

3171 N.E. Carnegie Drive, Suite A Lee's
Summit, MO 64064
P: (816) 525-2800 F: (816) 525-4077
www.summitdoctors.com

Dear Parent,

Thank you for contacting our office to request an evaluation of your child's behavioral or mental health.

We value being a part of your child's success in school, at home, and in life. If your child is struggling with symptoms such as hyperactivity, forgetfulness, impulsiveness, distractibility, and is having difficulty with attention at home or school, they need to complete a full evaluation for diagnosis and treatment.

Diagnosing ADHD requires a tremendous amount of background information and a substantial amount of time to diagnose and manage this chronic disorder. **PLEASE NOTE: DUE TO A SIGNIFICANT INCREASE IN EVALUATION REQUEST THIS PROCESS COULD TAKE A MINIMUM OF 2-4 MONTHS.** If your child needs immediate assessment, we recommend checking with your insurance to find other resources that may be able to provide this sooner.

To begin the evaluation, we are including screening questionnaires to assess behavior at home and in the classroom. Each section will indicate if the form is for parent(s) or teacher(s) to fill out. Filling out forms incorrectly may cause delays in evaluation. **These forms need to be completed fully and submitted as one COMPLETE packet by a parent. We are not able to continuously follow up on incomplete packets.**

Forms to be completed:

- Behavioral & ADHD Screening Intake Form
- Vanderbilt Assessment Scale
 - Parent- **1 from each parent.** *Opinions on interactions with your child may differ, it's important each parent/guardian fill out a form*
 - Teacher (1+) at least one, but two is preferred.
- SCARED Anxiety Assessment child form- parent can read form to child and assist in answering questions
- SCARED Anxiety Assessment parent form **1 from each parent**
- PHQ-9 Assessment (ages 12 and older, to be filled out by the child)
- GAD-7 Assessment (ages 12 and older, to be filled out by the child)

In addition, please also send the following if applicable.

Copies of report/grade cards Notes & emails from teachers

Copies of homework or assignments (if learning is a concern)

Copies of any previous evaluations including psychiatrist, psychologist, IEP (Individualized Education Plan) or 504 plans

To submit completed paperwork, please fax to (816) 525-4077, upload to your child's patient portal (recommended), or deliver to the office. Please include "attention: ADHD coordinator." We also ask for your patience as we score and review your child's forms. We will contact you to schedule a behavioral consultation once these forms are reviewed by your physician.

We understand that your time is important, please make all follow-up appointments months in advance. Your child's yearly checkup well visit also needs to be completed separately to allow for a thorough exam and focus on overall health.

Kindest regards,

Tamara Peterson, DO

Sara Myers, MD

Quyen dam, MD

Mandi Menard, DO Kailey

Wilson, DO

Adam Grumke, MD

CURRENT MEDICATIONS:

PRESCRIPTION _____

OVER THE COUNTER _____

SUPPLEMENTS _____

PRENATAL HISTORY LIST ALL OF MOTHER'S PREGNANCIES – INCLUDE MISCARRIAGES

YEAR	SEX	LENGTH OF PREGNANCY	BIRTH WEIGHT	VAGINAL/ C-SECTION	COMPLICATIONS
1)	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY

PRENATAL: CHECK ANY OF THE FOLLOWING WHICH OCCURRED DURING THE PREGNANCY OF THIS CHILD:

- ___ HIGH BLOOD PRESSURE ___ HIGH FEVER ___ HOSPITALIZATION
- ___ INFLUENZA ___ VAGINAL BLEEDING ___ ACCIDENTS / FALLS
- ___ INFECTIONS ___ AMNIOCENTESIS

CHECK ANY MEDICATIONS / SUBSTANCES USED DURING THE PREGNANCY OF THIS CHILD:

- ___ ANTIBIOTICS ___ PRENATAL VITAMINS ___ OTC COLD MEDICINE
- ___ SEIZURE MEDICATION ___ THYROID MEDICATION ___ TOBACCO
- ___ MARIJUANA ___ ALCOHOL ___ AMPHETAMINES
- ___ COCAINE ___ OTHER _____

