

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.

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 parents(s) or teacher(s) to fill out.

Forms included in this packet:

- Behavioral & ADHD Screening Intake Form
- Vanderbilt Assessment Scales
 - Parent (2) **(one from EACH parent/guardian)**. It's important to have EACH perspective!
 - Teacher (1+). *If your child is not in public school a non-family figure such as coach, dance teacher, etc. might be able to fill in for the teacher form.
- BEARS sleep screener.
- SCARED Anxiety Assessment (ages 8-+ years, for the child to fill out & one for **EACH parent/guardian** to fill out)
 - 8-11 year, the child form is best done with parents reading about 5 questions at a time.
- PHQ-9 Assessment (ages 12 years or older, for the child to fill out)
- GAD-7 Assessment (age 13 years or older, for the child to fill out)
- Short Mood and Feelings Questionnaire (age 6-11 years, one for child plus at least one parent version)

The forms listed above need to be completed fully and submitted as one COMPLETE packet by a parent. 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, 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.

Appointment availability varies from 1-4 months **after** turning in the **entire** completed packet.

Diagnosing ADHD requires a tremendous amount of background information and management of this chronic disorder requires follow-up at designated intervals in the office. 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

PRIOR TREATMENT / SERVICES

WHERE WERE SERVICES COMPLETED

NAME OF SERVICE PROVIDER

_____ COUNSELING OR THERAPY	_____	_____
_____ IEP, 504 PLAN, OR IQ testing	_____	_____
_____ RESOURCE ROOM/SAFE SEAT	_____	_____
_____ BEHAVIOR EVALUATION	_____	_____
_____ LEARNING DISORDER EVALUATION	_____	_____
_____ ALREADY DIAGNOSED WITH ADHD	_____	_____
_____ DIAGNOSED OTHER MENTAL HEALTH	_____	_____
_____ MENTAL HEALTH HOSPITALIZATION	_____	_____

CURRENT MEDICATIONS:

PRESCRIPTION _____

OVER THE COUNTER _____

SUPPLEMENTS _____

SUBSTANCE USE of your child/adolescent:

	Type	Average Usage	Current	Past	When Last Used
Caffeine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nicotine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

STRESSORS (FAMILY STRESS OR PROBLEMATIC RELATIONSHIPS, BULLYING, SOCIAL PRESSURES, ETC. EXPLAIN IF ANY)

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 OR NICU ANTIBIOTICS? _____

PREVIOUS DIAGNOSIS OF:

_____ 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
_____	____/____/____	_____
_____	____/____/____	_____

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 _____ UNRESSED 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? _____

WHO HELPS YOUR CHILD REMEMBER VITAMINS OR MEDICATION: _____

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 _____

ACADEMIC HISTORY

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

CHILD’S BEHAVIOR IN SCHOOL

_____ AVERAGE _____ POOR
_____ AVERAGE _____ POOR
_____ AVERAGE _____ POOR
_____ AVERAGE _____ POOR

_____ SCHOOL FAILURE OR REPEATED GRADE LEVEL _____ PROBLEM WITH PERFORMANCE 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? _____

CURRENT SCHOOL, DISTRICT, & GRADE _____

IF HOMESCHOOLED, IS YOUR CHILD IN SPORTS, DANCE, OR OTHER EXTRACURRICULAR ACTIVITIES? IF SO, INDICATE WHAT AND HOW MANY TIMES PER WEEK: _____

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

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 (please specify if a concern or already diagnosed):

_____ 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? _____

TREATMENT CONCERNS:

IF YOUR CHILD MEETS THE CRITERIA FOR ADHD OR ANOTHER MENTAL HEALTH CONDITION, ARE YOU FAMILIAR WITH:

OCCUPATIONAL THERAPY (EXECUTIVE FUNCTION): _____ YES / _____ NO

PARENT TRAINING IN BEHAVIOR MANAGEMENT: _____ YES / _____ NO

NON-STIMULANT MEDICATION FOR ADHD: _____ YES / _____ NO

STIMULANT MEDICATION FOR ADHD: _____ YES / _____ NO

MEDICATION FOR MENTAL HEALTH: _____ YES / _____ NO

IF A FAMILY MEMBER HAS ADHD OR ANOTHER MENTAL HEALTH CONDITION, WHAT MEDICATION WORKS FOR THEM:

AND WHAT DID NOT WORK FOR THE FAMILY MEMBER _____

CAN YOUR CHILD SWALLOW PILLS OR CAPSULES _____ YES / _____ NO

CLINICAL CARDIAC SCREEN PRIOR TO POTENTIAL USE OF STIMULANT PRESCRIPTION MEDICATION

Respond with "Yes" or "no." if you are 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 and what age? _____

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

_____ Has your child complained about the heart skipping beats?

_____ Has any doctor said your child has an irregular heartbeat?

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

_____ Do any blood relatives have heart trouble? If yes, what kind, who is it, and what age was it diagnosed? _____

_____ Do any blood relatives have trouble with irregular heartbeats or arrhythmias? If yes,

Do they take medication or have a pacemaker? _____

What age was it diagnosed, and their current age? _____

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

Cause of death (if known) _____

BEARS Questionnaire

BEARS is a user-friendly screening tool to help identify sleep problems in children. Ask yourself these questions.

B - Bedtime

Does my child have trouble going to bed? Or trouble falling asleep? _____

E - Excessive Daytime Sleepiness

Is my child difficult to wake up in the morning? _____

Does my child seem sleepy or groggy during the day? _____

Does my child often seem tired during the day? (In children, tired may mean moody, hyperactive, "out-of-it," as well as sleepy.) _____

A - Awakening

During the Night Does my child awaken during the night and have trouble going back to sleep? _____

Is anything else interrupting my child's sleep? _____

R - Regularity and Duration of Sleep

How many hours of sleep does my child need at this age? _____

What time does my child go to bed and get up on weekdays? _____

On weekends? _____

Does this allow my child to get enough sleep every day? _____

S - Snoring

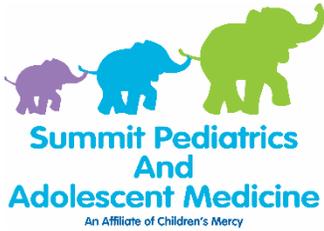
Does my child snore? _____ Loudly? _____ Every Night? _____

Does my child stop breathing, gasp, or choke during sleep? _____

If you answered "yes" to any of these questions, your child may have a sleep problem that should be discussed with your pediatrician or pediatric sleep specialist.

FAMILY MEDICAL HISTORY (update for ADHD or behavioral evaluation visit)

	Person with condition – Parent, sibling of child, mom/dad side aunt/uncle, or mom/dad side grandma/grandpa (please indicate how related)	Age of diagnosis (if known)
Sudden death before 40 yrs old		
ADHD		
Learning Disorders		
Speech delay		
Reading problems		
Autism		
Cardiomyopathy		
Criminal behavior		
Anxiety		
Depression		
Bipolar disorder		
Schizophrenia		
Alcoholism		
Drug/substance use		
Migraines		
Seizures		
Tics or Tourette disorder		
Thyroid disorder		
Sleep disorder		
Suicide attempts		
Post traumatic stress disorder		
Obsessive compulsive disorder		
Other family mental illness		



BEHAVIORAL & MENTAL HEALTH MEDICATION RULES

- ✓ We agree to take the medication **ONLY** as prescribed and will not change the dose without getting approval from our physician or provider.
- ✓ We agree not to share, sell, or otherwise dispense this medication to anyone else.
- ✓ We agree not to seek ADHD/mental health medicine from any other source, including other physicians, emergency departments, or clinics unless there is a safety emergency.
- ✓ Medications are sent electronically to the pharmacy. Children's Mercy Summit Pediatrics will not replace lost/misplaced medications unless medically necessary.
- ✓ Renewals for prescriptions require a **72-hour notice** to allow sufficient time for your physician to be in office to send the prescription. Patients receive up to three electronic prescriptions at a time, each to be filled 30 days apart. You should contact your pharmacy first to see if any of these prescriptions are in the system there. In the very rare event of a paper prescription the parent should be the one picking up the prescription.
- ✓ Prescription Refill requests: You can request refills at any time in your patient portal. You may also call our Patient Care Coordinator during business hours to request refills. In your message, please specify which pharmacy you would like your prescription sent to and update the pharmacy in the portal if needed. Requests are typically addressed the next business day that your physician is at work. Prescriptions will not be filled outside of office hours. Prescriptions will not be sent elsewhere than Missouri/Kansas/mail-order pharmacies.
- ✓ Should there ever be a change in dosage or medication, we agree to dispose of any unused medication from previous prescriptions according to the guidelines that were provided by Summit Pediatrics – see attached.

