Capital Area Pediatrics
your neighborhood pediatrician

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*

ALL FORMS ARE PRINTED ON BOTH SIDES OF PAPER – PLEASE COMPLETE FRONT and BACK

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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	☐	Having trouble in school	☐
Development	☐	Attention/Hyperactivity Problems	☐
Ability to Learn	☐	Symptoms that may be autism	☐

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
☐	Paying close attention	Makes many careless errors, rushes through things, focuses on unimportant details	
☐	Sustained attention	Attention is hard to attract, has trouble shifting attention, loses focus easily, has trouble staying alert	
☐	Listening	Misses important information, forgets what he/she has just heard, keeps tuning in and out, daydreams	
☐	Organization	Has trouble planning work, does not use strategies, disorganized with time, disorganized work space	
☐	Mental Effort	Has difficulty starting homework or things that are difficult, has trouble finishing things	
☐	Distraction	Easily distracted by sounds, or visual Things	
☐	Being forgetful	Misses homework, loses things often, forgetful in daily activities	
☐	Inconsistent performance	Has good and bad days, unpredictable school work, unpredictable behavior	
☐	Hyperactivity	Feels restless, fidgets, leaves seat, "driven by a motor", agitated when can't exercise	
☐	Waiting his/her turn	Doesn't think before acting, blurts out answers, talks excessively, says things that don't fit in the conversation	
☐	Satisfaction	Has trouble delaying gratification, gets bored easily	
☐	Self-monitoring	Fails to notice when bothering others, has trouble knowing how he/she is doing	
☐	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 ☐	Rejection by peers ☐	Refuses to accept responsibility ☐
Worries a lot ☐	Relates better to older or younger ☐	Disobeying parents ☐
Seems sad ☐	Annoys peers ☐	Is mean to animals ☐
Negative comments about self ☐	Trouble talking like peers ☐	Argues a lot ☐
Believes he/she is not smart ☐	Upset about peer relationships ☐	Temper tantrums ☐
Has many fears ☐	Trouble making friends ☐	Trouble with authority ☐
Unpredictable changes in mood ☐	Is reluctant to call friends ☐	Doesn't follow rules ☐
Unrealistic ideas (grandiose) ☐	Spends a lot of time alone ☐	Fights with other students ☐
Panics easily ☐	Trouble with conflict with friends ☐	Uses excessive bad language ☐
Lost interest in enjoyable things ☐	Being picked on or bullied ☐	Stirs up trouble ☐
Has talked about killing self ☐	Lacks close friends ☐	Being mean to siblings ☐
Gets angry "flies off handle" ☐	Trouble relating to opposite sex ☐	Takes things that don't belong to him ☐
NONE ☐	NONE ☐	NONE ☐

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

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

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?
☐	Psychological/Educational Testing		
☐	Developmental Behavioral Evaluation		
☐	Sensory Integration Therapy		
☐	Early Intervention Support		
☐	Child Find Support		
☐	Psychologist		
☐	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) Where 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	☐ ☐	
Difficult to calm as infant	☐ ☐	
Trouble sleeping as infant	☐ ☐	
Picky eater as infant	☐ ☐	
Many temper tantrums as toddler	☐ ☐	
Behavior caused trouble in daycare?	☐ ☐	
Behavior caused trouble in preschool?	☐ ☐	

Please Explain:

_____

_____

_____

5) Patient health history

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

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)	☐ ☐	
Autism	☐ ☐	
Neurological Problems	☐ ☐	
Tics	☐ ☐	
Learning/Reading Problems	☐ ☐	
Anxiety	☐ ☐	
Depression	☐ ☐	
Bipolar disorder (manic)	☐ ☐	
Other mental condition	☐ ☐	
Alcohol / Drug Problems	☐ ☐	
History of Abuse (physical, sexual)	☐ ☐	
Trouble with the law	☐ ☐	
Thyroid Disease	☐ ☐	
Toxin Exposure (damaging substance)	☐ ☐	

