Adolescent Media and Health Screening Form

Boston Children's Hospital
Digital Wellness Lab
Where the world comes for answers

Name: _____ Date: _____

PART A – Please answer the following questions

1. Has screen media use *seriously* affected your **sleep?**	*For example:* • Trouble falling asleep • Difficulty waking up in the morning • Going to bed late or waking up in the middle of the night • Being sleepy during the day	Yes ☐ No ☐
2. Has screen media use *seriously* affected your **school performance?**	*For example:* • Missing homework or poor quality homework • Dropping grades • Trouble paying attention in class • Missing school or not wanting to go to school	Yes ☐ No ☐
3. Has screen media use *seriously* affected your **social life?**	*For example:* • Spending less time with friends and/or family • Giving up favorite activities or hobbies • Spending more time alone • Fighting more with friends and/or family	Yes ☐ No ☐

If you answered "Yes" to any of the questions above, please complete the attached IAT-Revised Form. Otherwise, please complete Part B below

PART B – Please answer the following questions

Are you concerned about how your media use has affected:

1. The way you spend your time?	Yes ☐ No ☐
2. Your relationships with friends and family?	Yes ☐ No ☐
3. Your physical health?	Yes ☐ No ☐
4. Your mental health?	Yes ☐ No ☐
5. Any other part of your life?	Yes ☐ No ☐