BEHAVIORAL & MENTAL HEALTH MEDICATION RISKS

- ✓ We understand this medication has potential side effects. These side effects include but are not limited to appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping. There may be a need for extra visits beyond the guidelines below.
- ✓ We understand this medication is potentially addictive and chances of addiction are less if the medications are closely monitored by our doctor or clinician and taken as directed. This requires regular office visits to follow progress.
- ✓ We agree that this medication will be stopped if our child's ability to function does not improve, if the medication loses its effectiveness, if we do not attend required office appointments, or if there is reason to believe someone is misusing the medication in any way.
- ✓ We have had the risks associated with taking this medication explained to me and have decided that the benefits outweigh the risks. We understand the medication is not a cure.
- ✓ If our child is unable to take the medication due to allergic reaction, other adverse reaction, or any other reason then we will notify the prescriber and discard the remainder.

Patient name: _____

DOB: _____

Parent's signature: _____

Date: _____

BEHAVIORAL & MENTAL HEALTH APPOINTMENT/FOLLOW-UP OUTLINE AND RULES

- ✓ All appointments are scheduled with the physician who writes your child’s prescriptions.
- ✓ A “NO-SHOW” for a behavioral/mental health appointment may result in your child running out of medication. Each physician has a limited number of such appointments available. It is necessary that you attend scheduled appointments.

2-3 WEEKS	After starting a new medication or any changes in medication dosing, an in-person appointment will be needed to evaluate dosage, side-effects, and provide additional prescriptions.
3-6 months	A routine follow-up visit with your child’s prescribing physician. Includes weight check, evaluation of side-effects, effectiveness of the medication dosage, and providing electronic prescriptions. Once the medicine and dose are stable it is common to have this visit every 6 months. If it has been more than 6 months since your last medication check appointment, prescriptions may not be filled.
1 PER YEAR	A separate yearly checkup appointment to evaluate general health and well-being not part of the behavioral or mental health appointments. If not up to date on yearly well checks, prescriptions may not be sent.

- ✓ We will remain up to date on routine yearly Well Exams separate from the ADHD/mental health visits.
- ✓ We realize our clinician has a limited number of ADHD/mental health appointments available. Our insurance company’s rules related to Co-Pays, Co-Insurance and/or deductibles apply to all behavioral/mental health physician visits and Weight Checks.
- ✓ We authorize Summit Pediatrics to review medication information with other doctors, hospitals, and pharmacists; additionally, to contact any groups and organizations involved with my care and involved with the investigation of medication and drug abuse. We give permission to my provider to discuss my care with past caregivers, all pharmacies, and policing agencies.
- ✓ If there are frequent cancellations, failure to comply with any of the above, or failure to comply with treatment recommendations made during visits, we agree that prescriptions will no longer be provided by Summit Pediatrics and we will need to transfer mental health care to another provider.
 - Not limited to 3 or more no show visits or cancellations of less than 24-hour notice
 - A 30-day courtesy prescription will be provided if Summit Pediatrics receives the new doctor’s record request with the date of the 1st appointment there.

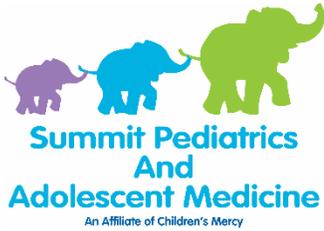
We understand that if we fail to comply with this agreement, Summit Pediatrics physicians may no longer prescribe medication and/or treatment.

Patient name: _____

DOB: _____

Parent’s signature: _____

Date: _____

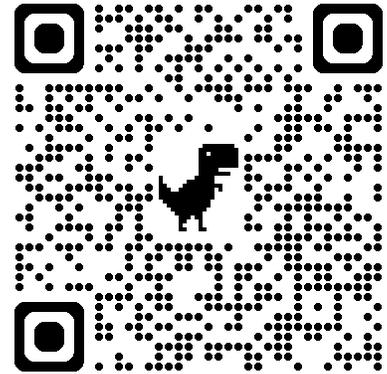


Handling of Your Medication

_____ (initial) Medications should be given as prescribed and discussed with your physician. The dose should not be changed at home without first discussing with your physician.

