



Intake Packet Cover Sheet

In order for your provider to have the most effective consultation about your child or teen, please complete the following packet prior to your visit. It is preferred that you return the information in advance of the date of your visit, by fax or by mail. However, if that is not possible, please bring the completed paperwork with you.

Please complete BOTH sides of all of the forms. Please answer all questions, even if they answer is "normal" or "none".

Ages 4-10 - your packet includes:

CAP School-Behavior PRE-VISIT History

Standardized Questionnaires:

- ❖ Vanderbilt Parent (can be completed by one or more than one parent)
- ❖ Vanderbilt Teacher (please give to one or more of your child's teachers)
- ❖ SCARED Parent (screen for anxiety, to be completed by parent)
- ❖ CAST (screen for Autism, to be completed by parent)
- ❖ PSC_P (Pediatric Symptom Checklist, to be completed by parent)

Ages 11-13 - your packet includes:

CAP School-Behavior PRE-VISIT History

Standardized Questionnaires:

- ❖ Vanderbilt Parent (can be completed by one or more than one parent)
- ❖ Vanderbilt Teacher (please give to one or more of your child's teachers)
- ❖ SCARED Child (to be completed by youth)
- ❖ CAST (screen for Autism, to be completed by parent)
- ❖ PSC-17 (Pediatric Symptom Checklist, to be completed by youth)

Ages 14-17 - your packet includes:

CAP School-Behavior PRE-VISIT History

Standardized Questionnaires:

- ❖ Vanderbilt Parent (can be completed by one or more than one parent)
- ❖ Vanderbilt Teacher (please give to one or more of your child's teachers)
- ❖ SCARED Child (screen for anxiety, to be completed by teen)
- ❖ PHQ-A (screen for depression, substance abuse, eating disorder – to be completed by teen)

**All teen questionnaires should be considered confidential and brought by patient to the visit*



ADD/ADHD RECOMMENDED READING

[Your Defiant Child](#) by: Russell Barkley, PhD

[Taking Charge of ADHD: The Complete, Authoritative Guide for Parents \(2000\)](#)

by: Russell Barkley, PhD ABPP

[Driven to Distraction \(2005\)](#) by: Hallowell & Ratey

[From Chaos to Calm](#) by: Janet Heninger and Sharon Weiss

[Straight Talk About Psychiatric Medications for kids](#) by: Timothy Wilens

[ADHD: Parents Medication Guide](#) PDF Revised: July 2013

[The Gift of ADHD Activity Book: 101 Ways to Turn Your Child's Problems into Strengths \(2008\)](#)

by: Lara Honos-Webb, PhD

[ADHD and Social Skills: A Step-by-Step Guide for Teachers and Parents \(2009\)](#)

by: Esta Rapoport

Especially for Kids:

[80HD: A Child's Perspective on ADHD](#) by: Trish Wood

[Attention, Girls!](#) By: Patricia Quinn

[Jumpin' Johnny Get Back to Work!: A Child's Guide to ADHD/Hyperactivity](#)

by: Michael Gordon

[Cory Stories: A Kid's Book About Living With ADHD](#) by: Jeanne Kraus

Other helpful books, not specific to ADHD:

[The Explosive Child](#) by: Ross Greene

[Living With Intensity](#) by: Susan Daniels and Michael Piechowski

[The Out of Sync Child](#) by: Carol Kranowitz and Lucy Jane Miller

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

Name of person completing the history form: _____

Relation to child/ self: _____

Date of form completion: _____

In preparation for our visit about your child, please complete the following detailed history. To best evaluate any child for school problems or behavior concerns, we must have an understanding of his/her early development and home situation. This history form, as well as any standardized questionnaires that have been included in your packet, should be forwarded to the doctor before the visit if at all possible – otherwise, bring the completed forms with you to the appointment. In addition, please bring copies of any assessments or testing that has been done privately or at school, including standardized school tests such as the DRA (elementary) or the Naglieri.

PLEASE CHECK ALL THAT APPLY:

1) Who is concerned about your child? Parent(s) ☐ School ☐ Patient ☐ Other _____

2) Does your child have difficulty functioning in any of the following areas? Home ☐ School ☐ Peer ☐

3) My concerns are in the following area(s):

Behavior	<input type="checkbox"/>	Having trouble in school	<input type="checkbox"/>
Development	<input type="checkbox"/>	Attention/Hyperactivity Problems	<input type="checkbox"/>
Ability to Learn	<input type="checkbox"/>	Symptoms that may be autism	<input type="checkbox"/>

4) How long have you had these concerns? _____

5) Describe briefly the things that concern you the most about your child.

