WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

HONESDALE BEHAVIORAL HEALTH OFFICE

NOTICE OF NEW POLICY REGARDING PATIENT APPOINTMENTS

PLEASE BE ADVISED THAT DUE TO THE OVERWHELMING DEMAND FOR APPOINTMENTS IN OUR HONESDALE OFFICE, WE ARE IMPLEMENTING THE FOLLOWING NEW POLICY:

IF YOU "NO SHOW" FOR THREE MEDICATION APPOINTMENTS IN 1 YEAR OR 2 THERAPY APPOINTMENTS IN 1 YEAR:

("NO SHOW" MEANS YOU DON'T CALL TO CANCEL OR RESCHEDULE AND DON'T COME TO YOUR APPOINTMENT)

1. **YOU WILL NO LONGER BE ABLE TO BOOK ANY APPOINTMENTS IN ADVANCE, AND WILL ONLY BE ABLE TO CALL IN ON A GIVEN DAY, TO BE PLACED ON A CANCELLATION LIST FOR THAT DAY ONLY.**

2. **IF YOU NO SHOW REGULARLY, THE PROVIDERS RESERVE THE RIGHT TO DISMISS YOU COMPLETELY FROM THE PRACTICE.**

3. **IF YOU ARE DUE FOR A FOLLOW-UP APPOINTMENT, THE PROVIDERS WILL NOT FILL YOUR MEDICATIONS UNTIL YOU ARE SEEN, SO YOU WILL NOT BE GRANTED REFILLS OVER THE PHONE IF YOU MISS YOUR APPOINTMENT.**

4. **PLEASE ALSO BE ADVISED, THAT IF YOU ARRIVE MORE THAN 10 MINUTES LATE FOR YOUR DOCTOR'S APPOINTMENT, OR 15 MINUTES LATE TO YOUR THERAPY SESSION, WE RESERVE THE RIGHT TO CANCEL YOUR APPOINTMENT AND RESCHEDULE IT.**

IF YOU ARE CANCELLING YOUR APPOINTMENT, PLEASE BE COURTEOUS TO OTHERS AND CALL AT LEAST 24 HOURS AHEAD, SO WE CAN FILL YOUR SPOT WITH SOMEONE ON THE WAITING LIST

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
BEHAVIORAL HEALTH PRACTICES
MEDICATION GUIDELINES

WE DO NOT PRESCRIBE MEDICAL MARIJUANA.

The WMCHC Behavioral Health Practices will not prescribe Xanax.

If a patient is prescribed a controlled substance, the provider may order a urine drug screen or pill count at their discretion.

The WMCHC Behavioral Health Practices will not prescribe immediate release stimulants to adults.

The WMCHC Behavioral Health Practices will not prescribe benzodiazepines to any patient who may be taking them in combination with opioids and/or stimulants and/or recreational substances.

Controlled substance prescriptions that are lost or stolen will not be replaced, under any circumstances.

Controlled substance prescriptions will not be refilled early, under any circumstances.

Complaints regarding medication abuse will result in periodic random urine drug screening without prior notice, for a period of at least 3 months or longer and/or random pill counts, at the discretion of the provider or, could result in discharge.

Evidence of manipulating a controlled substance prescription or selling prescribed medications is a felony and will result in discharge from the practice and a report to the Attorney General.

Any abusive/threatening behavior by patients will result in immediate discharge from the practice.

The Behavioral Health Practices of Wayne Memorial Community Health Centers seek to provide services in a professional, compassionate and respectful manner. WMCHC requires the same respect from patients when interacting with providers and staff.

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

DEMOGRAPHICS

DATE _____ FIRST NAME_____MIDDLE _____ LAST NAME _____

DATE OF BIRTH _____ MARITAL STATUS: _____ PRIOR LAST NAME _____

ADDRESS: _____ SOCIAL SECURITY # _____

_____ SEX: Male Female

PRIMARY PHONE: (_____) _____ SECONDARY PHONE: (_____) _____

Circle one: Home Cell Work Other:_____

☐ OK to leave a message with detailed information

☐ Leave call back number ONLY

Circle one: Home Cell Work Other:_____

☐ OK to leave a message with detailed information

☐ Leave call back number ONLY

EMAIL:_____

INSURANCE

INSURANCE INFORMATION-PLEASE PROVIDE CARD

PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

*** * GUARANTOR IS THE PERSON FINANCIALY RESPONSIBLE FOR BALANCES. * ***

IF OTHER THAN THE PATIENT PLEASE PROVIDE REQUIRED INFORMATION:

GUARANTOR IS: PATIENT OTHER _____

ADDRESS: _____ DATE OF BIRTH _____

SOCIAL SECURITY #_____ TELEPHONE # OF GUARANTOR: _____

PHARMACY

PHARMACY PREFERENCE_____ PHONE # (_____) _____

CITY/STATE _____

MISCELLANEOUS

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____

TELEPHONE # (_____) _____

IF MINOR CHILD – NAME OF PARENT OR GUARDIAN: _____

PRIMARY CARE PHYSICIAN: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

SIGNATURE

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Relationship: _____ Date: _____

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.

Voluntary Confidential Information

Why are we asking for this information? WMCHC develops and expands services in our community utilizing federal grant funds. Collection of the information below allows us to access grant funds bringing more health care services and health care jobs to our area. Your help in obtaining this information is greatly appreciated. **These statistics are reported to the government in total not by individual name.** We would like you to fill out the form completely but understand if there are questions you do not want to answer. **Thank You**.