_____ (initial) Stimulant medication are easily abused. These and other behavioral and mental health medications are best stored in a locked box. You should notify the office if the medication is lost, stolen, or damaged beyond use. However, replacement prescriptions are not provided. Example information on a lockbox can be viewed by scanning this QR code.

_____ (initial) Inappropriate handling of medication may require transfer of ADHD, behavioral, or mental health care to another office. Courtesy prescriptions may not apply in this scenario. In the event of suspected abuse or misuse of certain prescriptions, Summit Pediatrics may be required to file a police report in addition to requiring transfer of care.



As part of our commitment to your health and safety, we would like to provide you with valuable information regarding the proper disposal of medications.

The improper disposal of medications can pose risks to individuals, pets, and the environment. Therefore, it is crucial to follow proper guidelines for their disposal.

To ensure the safe and responsible disposal of medications, please consider the following steps:

- **DO NOT FLUSH:** Do not flush medications down the toilet or drain, as this can contribute to water contamination.
- **REMOVE PERSONAL INFORMATION:** Before disposing of the medication packaging, be sure to remove any personal information to protect your privacy.
- **MEDICATION DISPOSAL LOCATIONS (subject to change):**

CVS Pharmacy	3201 South 7 Highway Blue Springs, MO
CVS Pharmacy	3825 South Noland Rd. Independence, MO
Wal-Mart Pharmacy	1000 NE Sam Walton Lane Lee's Summit, MO
Wal-Mart Pharmacy	4000 S Bolger Drive Independence, MO
Wal-Mart Pharmacy	1700 North 7 Highway Blue Springs, MO
Wal-Mart Pharmacy	3411 South Noland Rd. Independence, MO
Hy-Vee Pharmacy	Langsford Landing Lee's Summit, MO
Hy-Vee Pharmacy	625 SW Highway 40 Blue Springs, MO
Saint Luke's East Hospital	100 NE Saint Lukes Blvd. Lee's Summit, MO
- **DEA DRUG TAKE-BACK EVENTS:** The Drug Enforcement Administration (DEA) periodically hosts National Prescription Drug Take-Back Events. Please visit the DEA website (www.deadiversion.usdoj.gov) for information on upcoming events or other authorized collection sites. Your local police department/city hall may occasionally offer drug take back events as well.

Patient name: _____

DOB: _____

Parent's signature: _____

Date: _____

- **HOUSEHOLD TRASH:** If no other options are available, you may dispose of the medication in your household trash. However, take precautions to make the medication less appealing to children and pets. Mix the medication with an undesirable substance (e.g., coffee grounds or cat litter) in a sealed plastic bag before placing it in the trash.

By following these guidelines, you are contributing to the safety of your community and the environment. If you have any questions or concerns regarding the disposal of your medications, please do not hesitate to contact our office at 816-525-2800. Thank you for your attention to this matter. Your commitment to responsible medication disposal is an essential part of promoting a healthy and safe community.

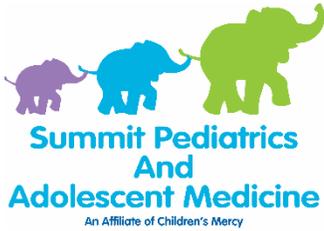
We agree to properly dispose of previously prescribed ADHD medication when the dose changes, the brand/form of the medication changes, or my child is no longer receiving ADHD care at Summit Pediatrics.

Patient name: _____

DOB: _____

Parent's signature: _____

Date: _____



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Parental Consent Form to the School

I hereby give permission to (child's school) _____
to release information regarding my child's grades, test scores, psychoeducational status, and teacher reports
for clinical use by Children's Mercy Summit Pediatrics.

I understand that the teacher will be asked to complete questionnaires regarding my child's academic
performance, limitations (if any), behavior problems (if any), and placement in special programs (if applicable).

The above name pediatric clinic also has my permission to discuss any findings and treatment
recommendations with the designated school personnel.

I am aware that the information will be kept highly confidential and reviewed only by the necessary
professionals, I understand that releasing individually identifiable information about my child requires written
consent, except as otherwise requires by law.

I have been informed that I may withdraw this consent at any time.