6) How is your child doing in school this year?

7) Has your child have currently had any school or learning support? (example: IEP, 504 Plan, OT/PT, Speech)
Please list all support that your child currently receives either through the school or privately.

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

SYMPTOMS OF INATTENTION OR HYPERACTIVITY:

Many children who are having difficulty with school, learning or behavior have some of the following symptoms. Please check the boxes that apply and give examples of where these symptoms may be a problem for your child.

	My child has difficulty with...	For example...	Explain or give an example
<input type="checkbox"/>	Paying close attention	Makes many careless errors, rushes through things, focuses on unimportant details	
<input type="checkbox"/>	Sustained attention	Attention is hard to attract, has trouble shifting attention, loses focus easily, has trouble staying alert	
<input type="checkbox"/>	Listening	Misses important information, forgets what he/she has just heard, keeps tuning in and out, daydreams	
<input type="checkbox"/>	Organization	Has trouble planning work, does not use strategies, disorganized with time, disorganized work space	
<input type="checkbox"/>	Mental Effort	Has difficulty starting homework or things that are difficult, has trouble finishing things	
<input type="checkbox"/>	Distraction	Easily distracted by sounds, or visual Things	
<input type="checkbox"/>	Being forgetful	Misses homework, loses things often, forgetful in daily activities	
<input type="checkbox"/>	Inconsistent performance	Has good and bad days, unpredictable school work, unpredictable behavior	
<input type="checkbox"/>	Hyperactivity	Feels restless, fidgets, leaves seat, "driven by a motor", agitated when can't exercise	
<input type="checkbox"/>	Waiting his/her turn	Doesn't think before acting, blurts out answers, talks excessively, says things that don't fit in the conversation	
<input type="checkbox"/>	Satisfaction	Has trouble delaying gratification, gets bored easily	
<input type="checkbox"/>	Self-monitoring	Fails to notice when bothering others, has trouble knowing how he/she is doing	
<input type="checkbox"/>	Reinforcing behavior	Punishment doesn't make a difference, doesn't seem to learn from mistakes	

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

CURRENT BEHAVIORS AND SYMPTOMS:

1) Does your child experience any of the following **moods or behaviors**?

MOOD CONCERNS	SOCIAL CONCERNS	AGGRESSION CONCERNS
Moodiness <input type="checkbox"/>	Rejection by peers <input type="checkbox"/>	Refuses to accept responsibility <input type="checkbox"/>
Worries a lot <input type="checkbox"/>	Relates better to older or younger <input type="checkbox"/>	Disobeying parents <input type="checkbox"/>
Seems sad <input type="checkbox"/>	Annoys peers <input type="checkbox"/>	Is mean to animals <input type="checkbox"/>
Negative comments about self <input type="checkbox"/>	Trouble talking like peers <input type="checkbox"/>	Argues a lot <input type="checkbox"/>
Believes he/she is not smart <input type="checkbox"/>	Upset about peer relationships <input type="checkbox"/>	Temper tantrums <input type="checkbox"/>
Has many fears <input type="checkbox"/>	Trouble making friends <input type="checkbox"/>	Trouble with authority <input type="checkbox"/>
Unpredictable changes in mood <input type="checkbox"/>	Is reluctant to call friends <input type="checkbox"/>	Doesn't follow rules <input type="checkbox"/>
Unrealistic ideas (grandiose) <input type="checkbox"/>	Spends a lot of time alone <input type="checkbox"/>	Fights with other students <input type="checkbox"/>
Panics easily <input type="checkbox"/>	Trouble with conflict with friends <input type="checkbox"/>	Uses excessive bad language <input type="checkbox"/>
Lost interest in enjoyable things <input type="checkbox"/>	Being picked on or bullied <input type="checkbox"/>	Stirs up trouble <input type="checkbox"/>
Has talked about killing self <input type="checkbox"/>	Lacks close friends <input type="checkbox"/>	Being mean to siblings <input type="checkbox"/>
Gets angry "flies off handle" <input type="checkbox"/>	Trouble relating to opposite sex <input type="checkbox"/>	Takes things that don't belong to him <input type="checkbox"/>
NONE <input type="checkbox"/>	NONE <input type="checkbox"/>	NONE <input type="checkbox"/>

2) Does your child experience any of the following **symptoms**?