BIRTH HISTORY: WAS THIS CHILD BORN PREMATURE? YES / NO

IF YES, WHAT WAS GESTATION _____ WEEKS _____ DAYS MATERNAL AGE AT DELIVERY _____

APGAR SCORES: 1 MIN _____ 5 MIN _____ LABOR: _____ INDUCED _____ SPONTANEOUS _____ GENERAL ANESTHESIA

NEWBORN PROBLEMS:

- ___ ANEMIA ___ JAUNDICE ___ PHOTOTHERAPY ___ NEEDED OXYGEN ___ INFECTION
- ___ HOSPITALIZED IN NICU OR SPECIALTY CARE OR ANY VENTILATOR USE? _____

PREVIOUS DIAGNOSIS

- ___ CHRONIC EAR INFECTIONS ___ HEARING PROBLEMS ___ ASTHMA
- ___ EYE PROBLEMS ___ SINUS INFECTIONS ___ TIC DISORDER
- ___ MENINGITIS ___ SEIZURES ___ PROLONGED OR HIGH FEVER
- ___ IRON DEFICIENCY ___ HEART MURMUR ___ HEART PALPITATIONS
- ___ HIGH BLOOD PRESSURE ___ HEADACHES ___ ENLARGEMENT OF ADENOIDS/TONSILS
- ___ ABDOMINAL PAIN ___ CHRONIC CONSTIPATION ___ CHRONIC DIARRHEA
- ___ HEAD TRAUMA / CONCUSSION ___ SPEECH / LANGUAGE DELAYS OR DIFFICULTIES

PAST SURGICAL HISTORY

SURGERY PERFORMED _____

DATE OF SURGERY _____

NAME OF SURGEON AND/OR FACILITY _____

STRESSORS (FAMILY STRESS OR PROBLEMATIC RELATIONSHIPS, BULLYING, SOCIAL PRESSURES, ETC)

IF ANY PLEASE EXPLAIN _____

DEVELOPMENT AGE OF CHILD NOW: _____ (INDICATE BELOW WHEN YOUR CHILD WAS ABLE TO PERFORM EACH SKILL)

_____ SAT WITHOUT SUPPORT

_____ SPOKE SINGLE WORDS

_____ TIED SHOELACES

_____ CRAWLED

_____ UNDRESSED SELF

_____ FED SELF WITH SPOON

_____ WALKED

_____ PEDALED TRICYCLE

_____ SPOKE SENTENCES

WAS HE/SHE A "CUDDLY" BABY? _____ WAS HE/SHE AN "ACTIVE" BABY? _____

WAS HE/SHE A "COLIC" BABY? _____

TOILET TRAINING: AGE WHEN TOILET TRAINING WAS STARTED _____ AGE COMPLETED _____

DOES YOUR CHILD HAVE ACCIDENTS DURING THE DAY OR NIGHT? _____

SLEEP HABITS:

AGE CHILD BEGAN SLEEPING THROUGH THE NIGHT _____

CURRENT BEDTIME _____ CURRENT WAKE UP TIME _____ WHERE DOES CHILD SLEEP _____

ANY CHANGES IN SLEEP IN THE PAST 6 MONTHS? _____

_____ NIGHT WAKING _____ NIGHTMARES OR NIGHT TERRORS _____ SLEEPWALKING _____ RESTLESS SLEEP

_____ DIFFICULTY FALLING ASLEEP _____ APNEA (PAUSE IN BREATHING) _____ DAYTIME SLEEPINESS

_____ WHAT ELECTRONICS ARE IN BEDROOM? _____

APPETITE:

_____ EATS CONSTANTLY _____ AVERAGE _____ PICKY EATER _____ CAFFEINE USE

_____ WEIGHT LOSS OR WEIGHT GAIN, WHY? _____

PROBLEMS AT MEALTIME: _____

JOBS/RESPONSIBILITIES

_____ CHORES: PLEASE LIST _____

DOES YOUR CHILD COMPLY WITH DOING RESPONSIBILITIES AND CHORES? _____

PLAY

WHO ARE YOUR CHILD'S BEST FRIENDS? _____

IS YOUR CHILD THE BEST FRIEND OF SOMEONE ELSE? _____

FAVORITE ACTIVITIES _____

DISCIPLINE

_____ SPANKING _____ TIME OUT _____ SEND TO ROOM _____ WITHHOLD PRIVILEGES _____ REASONING

WHAT METHOD IS MOST EFFECTIVE? _____

DO PARENTS AGREE ON DISCIPLINE? EXPLAIN _____

ACEDMIC HISTORY

CHILD'S BEHAVIOR

PRESCHOOL	_____ GOOD	_____ AVERAGE	_____ POOR
KINDERGARTEN	_____ GOOD	_____ AVERAGE	_____ POOR
GRADES 1-3	_____ GOOD	_____ AVERAGE	_____ POOR
CURRENT GRADE	_____ GOOD	_____ AVERAGE	_____ POOR

_____ SCHOOL FAILURE OR REPEATED GRADE LEVEL _____ PROBLEM WITH PREFORMANCE ON STANDARDIZED TESTS

_____ CONCERN FOR LEARNING DISABILITY _____ DETENTION, SUSPENSION, OR EXPULSION

DOES YOUR CHILD HAVE OR EVER HAD AN IEP (INDIVIDUALIZED EDUCATION PLAN) OR A 504 PLAN? _____ YES _____ NO

IF YES, WHEN WAS IT LAST UPDATED? _____

REVIEW OF SYSTEMS HAS YOUR CHILD EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING (elaborate please):

CARDIAC:

_____ CHEST PAIN _____ SHORTNESS OF BREATH WITH EXERCISE _____ PALPITATIONS

_____ FAINTING / DIZZINESS WITH EXERCISE _____ UNEXPLAINED OR NOTICABLE CHANGE IN EXERCISE TOLERANCE

NEUROLOGIC:

_____ RESTLESS LEG SYNDROME OR PERIODIC LIMB MOVEMENT DISORDER _____ SEIZURES

_____ LEARNING DIFFICULTIES _____ DEVELOPMENTAL DELAY

PSYCHIATRIC:

_____ ANXIETY _____ DEPRESSION _____ OPPOSITIONAL-DEFIANT DISORDER _____ CONDUCT DISORDER

_____ DISRUPTIVE BEHAVIOR _____ SUICIDAL THOUGHTS/ACTIONS _____ DELUSIONS _____ MOOD INSTABILITY

_____ SUBSTANCE USE (CIGARETTES, ALCOHOL, DRUGS, PRESCRIPTION MEDICATIONS)

Comments on above items: _____

PREVENTATIVE SCREENINGS

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING STUDIES?

_____ EKG _____ ECHOCARDIOGRAM _____ GENETIC SCREENING _____ SLEEP STUDY

IF SO, WHERE? _____

FAMILY MEDICAL HISTORY

	YES	NO	WHO? Mother (of patient), Father (of patient) Sibling (specify who), Maternal / Paternal Grandfather or grandmother (of patient), Maternal / Paternal Aunt or Uncle (of patient)	Comments: Age diagnosed (if known)
ADHD				
ANEMIA				
ARRYTHMIA				
ASTHMA				
CANCER (specific type)				
CARDIOMYOPATHY				
CONGENITAL BIRTH DEFECTS (specify)				
DEVELOPMENTAL DISABILITY				
DIABETES (specify type)				
DRUG ALLERGY				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HEART DISEASE (details if known)				
HEART ATTACK				
KIDNEY DISEASE				
LEARNING DELAY OR DISABILITY				
MENTAL ILLNESS/DEPRESSION (specify)				
MIGRAINES				
SEIZURES				
STROKE				
SUBSTANCE USE/ABUSE				
SUDDEN DEATH <35 YEARS OF AGE				
THYROID DISORDERS (specify type)				
OTHER:				