Parents Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Name: _____

School: _____

School District: _____

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	0	1	2	3	
2. Has difficulty keeping attention to what needs to be done	0	1	2	3	
3. Does not seem to listen when spoken to directly	0	1	2	3	
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3	
5. Has difficulty organizing tasks and activities	0	1	2	3	
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3	
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)	0	1	2	3	
8. Is easily distracted by noises or other stimuli	0	1	2	3	
9. Is forgetful in daily activities	0	1	2	3	For Office Use Only /9
10. Fidgets with hands or feet or squirms in seat	0	1	2	3	
11. Leaves seat when remaining seated is expected	0	1	2	3	
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3	
13. Has difficulty playing or beginning quiet play activities	0	1	2	3	
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3	
15. Talks too much	0	1	2	3	
16. Blurts out answers before questions have been completed	0	1	2	3	
17. Has difficulty waiting his or her turn	0	1	2	3	
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3	For Office Use Only /9

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	0	1	2	3	
20. Loses temper	0	1	2	3	
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3	
22. Deliberately annoys people	0	1	2	3	
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3	
24. Is touchy or easily annoyed by others	0	1	2	3	
25. Is angry or resentful	0	1	2	3	
26. Is spiteful and wants to get even	0	1	2	3	For Office Use Only /8
27. Bullies, threatens, or intimidates others	0	1	2	3	
28. Starts physical fights	0	1	2	3	
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3	
30. Is truant from school (skips school) without permission	0	1	2	3	
31. Is physically cruel to people	0	1	2	3	
32. Has stolen things that have value	0	1	2	3	
33. Deliberately destroys others' property	0	1	2	3	
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3	
35. Is physically cruel to animals	0	1	2	3	
36. Has deliberately set fires to cause damage	0	1	2	3	
37. Has broken into someone else's home, business, or car	0	1	2	3	
38. Has stayed out at night without permission	0	1	2	3	
39. Has run away from home overnight	0	1	2	3	
40. Has forced someone into sexual activity	0	1	2	3	For Office Use Only /14
41. Is fearful, anxious, or worried	0	1	2	3	
42. Is afraid to try new things for fear of making mistakes	0	1	2	3	
43. Feels worthless or inferior	0	1	2	3	
44. Blames self for problems, feels guilty	0	1	2	3	
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3	
46. Is sad, unhappy, or depressed	0	1	2	3	
47. Is self-conscious or easily embarrassed	0	1	2	3	For Office Use Only /7

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading	1	2	3	4	5	
49. Writing	1	2	3	4	5	For Office Use Only 4c /3
50. Mathematics	1	2	3	4	5	For Office Use Only 5c /3
51. Relationship with parents	1	2	3	4	5	
52. Relationship with siblings	1	2	3	4	5	
53. Relationship with peers	1	2	3	4	5	For Office Use Only 4c /4
54. Participation in organized activities (eg, teams)	1	2	3	4	5	For Office Use Only 5c /4

Other Conditions

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

-
- 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.
 - 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.
 - 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Is your child on medication for a tic disorder or Tourette syndrome? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Has your child been diagnosed with depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Is your child on medication for depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Has your child been diagnosed with an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Is your child on medication for an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Has your child been diagnosed with a learning or language disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
-

Comments:

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	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

For Office Use Only
/9

For Office Use Only
/9

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	0	1	2	3	
20. Loses temper	0	1	2	3	
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3	
22. Deliberately annoys people	0	1	2	3	
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3	
24. Is touchy or easily annoyed by others	0	1	2	3	
25. Is angry or resentful	0	1	2	3	
26. Is spiteful and wants to get even	0	1	2	3	For Office Use Only /8
27. Bullies, threatens, or intimidates others	0	1	2	3	
28. Starts physical fights	0	1	2	3	
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3	
30. Is truant from school (skips school) without permission	0	1	2	3	
31. Is physically cruel to people	0	1	2	3	
32. Has stolen things that have value	0	1	2	3	
33. Deliberately destroys others' property	0	1	2	3	
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3	
35. Is physically cruel to animals	0	1	2	3	
36. Has deliberately set fires to cause damage	0	1	2	3	
37. Has broken into someone else's home, business, or car	0	1	2	3	
38. Has stayed out at night without permission	0	1	2	3	
39. Has run away from home overnight	0	1	2	3	
40. Has forced someone into sexual activity	0	1	2	3	For Office Use Only /14
41. Is fearful, anxious, or worried	0	1	2	3	
42. Is afraid to try new things for fear of making mistakes	0	1	2	3	
43. Feels worthless or inferior	0	1	2	3	
44. Blames self for problems, feels guilty	0	1	2	3	
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3	
46. Is sad, unhappy, or depressed	0	1	2	3	
47. Is self-conscious or easily embarrassed	0	1	2	3	For Office Use Only /17