Recent change in weight <input type="checkbox"/>	Shortness of breath with exercise <input type="checkbox"/>	Ever had tics or twitches <input type="checkbox"/>
Difficulty gaining weight <input type="checkbox"/>	Change in exercise tolerance <input type="checkbox"/>	Difficulty with fine or gross motor <input type="checkbox"/>
Fatigue <input type="checkbox"/>	Palpitations <input type="checkbox"/>	Sensory sensitivity <input type="checkbox"/>
Snoring <input type="checkbox"/>	Frequent stomach aches <input type="checkbox"/>	Nightmares <input type="checkbox"/>
Chronic congestion <input type="checkbox"/>	Stool accidents <input type="checkbox"/>	Trouble falling asleep <input type="checkbox"/>
Chronic or recurrent cough <input type="checkbox"/>	Urine accidents <input type="checkbox"/>	Trouble staying asleep <input type="checkbox"/>
Fainting or dizziness with exercise <input type="checkbox"/>	Sensitive skin <input type="checkbox"/>	Trouble getting up in the morning <input type="checkbox"/>
Chest pain with exercise <input type="checkbox"/>	Frequent headaches <input type="checkbox"/>	Intense mood <input type="checkbox"/>

Please explain any boxes that are checked above:

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

SCHOOL AND PRIOR EVALUATION HISTORY:

- 1) Current Grade in School _____ Name of School: _____
2) Has your child had previous testing or therapy? **PLEASE BRING COPIES OF TEST RESULTS WITH YOU.**

	TYPE	NAME OF GROUP or DOCTOR	WHEN?
<input type="checkbox"/>	Psychological/Educational Testing		
<input type="checkbox"/>	Developmental Behavioral Evaluation		
<input type="checkbox"/>	Sensory Integration Therapy		
<input type="checkbox"/>	Early Intervention Support		
<input type="checkbox"/>	Child Find Support		
<input type="checkbox"/>	Psychologist		
<input type="checkbox"/>	Psychiatrist		

- 3) Does your child have a specific learning, behavioral, or developmental diagnosis given by a doctor? (example: ADD, dyslexia, autism)

- 4) Has your child ever been on medication for ADD / ADHD in the past? Please list name of medicine, age/year given, did it work and were there side effects.

MEDICAL / FAMILY / SOCIAL HISTORY:

- 1) Parent age at birth: Mother _____ Father _____

- 2) Were there any difficulties with the pregnancy or shortly after birth? Yes ☐ (see below) No ☐

a. Prematurity: _____

b. Problems during delivery:

c. Neonatal problems: _____

d. Exposure during pregnancy to drugs/alcohol/tobacco? Please be specific:

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

3) Early Developmental History:

MILESTONE	AGE / COMMENT
Sat alone	
Walked independently	
Rode a tricycle	
Spoke 2-3 word sentences	
Could read simple words	
Potty trained (daytime)	
Slept through the night	
Able to separate easily from mother for school / play	
OTHER CONCERNS in development?	

4) Early Behavioral History

	YES/NO	COMMENT
Cried frequently as infant	<input type="checkbox"/> <input type="checkbox"/>	
Difficult to calm as infant	<input type="checkbox"/> <input type="checkbox"/>	
Trouble sleeping as infant	<input type="checkbox"/> <input type="checkbox"/>	
Picky eater as infant	<input type="checkbox"/> <input type="checkbox"/>	
Many temper tantrums as toddler	<input type="checkbox"/> <input type="checkbox"/>	
Behavior caused trouble in daycare?	<input type="checkbox"/> <input type="checkbox"/>	
Behavior caused trouble in preschool?	<input type="checkbox"/> <input type="checkbox"/>	

Please Explain:

5) Patient health history

Anemia	<input type="checkbox"/>	Vision problem	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>
Allergies (significant)	<input type="checkbox"/>	Head injury (concussion)	<input type="checkbox"/>	Lead poisoning	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Meningitis/Encephalitis	<input type="checkbox"/>	Hospitalizations	<input type="checkbox"/>
Birth defects/birthmarks	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>
Bowel problems (chronic)	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Vitamins	<input type="checkbox"/>
Difficulty with growth	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Health Supplements	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Heart murmur (significant)	<input type="checkbox"/>	Herbal Medicines	<input type="checkbox"/>
Ear infections (recurrent)	<input type="checkbox"/>	Fainting with exercise	<input type="checkbox"/>	Alternative medical treatments	<input type="checkbox"/>
Hearing problem	<input type="checkbox"/>	Heart disease (at birth)	<input type="checkbox"/>		

Please explain any boxes that are checked above:

Capital Area Pediatrics, Inc.

