Summit Pediatrics And Adolescent Medicine
An Affiliate of Children's Mercy

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 for your child's behavioral 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, impulsivity, distractibility and is having difficulty with attention at home or school, they need to complete a full evaluation for diagnosis and management.

To begin the evaluation, we are including screening questionnaires to assess behavior at home and in the classroom. Each section will be clearly marked to be filled out by parent(s) or teacher(s).

Forms included in this packet:

- □ Behavioral & ADHD Screening Intake Form
- □ Vanderbilt Assessment Scale
  - □ Parent (2) □ Teacher (1+)
- □ SCARED Anxiety Assessment (ages 8-18, to be filled out by the child and 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)

These forms need to be completed in their entirety 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 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 returned forms. We will contact you to schedule a behavioral consult once these are reviewed by your physician.

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 consider making all follow up appointments well in advance. Your child's yearly 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

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BEHAVIOR & ADHD SCREENING INTAKE FORM

PATIENT

NAME: _____ TODAYS DATE _____/_____/_____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ AGE: _____ GRADE LEVEL:_____ SCHOOL:_____

PERSON COMPLETING FORM: MOTHER / FATHER / GAURDIAN / OTHER: _____

MOTHER

NAME: _____
LAST FIRST

AGE_____ MARITAL STUTUS: _____

OCCUPATION _____

HIGHEST EDUCATION LEVEL _____

ACEDEMIC DIFFICULTIES? _____

PHONE (_____) _____ - _____

FATHER

NAME: _____
LAST FIRST

AGE_____ MARITAL STUTUS: _____

OCCUPATION _____

HIGHEST EDUCATION LEVEL _____

ACEDEMIC DIFFICULTIES? _____

PHONE (_____) _____ - _____

ADDITIONAL CARETAKERS, RELATIONSHIP & PHONE NUMBER

_____

_____

_____

PRIMARY CONCERNS FROM PARENT:

1) _____ 3) _____

2) _____ 4) _____

AGE OF ONSET OF SYMPTOMS: _____ DURATION OF PROBLEM BEHAVIOR _____

FREQUENCY THAT BEHAVIOR IS A CONCERN: DAILY / 1-3 TIMES A WEEK / WEEKLY / MONTHLY

SITUATIONS THAT WORSEN BEHAVIOR: _____

_____

SITUATIONS THAT IMPROVE BEHAVIOR: _____

_____

PREVIOUS TREATMENT AND RESULTS: _____

_____

PRIOR SERVICES

	WHERE WERE SERVICES COMPLETED	NAME OF SERVICE PROVIDER
_____ COUNSELING OR THERAPY	_____	_____
_____ IEP OR 504 PLAN	_____	_____
_____ BEHAVIOR EVALUATION	_____	_____
_____ LEARNING DISORDER EVALUATION	_____	_____

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 PREFORMED	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:_____

_____ SAT WITHOUT SUPPORT _____ SPOKE SINGLE WORDS _____TIED SHOELACES

_____ CRAWLED _____ UNDRESSED SELF _____ FED SELF WITH SPOON

_____WALKED _____ PEDALED TRICYCLE _____ SPOKE SENTENCES

WAS THIS A "CUDDLY" BABY? _____ WAS THIS AN "ACTIVE" BABY? _____ WAS THIS 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 ACTIVITES _____

DISCIPLINE

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

WHAT METHOD IS MOST EFFECTIVE? _____

DO PARENTS AGREE ON DISCIPLINE? EXPLAIN _____

ACADEMIC 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:

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)

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, Father, Sibling, Maternal / Paternal Grandparent, Maternal / Paternal Aunt or Uncle	Comments: Age diagnosed (if known)
ADHD				
ANEMIA				
ARRYTHMIA				
ASTHMA				
CANCER				
CARDIOMYOPATHY				
CONGENITAL BIRTH DEFECTS				
DEVELOPMENTAL DISABILITY				
DIABETES				
DRUG ALLERGY				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HEART DISEASE				
HEART ATTACK				
KIDNEY DISEASE				
LEARNING DELAY OR DISABILITY				
MENTAL ILLNESS/DEPRESSION				
MIGRAINES				
SEIZURES				
STROKE				
SUBSTANCE ABUSE				
SUDDEN DEATH <35 YEARS OF AGE				
THYROID DISORDERS				
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: _____ 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, or 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
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
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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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
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

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ 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, or 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
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
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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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
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

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ 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: _____.

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. 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, or 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 on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's 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
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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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

Performance *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
38. Written expression	1	2	3	4	5

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
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

American Academy of Pediatrics

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11-20/rev0303

GAD-7 Anxiety

Over the last two weeks, 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
☐	☐	☐	☐

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.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Screen for Child Anxiety Related Disorders (SCARED)

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

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

Screen for Child Anxiety Related Disorders (SCARED)

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

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

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT) 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.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the 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.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
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.)	○	○	○
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.	○	○	○
41. My child is shy.	○	○	○