SOS Signs of Suicide® Prevention Program

Student Information

Name (First and Last): _____ Grade: _____

Teacher: _____

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**
7. 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 for a friend (example: "My English teacher," "counselor," "my mother," "uncle," etc.)

In School: _____ Out of School: _____

Based on the video and/or screening, I feel

- ○ I need to talk to someone today (emergency)…
- ○ I would like to talk to someone within the week (non-emergency)…
- ○ I do not need to talk to someone…

…ABOUT MYSELF OR A FRIEND