Name of Child _____ Chart # _____ Birth Date _____
Please print

6) Family History

	YES/NO		WHO/COMMENT
ADD (Attention Problems)	<input type="checkbox"/>	<input type="checkbox"/>	
Autism	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Tics	<input type="checkbox"/>	<input type="checkbox"/>	
Learning/Reading Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar disorder (manic)	<input type="checkbox"/>	<input type="checkbox"/>	
Other mental condition	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol / Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	
History of Abuse (physical, sexual)	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble with the law	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Toxin Exposure (damaging substance)	<input type="checkbox"/>	<input type="checkbox"/>	

7) Family Cardiac Risk (if you have not heard of some of these, they are not likely to be in your family)

	YES/NO		WHO/COMMENT
Sudden unexplained death in someone young	<input type="checkbox"/>	<input type="checkbox"/>	
Event requiring CPR under age 35	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack under age 35	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden death during exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac rhythm problems	<input type="checkbox"/>	<input type="checkbox"/>	
Marfan Syndrome or Hypertrophic cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	

8) Social History

a. How is the child related to you? (Biological ☐ Adopted ☐ Grandchild ☐ Foster child ☐ Stepchild ☐ other ☐)

b. Father age: _____ School level completed _____ Occupation: _____

c. Mother age: _____ School level completed _____ Occupation: _____

d. Child lives mostly with: _____

e. Regular caretakers include: _____

f. Has this child endured any extremely stressful experiences? Are they still occurring? Please explain:

g. Primary language spoken at home: _____

h. Who lives with the child at home? (continue on back if needed)

NAME	AGE	RELATIONSHIP

Screening for Learning or Behavior Concerns (complete front & back p.1-6)

Revised: 03/18

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 | | | | |
| 2. Has difficulty keeping attention to what needs to be done | | | | |
| 3. Does not seem to listen when spoken to directly | | | | |
| 4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand) | | | | |
| 5. Has difficulty organizing tasks and activities | | | | |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort | | | | |
| 7. Loses things necessary for tasks or activities (toys, assignments, pencils, books) | | | | |
| 8. Is easily distracted by noises or other stimuli | | | | |
| 9. Is forgetful in daily activities | | | | |

For Office Use Only
_____/9

- | | | | | |
|--|--|--|--|--|
| 10. Fidgets with hands or feet or squirms in seat | | | | |
| 11. Leaves seat when remaining seated is expected | | | | |
| 12. Runs about or climbs too much when remaining seated is expected | | | | |
| 13. Has difficulty playing or beginning quiet play activities | | | | |
| 14. Is "on the go" or often acts as if "driven by a motor" | | | | |
| 15. Talks too much | | | | |
| 16. Blurts out answers before questions have been completed | | | | |
| 17. Has difficulty waiting his or her turn | | | | |
| 18. Interrupts or intrudes in on others' conversations and/or activities | | | | |

For Office Use Only
_____/9

Child's Name: _____ Date of Birth: _____



NICHQ Vanderbilt Assessment Scale: Parent Informant

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

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



Other Conditions

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

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

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

- | | | |
|--|-----------------------------|------------------------------|
| 1. Has your child been diagnosed with a tic disorder or Tourette syndrome? | <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				
--	--	--	--	--