**CLINICAL CARDIAC SCREEN PRIOR TO INITIATING STIMULANT PRESCRIPTION
MEDICATION**

The following clinical screen is unofficial and not formally endorsed, but is used by some pediatric psychiatrists when screening patients for whom initiation of psycho-stimulant medication is being considered in treating ADHD

Respond with yes or no if you're not sure mark a 0

_____ At any time in your child's life, has any doctor told you that your child has an abnormality of the heart?

_____ Has your child had an illness that affected the heart? If so, what was the illness?

_____ At any time, has any doctor told you there is a heart murmur? If yes, what was done about it? _____

_____ Has your child complained about the heart skipping beats?

_____ Has any doctor said your child has irregular heartbeats?

_____ Has your child fainted; if yes, how many times? _____

_____ Do any blood relatives have heart trouble? If yes, what kind and who?

_____ Do any blood relatives have trouble with irregular heartbeats? If yes, do they take medication or wear a pacemaker? _____

What is their age? _____

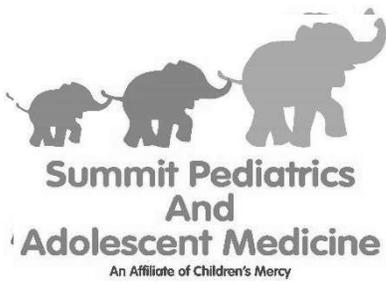
_____ Have any blood relatives died suddenly? At what age and who?

Cause of death (if known) _____

*Source: Child Psychopharmacology listserv - contributing Child/Adolescent Psychiatrist
May 12, 2009*

Transcribed by Samuel Zinner, MD – University of Washington

CAUTION: Neither Dr. Zinner nor any member of the Child Psychopharmacology listserv is not responsible for the contents of this screening instrument. This screening tool has been provided only as a clinical suggestion prepared by an anonymous member the referenced listserv.



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ADHD MEDICATION RULES

- ✓ Medications used to treat attention deficit disorders are controlled medications requiring a written or electronic prescription.
- ✓ CMSP physicians WILL NOT replace lost/misplaced prescriptions for ADHD medications.
- ✓ Renewals for ADHD prescriptions require at least a **72-hour notice** to allow sufficient time to e-prescribe the prescriptions as well as to allow time for the pharmacy to fill the prescription and possibly order your specific medication. Generally, 3-4 electronic prescriptions will be sent to the pharmacy of your choice once patient is stable on medication. Please contact the pharmacy to obtain your refills. After your last refill, then please contact Summit Pediatrics to obtain another set of refills or to schedule an office visit if necessary.
- ✓ ADHD Medications may cause weight loss, so we **MUST** monitor your child's weight periodically.

ADHD APPOINTMENT/FOLLOW-UP OUTLINE AND RULES

- ✓ All ADHD appointments are scheduled with the physician who writes your child's ADHD prescriptions.
- ✓ A "NO-SHOW" for an ADHD appointment may result in your child running out of medication. Each physician has a limited number of ADHD appointments available. It is imperative that you honor scheduled appointments.
- ✓ Your **INSURANCE COMPANY'S RULES** related to Co-Pays, Co-Insurance and/or deductibles apply to all ADHD physician visits and ADHD Weight Checks.

WHEN WILL MY CHILD NEED A FOLLOW-UP APPOINTMENT?

3 weeks	After starting a new medication, to evaluate dosage, side-effects and provide additional prescriptions. May need to continue monthly visits until your child is stable on a medication dose.
3 MONTHS Once stable	Weight check and obtain additional prescriptions. This is important for compliance with drug monitoring even if your child is not completely out of medication.
6 MONTHS Once stable	An interval visit with your child's prescribing physician. Includes weight check, evaluation of side-effects, effectiveness of medication dosage and providing additional prescriptions.
12 MONTHS	Annual re-evaluation of status of ADHD, medication effectiveness, side effects, etc. This visit is with the prescribing physician; good to schedule in summer. This is not generally combined with annual well check.