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	☐ ☐	
Event requiring CPR under age 35	☐ ☐	
Heart attack under age 35	☐ ☐	
Sudden death during exercise	☐ ☐	
Cardiac rhythm problems	☐ ☐	
Marfan Syndrome or Hypertrophic cardiomyopathy	☐ ☐	

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

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:_____

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	○	○	○	○	○	For Office Use Only 4s:_____/3
50. Mathematics	○	○	○	○	○	For Office Use Only 5s:_____/3
51. Relationship with parents	○	○	○	○	○	
52. Relationship with siblings	○	○	○	○	○	
53. Relationship with peers	○	○	○	○	○	For Office Use Only 4s:_____/4
54. Participation in organized activities (eg, teams)	○	○	○	○	○	For Office Use Only 5s:_____/4

Other Conditions

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

1. **Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, or repetition of words or short phrases.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

3. If **YES** to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? ☐ No ☐ Yes

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

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

Comments:

NICHQ Vanderbilt Assessment Scale: Teacher Informant

Child's Name: _____

Child's Date of Birth: _____

Teacher's Name: _____

Today's Date: _____

Class Time: _____

Class Name/Period: _____

Grade Level: _____

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

Symptoms	Never	Occasionally	Often	Very Often	
1. Fails to give attention to details or makes careless mistakes in schoolwork	◯	◯	◯	◯	
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 2 & 3s: ___/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 2 & 3s: ___/7

Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
36. Reading	○	○	○	○	○	
37. Mathematics	○	○	○	○	○	For Office Use Only 4s: 0 /3
38. Written expression	○	○	○	○	○	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	○	○	○	○	○	For Office Use Only 4s: ___/5
43. Organizational skills	○	○	○	○	○	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.	○	○	○
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.	○	○	○

Name: _____ Date: _____

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.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 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.*

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PATIENT HEALTH QUESTIONNAIRE FOR ADOLESCENTS (PHQ-A Version 3.6.05)

INSTRUCTIONS: This questionnaire will help in understanding some problems that you may have. Please make sure to circle YES or NO for each question unless the instructions tell you to skip over some questions.

First, here are some questions about depression and your mood.

Have you had any of the following problems during the last 2 weeks?

1. Little interest or pleasure in doing things?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
2. Feeling down, depressed, irritable or hopeless?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
3. Trouble falling asleep, staying asleep, or sleeping too much?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
4. Feeling tired or having little energy?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
5. Poor appetite, weight loss, or overeating?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
7. Trouble concentrating on things like school work, reading, or watching TV?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	**YES**: Nearly every day ◯ in the past 2 weeks.	**YES**: A few days in ◯ the past 2 weeks.	**NO** ◯

9. Have you felt sad, upset, irritable, or depressed on more than half of the days in the past year?	YES ○	NO ○
10. In the past year, have you felt so sad, upset, irritable, or depressed that it has often been hard for you to do your work, take care of things at home, or get along with other people?	YES ○	NO ○
11. In the past year, has there been a time when you didn't feel sad, upset, irritable, or depressed for two months in a row or longer? That is, has there been a time in the past year when you felt happy most of the time for at least two months in a row?	YES ○	NO ○
12. In the last 2 weeks, have you often felt hopeless about the future?	YES ○	NO ○
13. In the last 2 weeks, have you often had thoughts that you would be better off dead, or of hurting yourself in some way?	YES ○	NO ○
14. Has there been a time in the past month when you have had serious thoughts about ending your life?	YES ○	NO ○

15. In the past 2 weeks, have you been so sad, down, irritable, or depressed that it has been difficult for you to do your work, take care of things at home, or get along with other people?
Please select one of the following answers:

Not difficult at all	A little difficult	Quite difficult	Very difficult	Extremely difficult
☐	☐	☐	☐	☐

Now, here are some questions about fear and anxiety.

16. In the last month, have you had an anxiety attack,when you suddenly felt fear or panic?	YES ○	NO ○

If your answer to the above question was YES, please answer the rest of the questions on this page. If your answer was NO, please turn to the next page.