2. Has difficulty sustaining attention to tasks or activities				
---	--	--	--	--

3. Does not seem to listen when spoken to directly				
--	--	--	--	--

4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)				
---	--	--	--	--

5. Has difficulty organizing tasks and activities				
---	--	--	--	--

6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
--	--	--	--	--

7. Loses things necessary for tasks or activities (school assignments, pencils, books)				
--	--	--	--	--

8. Is easily distracted by extraneous stimuli				
---	--	--	--	--

9. Is forgetful in daily activities				
-------------------------------------	--	--	--	--

For Office Use Only
_____/9

10. Fidgets with hands or feet or squirms in seat				
---	--	--	--	--

11. Leaves seat in classroom or in other situations in which remaining seated is expected				
---	--	--	--	--

12. Runs about or climbs excessively in situations in which remaining seated is expected				
--	--	--	--	--

13. Has difficulty playing or engaging in leisure activities quietly				
--	--	--	--	--

14. Is "on the go" or often acts as if "driven by a motor"				
--	--	--	--	--

15. Talks excessively				
-----------------------	--	--	--	--

16. Blurts out answers before questions have been completed				
---	--	--	--	--

17. Has difficulty waiting in line				
------------------------------------	--	--	--	--

18. Interrupts or intrudes in on others (eg, butts into conversations/games)				
--	--	--	--	--

For Office Use Only
_____/9

Symptoms (continued)	Never	Occasionally	Often	Very Often
----------------------	-------	--------------	-------	------------

- | | | | | |
|---|--|--|--|--|
| 19. Loses temper | | | | |
| 20. Activity defies or refuses to comply with adults' requests or rules | | | | |
| 21. Is angry or resentful | | | | |
| 22. Is spiteful and vindictive | | | | |
| 23. Bullies, threatens, or intimidates others | | | | |
| 24. Initiates physical fights | | | | |
| 25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others) | | | | |
| 26. Is physically cruel to people | | | | |
| 27. Has stolen items of nontrivial value | | | | |
| 28. Deliberately destroys others' property | | | | |

For Office Use Only
/10

- | | | | | |
|--|--|--|--|--|
| 29. Is fearful, anxious, or worried | | | | |
| 30. Is self-conscious or easily embarrassed | | | | |
| 31. Is afraid to try new things for fear of making mistakes | | | | |
| 32. Feels worthless or inferior | | | | |
| 33. Blames self for problems; feels guilty | | | | |
| 34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her" | | | | |
| 35. Is sad, unhappy, or depressed | | | | |

For Office Use Only
/7

Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
----------------------	-----------	---------------	---------	-----------------------	-------------

- | | | | | | |
|------------------------|--|--|--|--|--|
| 36. Reading | | | | | |
| 37. Mathematics | | | | | |
| 38. Written expression | | | | | |

For Office Use Only
4s: /3

For Office Use Only
5s: /3

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
----------------------------------	-----------	---------------	---------	-----------------------	-------------

- | | | | | | |
|-----------------------------|--|--|--|--|--|
| 39. Relationship with peers | | | | | |
| 40. Following directions | | | | | |
| 41. Disrupting class | | | | | |
| 42. Assignment completion | | | | | |
| 43. Organizational skills | | | | | |

For Office Use Only
4s: /5

For Office Use Only
5s: /5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

Screen for Child Anxiety Related Disorders (SCARED)

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

Name: _____

Date: _____

Directions:

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

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

Child's Name: _____ Date of Birth: _____



CARING FOR CHILDREN WITH ADHD: A RESOURCE TOOLKIT FOR CLINICIANS, 2ND EDITION

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

SCORING:

A total score of ≥ 25 may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**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.*

The Childhood Asperger Syndrome Test (CAST)

Child's Name: Age: Sex: " M /"" F

Birth Order: Twin or Single Birth:

Parent/Guardian:

Parent(s) occupation:

Age parent(s) left full-time education:

Address:
.....
.....

Tel.No: School:

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

- | | | |
|--|-----|----|
| 1. Does s/he join in playing games with other children easily? | Yes | No |
| 2. Does s/he come up to you spontaneously for a chat? | Yes | No |
| 3. Was s/he speaking by 2 years old? | Yes | No |
| 4. Does s/he enjoy sports? | Yes | No |
| 5. Is it important to him/her to fit in with the peer group? | Yes | No |
| 6. Does s/he appear to notice unusual details that others miss? | Yes | No |
| 7. Does s/he tend to take things literally? | Yes | No |
| 8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)? | Yes | No |
| 9. Does s/he like to do things over and over again, in the same way all the time? | Yes | No |
| 10. Does s/he find it easy to interact with other children? | Yes | No |
| 11. Can s/he keep a two-way conversation going? | Yes | No |