I understand that if I fail to comply with this agreement, the physician may discontinue medication and/or treatment.

Patient Name: _____ DOB: _____

Parents signature: _____ Date: _____

NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Name: _____

Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child

was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Has difficulty keeping attention to what needs to be done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does not seem to listen when spoken to directly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Has difficulty organizing tasks and activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Is easily distracted by noises or other stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Is forgetful in daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<small>For Office Use Only 2 & 3s: ___/9</small>				
10. Fidgets with hands or feet or squirms in seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Leaves seat when remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Runs about or climbs too much when remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Has difficulty playing or beginning quiet play activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Is "on the go" or often acts as if "driven by a motor"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Talks too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Blurts out answers before questions have been completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Has difficulty waiting his or her turn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Interrupts or intrudes in on others' conversations and/or activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<small>For Office Use Only 2 & 3s: ___/9</small>				

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
20. Loses temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
21. Actively defies or refuses to go along with adults' requests or rules	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
22. Deliberately annoys people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
23. Blames others for his or her mistakes or misbehaviors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
24. Is touchy or easily annoyed by others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
25. Is angry or resentful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
26. Is spiteful and wants to get even	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For Office Use Only 2 & 3s: /8
27. Bullies, threatens, or intimidates others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
28. Starts physical fights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
30. Is truant from school (skips school) without permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
31. Is physically cruel to people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
32. Has stolen things that have value	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
33. Deliberately destroys others' property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
35. Is physically cruel to animals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
36. Has deliberately set fires to cause damage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
37. Has broken into someone else's home, business, or car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
38. Has stayed out at night without permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
39. Has run away from home overnight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
40. Has forced someone into sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For Office Use Only 2&3s: /14
41. Is fearful, anxious, or worried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
42. Is afraid to try new things for fear of making mistakes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
43. Feels worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
44. Blames self for problems, feels guilty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
46. Is sad, unhappy, or depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
47. Is self-conscious or easily embarrassed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For Office Use Only 2 & 3s: /7

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading	<input type="radio"/>					
49. Writing	<input type="radio"/>	For Office Use Only 4s: /3				
50. Mathematics	<input type="radio"/>	For Office Use Only 5s: /3				
51. Relationship with parents	<input type="radio"/>					
52. Relationship with siblings	<input type="radio"/>					
53. Relationship with peers	<input type="radio"/>	For Office Use Only 4s: /4				
54. Participation in organized activities (eg, teams)	<input type="radio"/>	For Office Use Only 5s: /4				



Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1. **Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.
 No tics present. Yes, they occur nearly every day but go unnoticed by most people. Yes, noticeable tics occur nearly every day.
2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, or repetition of words or short phrases.
 No tics present. Yes, they occur nearly every day but go unnoticed by most people. Yes, noticeable tics occur nearly every day.
3. If **YES** to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? No Yes

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

1. Has your child been diagnosed with a tic disorder or Tourette syndrome? No Yes
2. Is your child on medication for a tic disorder or Tourette syndrome? No Yes
3. Has your child been diagnosed with depression? No Yes
4. Is your child on medication for depression? No Yes
5. Has your child been diagnosed with an anxiety disorder? No Yes
6. Is your child on medication for an anxiety disorder? No Yes
7. Has your child been diagnosed with a learning or language disorder? No Yes

Comments:

NICHQ Vanderbilt Assessment Scale: Teacher Informant

Child's Name: _____

Child's Date of Birth: _____

Teacher's Name: _____

Today's Date: _____

Class Time: _____

Class Name/Period: _____

Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
<small>For Office Use Only</small>				
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes in on others (eg, butts into conversations/games)	0	1	2	3
<small>For Office Use Only</small>				
				/9



Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Loses temper	0	1	2	3	
20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3	
21. Is angry or resentful	0	1	2	3	
22. Is spiteful and vindictive	0	1	2	3	
23. Bullies, threatens, or intimidates others	0	1	2	3	
24. Initiates physical fights	0	1	2	3	
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3	
26. Is physically cruel to people	0	1	2	3	
27. Has stolen items of nontrivial value	0	1	2	3	
28. Deliberately destroys others' property	0	1	2	3	For Office Use Only _____/10
29. Is fearful, anxious, or worried	0	1	2	3	
30. Is self-conscious or easily embarrassed	0	1	2	3	
31. Is afraid to try new things for fear of making mistakes	0	1	2	3	
32. Feels worthless or inferior	0	1	2	3	
33. Blames self for problems; feels guilty	0	1	2	3	
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3	
35. Is sad, unhappy, or depressed	0	1	2	3	For Office Use Only _____/7

Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
36. Reading	1	2	3	4	5	
37. Mathematics	1	2	3	4	5	For Office Use Only 4s: ____/3
38. Written expression	1	2	3	4	5	For Office Use Only 5s: ____/3

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
39. Relationship with peers	1	2	3	4	5	
40. Following directions	1	2	3	4	5	
41. Disrupting class	1	2	3	4	5	
42. Assignment completion	1	2	3	4	5	For Office Use Only 4s: ____/5
43. Organizational skills	1	2	3	4	5	For Office Use Only 5s: ____/5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Patient Name: _____

Date of Birth: _____

Date: _____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I get headaches when I am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I don't like to be with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I get scared if I sleep away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I worry about other people liking me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When I get frightened, I feel like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I am nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I follow my mother or father wherever they go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. People tell me that I look nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I feel nervous with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I get stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. When I get frightened, I feel like I am going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I worry about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I worry about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. When I get frightened, I feel like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I have nightmares about something bad happening to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I worry about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. When I get frightened, my heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I get shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I have nightmares about something bad happening to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

Patient Name: _____

Date of Birth: _____

Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. When I get frightened, I sweat a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I am a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I get really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I am afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. It is hard for me to talk with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. When I get frightened, I feel like I am choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. People tell me that I worry too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I don't like to be away from my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I am afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. I worry that something bad might happen to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I feel shy with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. I worry about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. When I get frightened, I feel like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. I worry about how well I do things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. I am scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. I worry about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. When I get frightened, I feel dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. I am shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 To be filled out by both PARENTS

ONE PER PARENT

Parent Name: _____

Patient Name: _____

Date of birth: _____

Date: _____

Directions:

Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. My child gets headaches when he/she is at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My child doesn't like to be with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. My child gets scared if he/she sleeps away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. My child worries about other people liking him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When my child gets frightened, he/she feels like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. My child is nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. My child follows me wherever I go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. People tell me that my child looks nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. My child feels nervous with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. My child gets stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. When my child gets frightened, he/she feels like he/she is going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. My child worries about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. My child worries about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. When he/she gets frightened, he/she feels like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. My child has nightmares about something bad happening to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. My child worries about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. When my child gets frightened, his/her heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. He/she gets shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. My child has nightmares about something bad happening to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 To be filled out by both PARENTS

ONE PER PARENT

Parent Name: _____

Patient Name: _____

Date of birth: _____

Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. When my child gets frightened, he/she sweats a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. My child is a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. My child gets really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. My child is afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. It is hard for my child to talk with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. When my child gets frightened, he/she feels like he/she is choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. People tell me that my child worries too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. My child doesn't like to be away from his/her family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. My child is afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. My child worries that something bad might happen to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. My child feels shy with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. My child worries about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. When my child gets frightened, he/she feels like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. My child worries about how well he/she does things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. My child is scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. My child worries about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. When my child gets frightened, he/she feels dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. My child is shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>