17. Have you had any other anxiety attacks like this in the past year?	YES ○	NO ○
18. Do these feelings of panic sometimes come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable?	YES ○	NO ○
19. Do you often worry about having these anxiety attacks? Or, have you had to change your behavior or your lifestyle to avoid having more attacks?	YES ○	NO ○

Think about your last panic or anxiety attack:		
20. Were you short of breath?	YES ○	NO ○
21. Did your heart race, pound, or skip?	YES ○	NO ○
22. Did you have chest pain or pressure?	YES ○	NO ○
23. Did you sweat?	YES ○	NO ○
24. Did you feel as if you were choking?	YES ○	NO ○
25. Did you have hot flashes or chills?	YES ○	NO ○
26. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	YES ○	NO ○
27. Did you feel dizzy, unsteady, or faint?	YES ○	NO ○
28. Did you have tingling or numbness in parts of your body?	YES ○	NO ○
29. Did you tremble or shake?	YES ○	NO ○
30. Were you afraid that you were going crazy or losing control?	YES ○	NO ○
31. Were you afraid that you were dying?	YES ○	NO ○

32. Have you felt nervous, anxious, or on edge, or have you worried a lot on more than half the days in the last six months?	YES ○	NO ○
33. Have you been worrying a lot about many different kinds of things in the last six months?	YES ○	NO ○
34. Do you often find that it's very difficult to stop worrying?	YES ○	NO ○

In the last six months, have you often been bothered by any of these problems?			
35. Feeling restless so that it is hard to sit still?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○
36. Getting tired very easily?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○
37. Muscle tension, aches, or soreness?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○
38. Trouble falling asleep or staying asleep?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○
39. Trouble concentrating on things such as school work, reading, or watching TV?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○
40. Becoming easily annoyed or irritable?	**YES: More than half the days in the past 6 months.** ○	**YES: Less than half the days in the past 6 months.** ○	**NO** ○

41. How much have problems with fear or anxiety made it difficult for you to do your work, take care of things at home, or get along with other people? **Please select one of the following answers.**

Not difficult at all	**A little difficult**	**Quite difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐	☐

Now, here are some questions about alcohol and cigarettes.

Have any of the following things happened to you <u>in the last 6 months?</u>

42. Have there been any days in the past six months when you had <u>five or more</u> drinks of beer, wine or liquor?	**YES: a few days** ○	**YES: 1 or 2 days** ○	**NO** ○
43. Have there been any days in the past six months when you drank so much beer, wine or liquor that you got drunk or more than a little tipsy?	**YES: a few days** ○	**YES: 1 or 2 days** ○	**NO** ○

44. Have you been drinking alcohol, drunk or tipsy from alcohol, or hung over while you were working, studying, going to school, or taking care of other responsibilities?	**YES (more than once)** ○	**YES (once)** ○	**NO** ○
45. Have you missed or been late for school, work, or other responsibilities because you were drinking or hung over?	**YES (more than once)** ○	**YES (once)** ○	**NO** ○
46. Have you driven a car when you were drunk or tipsy from alcohol, or after having several drinks?	**YES (more than once)** ○	**YES (once)** ○	**NO** ○
47. Have you had any problems getting along with other people while you were drinking or because of your alcohol use?	**YES (more than once)** ○	**YES (once)** ○	**NO** ○

48. In the past 6 months, has anyone complained about your alcohol use, or told you that you have a drinking problem?	**YES** ○	**NO** ○
49. Has a doctor ever said that you should stop drinking for health reasons?	**YES** ○	**NO** ○
50. Have you had any legal problems because of your alcohol use?	**YES** ○	**NO** ○
51. Do you feel guilty or upset about your use of alcohol, or do you think that you drink too much, or that you might have an alcohol problem?	**YES** ○	**NO** ○

52. How many cigarettes would you say that you have smoked on an average day in the past month?
Please select one of the following answers.