Child's Name : _____ Age : _____

- | | | |
|--|-----|----|
| 12. Can s/he read appropriately for his/her age? | Yes | No |
| 13. Does s/he mostly have the same interests as his/her peers? | Yes | No |
| 14. Does s/he have an interest which takes up so much time that s/he does little else? | Yes | No |
| 15. Does s/he have friends, rather than just acquaintances? | Yes | No |
| 16. Does s/he often bring you things s/he is interested in to show you? | Yes | No |
| 17. Does s/he enjoy joking around? | Yes | No |
| 18. Does s/he have difficulty understanding the rules for polite behaviour? | Yes | No |
| 19. Does s/he appear to have an unusual memory for details? | Yes | No |
| 20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)? | Yes | No |
| 21. Are people important to him/her? | Yes | No |
| 22. Can s/he dress him/herself? | Yes | No |
| 23. Is s/he good at turn-taking in conversation? | Yes | No |
| 24. Does s/he play imaginatively with other children, and engage in role-play? | Yes | No |
| 25. Does s/he often do or say things that are tactless or socially inappropriate? | Yes | No |
| 26. Can s/he count to 50 without leaving out any numbers? | Yes | No |
| 27. Does s/he make normal eye-contact? | Yes | No |
| 28. Does s/he have any unusual and repetitive movements? | Yes | No |
| 29. Is his/her social behaviour very one-sided and always on his/her own terms? | Yes | No |
| 30. Does s/he sometimes say "you" or "s/he" when s/he means "I"? | Yes | No |

Child's Name : _____ Age : _____

- | | | |
|--|-----|----|
| 31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts? | Yes | No |
| 32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about? | Yes | No |
| 33. Can s/he ride a bicycle (even if with stabilisers)? | Yes | No |
| 34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems? | Yes | No |
| 35. Does s/he care how s/he is perceived by the rest of the group? | Yes | No |
| 36. Does s/he often turn conversations to his/her favourite subject rather than following what the other person wants to talk about? | Yes | No |
| 37. Does s/he have odd or unusual phrases? | Yes | No |

SPECIAL NEEDS SECTION

Please complete as appropriate

- | | | |
|--|-----|----|
| 38. Have teachers/health visitors ever expressed any concerns about his/her development? | Yes | No |
|--|-----|----|

If Yes, please specify.....

39. Has s/he ever been diagnosed with any of the following?:

- | | | |
|--|-----|----|
| Language delay | Yes | No |
| Hyperactivity/Attention Deficit Disorder (ADHD) | Yes | No |
| Hearing or visual difficulties | Yes | No |
| Autism Spectrum Condition, incl. Asperger's Syndrome | Yes | No |
| A physical disability | Yes | No |
| Other (please specify) | Yes | No |

Pediatric Symptom Checklist - Youth Report (Y-PSC)

Please mark under the heading that best fits you:

Never Sometimes Often

1. Complain of aches or pains.....	—	—	—
2. Spend more time alone.....	—	—	—
3. Tire easily, little energy.....	—	—	—
4. Fidgety, unable to sit still.....	—	—	—
5. Have trouble with teacher.....	—	—	—
6. Less interested in school.....	—	—	—
7. Act as if driven by motor.....	—	—	—
8. Daydream too much.....	—	—	—
9. Distract easily.....	—	—	—
10. Are afraid of new situations.....	—	—	—
11. Feel sad, unhappy.....	—	—	—
12. Are irritable, angry.....	—	—	—
13. Feel hopeless.....	—	—	—
14. Have trouble concentrating.....	—	—	—
15. Less interested in friends.....	—	—	—
16. Fight with other children.....	—	—	—
17. Absent from school.	—	—	—
18. School grades dropping.	—	—	—
19. Down on yourself.....	—	—	—
20. Visit doctor with doctor finding nothing wrong.....	—	—	—
21. Have trouble sleeping.....	—	—	—
22. Worry a lot.....	—	—	—
23. Want to be with parent more than before.....	—	—	—
24. Feel that you are bad.....	—	—	—
25. Take unnecessary risks.....	—	—	—
26. Get hurt frequently.....	—	—	—
27. Seem to be having less fun.....	—	—	—
28. Act younger than children your age.....	—	—	—
29. Do not listen to rules.....	—	—	—
30. Do not show feelings.....	—	—	—
31. Do not understand other people's feelings.....	—	—	—
32. Tease others.....	—	—	—
33. Blame others for your troubles.....	—	—	—
34. Take things that do not belong to you.....	—	—	—
35. Refuse to share.....	—	—	—

Patient Name: _____ Date of Birth: _____