SOS Signs of Suicide® Prevention Program

Student Screening Form

- Age: _____
- Gender:
  ☐ Female ☐ Male
  ☐ Transgender
- 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 the 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 _____