent Depression (BSAD)*

These questions are about feelings that people sometimes have and things that may have happened to you. **Most** of these questions are about the ***LAST FOUR WEEKS.***

Read each question carefully and answer it by circling the correct response.

1. In the last four weeks, has there been a time when nothing was fun for you and you just weren't interested in anything?	**Yes**	**No**
2. Do you have less energy than you usually do?	**Yes**	**No**
3. Do you feel you can't do anything well or that you are not as good-looking or as smart as most other people?	**Yes**	**No**
4. Do you think seriously about killing yourself?	**Yes**	**No**
5. Have you tried to kill yourself ***in the last year?***	**Yes**	**No**
6. Does doing even little things make you feel really tired?	**Yes**	**No**
7. In the last four weeks has it seemed like you couldn't think as clearly or as fast as usual?	**Yes**	**No**

Identifying Trusted Adults

List a trusted adult you could turn to if you need help for yourself or a friend (example: "My English teacher," "counselor," my mother," "uncle," etc.)

In school _____

Out of school _____