Capital Area Pediatrics
your neighborhood pediatrician

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
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
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)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Name:_____ Date: _____

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

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**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

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 ○

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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 ○

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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 ○

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Child's Name: _____ Child's age _____

Caregiver: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS*:* Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child. Our office staff will tally up the scores. Thank you!

	Please mark under the heading that best fits your child			***For Office Use***		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad.	☐	☐	☐	0		
2. Feel hopeless.	☐	☐	☐	0		
3. Feel down on him/herself.	☐	☐	☐	0		
4. Worry a lot.	☐	☐	☐	0		
5. Seem to be having less fun.	☐	☐	☐	0		
6. Fidget, is unable to sit still.	☐	☐	☐		0	
7. Daydream too much.	☐	☐	☐		0	
8. Distract easily.	☐	☐	☐		0	
9. Have trouble concentrating.	☐	☐	☐		0	
10. Act as if driven by a motor.	☐	☐	☐		0	
11. Fight with other children.	☐	☐	☐			0
12. Not listen to rules.	☐	☐	☐			0
13. Not understand other people's feelings.	☐	☐	☐			0
14. Tease others.	☐	☐	☐			0
15. Blame others for his/her troubles.	☐	☐	☐			0
16. Refuse to share.	☐	☐	☐			0
17. Take things that do not belong to him her.	☐	☐	☐			0

For office use: ***I***= 0 ***A***= 0 ***E***= 0 ***Total***= 0

PSC-17 Created by: Gardner W, Murphy M, Childs G et al. (1999)

This form is freely available online.

Patient Name: _____ Today's date: _____

Patient DOB: _____

Children's Eating Attitude Test (ChEAT)

	Always	Very Often	Often	Sometimes	Rarely	Never
1. I am scared about being overweight	(3)	(2)	(1)	(0)	(0)	(0)
2. I stay away from eating when I am hungry	(3)	(2)	(1)	(0)	(0)	(0)
3. I think about food a lot of the time	(3)	(2)	(1)	(0)	(0)	(0)
4. I have gone on eating binges where I feel that I might not be able to stop	(3)	(2)	(1)	(0)	(0)	(0)
5. I cut my food into small pieces	(3)	(2)	(1)	(0)	(0)	(0)
6. I am aware of the energy (calorie) content in foods that I eat	(3)	(2)	(1)	(0)	(0)	(0)
7. I try to stay away from foods such as breads, potatoes, and rice	(3)	(2)	(1)	(0)	(0)	(0)
8. I feel like others would like me to eat more	(3)	(2)	(1)	(0)	(0)	(0)
9. I vomit after I have eaten	(3)	(2)	(1)	(0)	(0)	(0)
10. I feel very guilty after eating	(3)	(2)	(1)	(0)	(0)	(0)
11. I think a lot about wanting to be thinner	(3)	(2)	(1)	(0)	(0)	(0)
12. I think about burning up energy (calories) when I exercise	(3)	(2)	(1)	(0)	(0)	(0)
13. Other people think I am too thin	(3)	(2)	(1)	(0)	(0)	(0)
14. I think a lot about having fat on my body	(3)	(2)	(1)	(0)	(0)	(0)
15. I take longer than others to eat my meals	(3)	(2)	(1)	(0)	(0)	(0)
16. I stay away from foods with sugar in them	(3)	(2)	(1)	(0)	(0)	(0)
17. I eat diet foods	(3)	(2)	(1)	(0)	(0)	(0)
18. I think that food controls my life	(3)	(2)	(1)	(0)	(0)	(0)
19. I can show self-control around food	(3)	(2)	(1)	(0)	(0)	(0)
20. I feel that others pressure me to eat	(3)	(2)	(1)	(0)	(0)	(0)
21. I give too much time and thought to food	(3)	(2)	(1)	(0)	(0)	(0)
22. I feel uncomfortable after eating sweets	(3)	(2)	(1)	(0)	(0)	(0)
23. I have been dieting	(3)	(2)	(1)	(0)	(0)	(0)
24. I like my stomach to be empty	(3)	(2)	(1)	(0)	(0)	(0)
25. I enjoy trying new rich foods	(3)	(2)	(1)	(0)	(0)	(0)
26. I have the urge to vomit after eating	(3)	(2)	(1)	(0)	(0)	(0)