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading	1	2	3	4	5	
49. Writing	1	2	3	4	5	For Office Use Only 4c /3
50. Mathematics	1	2	3	4	5	For Office Use Only 5c /3
51. Relationship with parents	1	2	3	4	5	
52. Relationship with siblings	1	2	3	4	5	
53. Relationship with peers	1	2	3	4	5	For Office Use Only 4c /4
54. Participation in organized activities (eg, teams)	1	2	3	4	5	For Office Use Only 5c /4

Other Conditions

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

-
- 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.
 - 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.
 - 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Is your child on medication for a tic disorder or Tourette syndrome? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Has your child been diagnosed with depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Is your child on medication for depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Has your child been diagnosed with an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Is your child on medication for an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Has your child been diagnosed with a learning or language disorder? | <input type="checkbox"/> No | <input type="checkbox"/> 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
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

For Office Use Only
/9

For Office Use Only
/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 /3
38. Written expression	1	2	3	4	5	For Office Use Only /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 /5
43. Organizational skills	1	2	3	4	5	For Office Use Only /5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's birthdate _____

Child's

Name

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

Child's name _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's DOB: _____

Today's date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
23. I am a worrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I get really frightened for no reason at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I am afraid to be alone in the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. It is hard for me to talk with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. When I get frightened, I feel like I am choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. People tell me that I worry too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I don't like to be away from my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I am afraid of having anxiety (or panic) attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I worry that something bad might happen to my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. I feel shy with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. I worry about what is going to happen in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. When I get frightened, I feel like throwing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I worry about how well I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. I am scared to go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. I worry about things that have already happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. When I get frightened, I feel dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. I am shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

One per parent thank you.

Parent Name: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's DOB: _____

Child's

Name

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

Parent Name: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's Name: _____

Child's DOB: _____

Today's 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. When my child gets frightened, he/she sweats a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. My child is a worrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. My child gets really frightened for no reason at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. My child is afraid to be alone in the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. It is hard for my child to talk with people he/she doesn't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. When my child gets frightened, he/she feels like he/she is choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. People tell me that my child worries too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My child doesn't like to be away from his/her family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. My child is afraid of having anxiety (or panic) attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. My child worries that something bad might happen to his/her parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. My child feels shy with people he/she doesn't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. My child worries about what is going to happen in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. When my child gets frightened, he/she feels like throwing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. My child worries about how well he/she does things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My child is scared to go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. My child worries about things that have already happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. When my child gets frightened, he/she feels dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. My child is shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

One per parent thank you.

Parent Name: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's DOB: _____

Child's

Name

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

Parent Name: _____

Screen for Child Anxiety Related Disorders (SCARED)

Child's Name: _____

Child's DOB: _____

Today's 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. When my child gets frightened, he/she sweats a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. My child is a worrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. My child gets really frightened for no reason at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. My child is afraid to be alone in the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. It is hard for my child to talk with people he/she doesn't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. When my child gets frightened, he/she feels like he/she is choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. People tell me that my child worries too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My child doesn't like to be away from his/her family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. My child is afraid of having anxiety (or panic) attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. My child worries that something bad might happen to his/her parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. My child feels shy with people he/she doesn't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. My child worries about what is going to happen in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. When my child gets frightened, he/she feels like throwing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. My child worries about how well he/she does things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My child is scared to go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. My child worries about things that have already happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. When my child gets frightened, he/she feels dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. My child is shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =
Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check **True**.

If it was only sometimes true, check **Sometimes**.

If a sentence was not true about you, check **Not True**.

	Not True	Sometimes	True
1. I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child's Name: _____

Child's DOB: _____

Date filled out: _____

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check **True**.

If it was only sometimes true, check **Sometimes**.

If a sentence was not true about your child, check **Not True**.

	Not True	Sometimes	True
1. S/he felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired that s/he just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent/guardian Name: _____

Child's Name: _____

Child's DOB: _____

Date filled out: _____