Intake Packet Cover Sheet

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 uploading to your patient portal, or dropping off at the office. If we do not receive the packet in advance, we may need to reschedule your visit.

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

Ages 4-11 – your packet includes:

CAP Learning-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_17 (Pediatric Symptom Checklist, to be completed by parent)
- ChEAT (eating disorder screen to be completed by parent for age 6-11)

Ages 12-19 – your packet includes:

PARENT TO COMPLETE IN ADVANCE OF VISIT

CAP Learning-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/teen's teachers)

PATIENT TO COMPLETE CONFIDENTIALLY IN ADVANCE and BROUGHT TO THE VISIT

- GAD-7 (anxiety screen to be completed by youth)
- PHQ-A (depression screen to be completed by youth)
- EAT (eating disorder screen to be completed by youth)

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

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 ☐	Frequent 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

Symptoms	Never	Occasionally	Often	Very Often
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	○	○	○	○	○	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

	Never	Occasionally	Often	Very Often	
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: ______________________

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. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

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

PHQ-9: Modified for Teens

Name ____

Clinician ______________________________ Date ________________

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
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?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

For Office Use Only Score ____0____

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit.* Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Eating Attitudes Test© (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: .... Day: .... Year: .... 2) Gender: ❑ Male ❑ Female

3) Height Feet: .... Inches: ....

4) Current Weight (lbs.): .... 5) Highest Weight (excluding pregnancy): ....

6) Lowest Adult Weight: .... 7) Ideal Weight: ....

	Part B: Please check a response for each of the following statements:	**Always**	**Usually**	**Often**	**Sometimes**	**Rarely**	**Never**
1.	Am terrified about being overweight.	❑	❑	❑	❑	❑	❑
2.	Avoid eating when I am hungry.	❑	❑	❑	❑	❑	❑
3.	Find myself preoccupied with food.	❑	❑	❑	❑	❑	❑
4.	Have gone on eating binges where I feel that I may not be able to stop.	❑	❑	❑	❑	❑	❑
5.	Cut my food into small pieces.	❑	❑	❑	❑	❑	❑
6.	Aware of the calorie content of foods that I eat.	❑	❑	❑	❑	❑	❑
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	❑	❑	❑	❑	❑	❑
8.	Feel that others would prefer if I ate more.	❑	❑	❑	❑	❑	❑
9.	Vomit after I have eaten.	❑	❑	❑	❑	❑	❑
10.	Feel extremely guilty after eating.	❑	❑	❑	❑	❑	❑
11.	Am preoccupied with a desire to be thinner.	❑	❑	❑	❑	❑	❑
12.	Think about burning up calories when I exercise.	❑	❑	❑	❑	❑	❑
13.	Other people think that I am too thin.	❑	❑	❑	❑	❑	❑
14.	Am preoccupied with the thought of having fat on my body.	❑	❑	❑	❑	❑	❑
15.	Take longer than others to eat my meals.	❑	❑	❑	❑	❑	❑
16.	Avoid foods with sugar in them.	❑	❑	❑	❑	❑	❑
17.	Eat diet foods.	❑	❑	❑	❑	❑	❑
18.	Feel that food controls my life.	❑	❑	❑	❑	❑	❑
19.	Display self-control around food.	❑	❑	❑	❑	❑	❑
20.	Feel that others pressure me to eat.	❑	❑	❑	❑	❑	❑
21.	Give too much time and thought to food.	❑	❑	❑	❑	❑	❑
22.	Feel uncomfortable after eating sweets.	❑	❑	❑	❑	❑	❑
23.	Engage in dieting behavior.	❑	❑	❑	❑	❑	❑
24.	Like my stomach to be empty.	❑	❑	❑	❑	❑	❑
25.	Have the impulse to vomit after meals.	❑	❑	❑	❑	❑	❑
26.	Enjoy trying new rich foods.	❑	❑	❑	❑	❑	❑
	Part C: Behavioral Questions. In the past 6 months have you:	**Never**	**Once a month or less**	**2-3 times a month**	**Once a week**	**2-6 times a week**	**Once a day or more**
A.	Gone on eating binges where you feel that you may not be able to stop?	❑	❑	❑	❑	❑	❑
B.	Ever made yourself sick (vomited) to control your weight or shape?	❑	❑	❑	❑	❑	❑
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	❑	❑	❑	❑	❑	❑
D.	Exercised more than 60 minutes a day to lose or to control your weight?	❑	❑	❑	❑	❑	❑
E.	Lost 20 pounds or more in the past 6 months		❑ Yes			❑ No	

• Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.

EAT-26: Garner et al. 1982, Psychological Medicine, 12, (871 878); adapted/reproduced by D. Garner with permission.