None	1 or 2 cigarettes	3 cigarettes or more	Half a pack a day (10 cigarettes) or more	A pack a day (20 cigarettes) or more
☐	☐	☐	☐	☐

Now, here are some questions about drug use.		
53. Have you used marijuana ("grass," "pot," "weed," or "hash") in the past 6 months?	YES ○	NO ○
54. Have you used cocaine or "crack" in the past 6 months?	YES ○	NO ○
55. Have you used "ecstasy," mushrooms, LSD, "acid," or other hallucinogenic drugs in the past 6 months?	YES ○	NO ○
56. In the past 6 months, have you used any other drugs to get high, including stimulants ("speed"), tranquilizers, or pain killers such as codeine or heroin?	YES ○	NO ○
57. In the past 6 months, have you sniffed glue or inhaled sprays or paints to get high?	YES ○	NO ○

58. How often have you used these or other kinds of drugs to get high in the past 6 months?
Please select one of the following answers.

Never	Once	Twice	A few times	More than a few times
☐	☐	☐	☐	☐

Have any of the following things happened to you in the last 6 months?			
59. Have you used drugs, or were you high or hung over from drug use while you were going to school, working, studying, or taking care of other responsibilities?	YES (more than once) ○	YES (once) ○	NO ○
60. Have you missed or were late for school, work, or other responsibilities because you were using drugs?	YES (more than once) ○	YES (once) ○	NO ○
61. Have you driven a car when you were "high" from drug use?	YES (more than once) ○	YES (once) ○	NO ○

62. Have you had any problems getting along with other people while you were using drugs or because of your drug use?	**YES (more than once)** ○	**YES (once)** ○	**NO** ○

63. In the past 6 months, has anyone complained about your drug use, or told you that you have a drug problem?	**YES** ○	**NO** ○
64. Has a doctor ever said that you should stop using drugs for health reasons?	**YES** ○	**NO** ○
65. Have you had any legal problems because of your drug use?	**YES** ○	**NO** ○
66. Do you feel guilty or upset about your drug use, or do you think that you use drugs too often, or that you might have a drug problem?	**YES** ○	**NO** ○

Now, here are some questions about eating and weight.
67. How much do you weigh? _____ (pounds)
68. How tall are you? _____ (feet) _____ (inches)

69. Do you think that you are too heavy, and that you should try to lose weight?	**YES** ○	**NO** ○
70. Do you often worry a great deal about gaining weight or becoming fat?	**YES** ○	**NO** ○
71. Does your weight or body shape very strongly affect the way you feel about yourself?	**YES** ○	**NO** ○
72. Do you often feel that you can't control what or how much you eat?	**YES** ○	**NO** ○
73. Do you sometimes eat what most people would regard as an unusually large amount of food within a 2-hour period?	**YES** ○	**NO** ○
74. Have you eaten very large amounts of food like this at least as twice a week, in an average week, for the past 6 months?	**YES** ○	**NO** ○

In the past 3 months, have you done any of these things to lose weight or to avoid gaining weight?		
75. Have you exercised almost every day for over an hour to lose or avoid gaining weight?	**YES** ○	**NO** ○
76. Have you used diet drugs almost every day for months to lose or avoid gaining weight?	**YES** ○	**NO** ○
77. Have you fasted (not eaten anything) for at least 24 hours to lose or avoid gaining weight?	**YES** ○	**NO** ○
78. Have you used high doses of laxatives or diuretics to lose or avoid gaining weight?	**YES** ○	**NO** ○
79. Have you made yourself vomit to lose weight or to avoid gaining weight?	**YES** ○	**NO** ○
80. Have you used enemas to lose weight or to avoid gaining weight?	**YES** ○	**NO** ○

81. How often have you done things like this to avoid gaining weight in the last 3 months?
Please select one of the following answers.

Never ☐	**Once or Twice** ☐	**Less Than Once a Week** ☐	**At Least Once a Week** ☐	**At Least Twice a Week** ☐

82. (**females only**) Have you had any menstrual periods in the past 3 months?	**YES** ○	**NO** ○

83. How much have any problems that you may have had with your eating habits or your weight made it difficult for you to do your work, take care of things at home, or get along with other people?
Please select one of the following answers.

Not difficult at all ☐	**A little difficult** ☐	**Quite difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