HEADSS for Teens with Intellectual/Developmental Disability (HEADSS- IDD)

Home

- Who lives in your house? Do you have any pets? How do you all get along?
- What jobs do your parents or caregivers have?
- Have you moved recently?

Education and employment

- Do you like school? Are reading and math easy or hard for you? What class do you like?
- Do you have problems at school? Do you get in trouble? Does anyone bother you?
- Do you have an IEP or 504? Have you had a case conference this year?
- Are you planning to stay in school until age 22?
- Have you started to plan for after high school? Have you done any jobs?

Activities

- Are you on any teams, clubs or church groups? Do you do activities with your family?
- What exercise do you do?
- How long are you on a screen each day (TV, phone, tablet/computer)? What online games or social media do you use?
- Do you have friends? Do you ever do things with them when you are not at school?
- Does anyone ever say bad things to you or about you that make your angry or sad?
- What would you say if someone asked you to do something that was against the rules? (Drive a scooter that wasn't yours? Paint your name on a building?)
- What would you say if someone you didn't know asked to give you a ride home?

Drugs

- Do you imagine smoking when you are older? Have you tried to smoke or vape?
- Do you imagine drinking alcohol when you are 21? Have you tried any?
- What would you do if a friend gave you a pill to make you feel good? Have you tried any?
- Do you drink caffeine (in coffee, tea, soda, energy drinks?)

Sexuality/Abuse

- Are you interested in dating? Have you ever seen someone you liked? A girl or boy?
- Have you had a girlfriend or boyfriend before? Do you have one now?
- Have you ever had sex?
- Has anyone hit, slapped, pushed or hurt you? Has anyone tried to kiss you or have sex with you? Has anyone touched a private body part when you didn't want them to?
- Has anyone you trusted stopped you from doing something you needed? Has anyone kept you from using your wheelchair or other equipment?

Adapted from Goldenring J. HEADSS. Contemp Peds, 1988. Jenkins H. Adapted PHQ-9/GAD-7, 2025.
McFarlane J. Abuse Assessment Screen–Disability (AAS-D) 2001.
Center for Youth and Adults with Conditions of Childhood, 2025.

Sleep/Suicide/Depression/Anxiety

Adapted PHQ-9

1. Have you felt less interested in doing things?
2. Have you felt sad?
3. Have you had problems with your sleep? When do you go to sleep? When do you get up? Do you wake up during the night?
4. Have you been feeling tired? Do you take a nap?
5. Have you been more or less hungry than normal? What do you eat for breakfast, lunch, dinner, snacks? What do you drink during the day?
6. Have you been feeling like you are no good? Or have you let yourself or other people down?
7. Has it been hard to pay attention to things?
8. Have you been moving or speaking more slowly? OR moving or speaking a lot faster?
9. Have you had thoughts about: Hurting yourself on purpose? Killing yourself? Do you ever wish you weren't alive?

Adapted GAD-7

1. Have you been feeling worried?
2. Has it been hard to stop worrying?
3. Have you been worrying about lots of different things?
4. Has it been hard to relax?
5. Has it been hard to sit still?
6. Have you felt angry?
7. Have you felt scared?

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