

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