1) **What is your primary language?**
- ☐ English
- ☐ Non-English
- ☐ Deaf/Sign Language
- ☐ Interpreter Required

2) **Sex at Birth:**
- ☐ Male
- ☐ Female

3) **Sexual Orientation:** ☐ **Choose not to disclose**
- ☐ Straight or heterosexual
- ☐ Lesbian /Gay
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't know

4) **Gender Identity:** ☐ **Choose not to disclose**
- ☐ Male
- ☐ Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Transgender Female/ Male-to-Female
- ☐ Other

5) **Ethnicity:** ☐ **Choose not to disclose**
Hispanic or Latino ☐ Yes ☐ No

6) **Race:** ☐ **Choose not to disclose**
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ White/Caucasian
- ☐ More than one race

7) **Insurance:**
- ☐ Chip
- ☐ Medicaid (Access includes Access HMO)
- ☐ Medicare (including Medicare replacement)
- ☐ Dual Eligible (Medicare/Medicaid)
- ☐ Self Pay
- ☐ Commercial (Aetna, Highmark, GHP, Unions)
- ☐ Other_____

8) **Income Range:** **(Total Family Income)** ☐ **Choose not to disclose**

Family Size: _____ (Number of dependents, including yourself and spouse)

If you do not wish to report your family income, please mark ☐ **(Choose not to disclose)**. Thank you.

- ☐ $0-$10,999
- ☐ $11,000-20,999
- ☐ $21,000-$30, 999
- ☐ $31,000-$40, 999
- ☐ $41,000-$50, 999
- ☐ $51,000-$60, 999
- ☐ $61,000-$70, 999
- ☐ $71,000-$80, 999
- ☐ $81,000-$90, 999
- ☐ $91,000-$100, 999
- ☐ $101,000 and above

Are you a dependent? ☐ Yes ☐ No

9) **Please check any of the following that apply:**

Are you a veteran of the armed services?	☐ Yes	☐ No
Migrant Agricultural Worker	☐ Yes	☐ No
Seasonal Agricultural Worker	☐ Yes	☐ No

10) **Homeless** ☐ Yes ☐ No (Definition of a homeless person- person who lack housing. This includes persons living with friends & relatives- doubling up.)
Please define type of Homeless
☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street

Reduced Fees:
☐ Yes, I would like to be contacted about the sliding fee program.
☐ No, I would not like to be contacted about the sliding fee program.

ACCESS PLUS
Adding Quality to Your Life

ADOLESCENT HEALTH HISTORY

(Use for ages 11-20 years)

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

PAST MEDICAL HISTORY

Previous doctor: ☐ None ☐ Yes (name)_____

Allergies/reactions to medicines or vaccines: _____

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: ☐ None ☐ Yes, (list) _____

Hospitalizations/ Operations: ☐ None ☐ Yes, (list) _____

Broken bones/Severe Injuries: ☐ None ☐ Yes, (list) _____

REVIEW OF SYSTEMS

Please check (✓) any current problems your child has on the list below:

General
___ fevers/chills/excessive sweating
___ unexplained weight loss/gain

Eyes
___ squinting/cross eyes

Ears/Nose/Throat
___ unusually loud voice/hard of hearing
___ mouth breathing/snoring
___ bad breath
___ frequently runny nose
___ problems with teeth/gums

Heart /Cardiovascular
___ tires easily with exercise
___ shortness of breath
___ fainting
___ chest pain with exercise

Lungs/Respiratory
___ cough/wheeze
___ chest pain

Gastrointestinal
___ nausea/vomiting/diarrhea
___ constipation
___ blood in bowel movement

Genitourinary
___ bedwetting
___ pain with urination
___ discharge: penis or vagina

Musculoskeletal
___ muscle/joint pain

Skin
___ rashes
___ unusual moles

Allergy
___ hay fever/itchy eyes

Neurological
___ headaches
___ weakness
___ clumsiness
___ speech problems

Psychiatric/Emotional
___ anxiety/stress
___ problems with sleep/nightmares
___ depression
___ nail biting/thumb sucking
___ bad temper/breath holding/jealousy

Blood/Lymph
___ unexplained lumps
___ easy bruising/bleeding

SOCIAL/SCHOOL HISTORY

Current grade: _____ Name of School: _____

Concerns about school performance? ☐ No ☐ Yes, _____

Concerns about relationships with teachers? ☐ No ☐ Yes, _____ Students? ☐ No ☐ Yes, _____

School grades: _____ Best friend? ☐ No ☐ Yes Many friends? ☐ No ☐ Yes Dating? ☐ No ☐ Yes

Sexually active? ☐ No ☐ Yes Using birth control? ☐ No ☐ Yes Would like more information? ☐ No ☐ Yes

Involved in activities/sports/exercise? ☐ No ☐ Yes (list) _____

Signature of person completing this form: _____

Reviewed by Provider: _____

2007-May

ADOLESCENT HEALTH HISTORY

Patient's Name: _____ Today's Date: _____

FAMILY HISTORY Please indicate family members (mother, father, sister, brother, aunt, uncle, grand parent

Alcoholism _____ Heart attack _____ High cholesterol _____ Stroke _____

Cancer _____ High blood pressure _____ Depression/suicide _____ Diabetes _____

In the past year, have there been any changes in your family? (check all that apply)

☐ Marriage ☐ Separation ☐ Divorce ☐ Move to new neighborhood ☐ Change to new school ☐ Serious illness

☐ Loss of job ☐ Death ☐ Birth ☐ Other changes/stresses _____

Who lives at home with you?

Name	Age	Relationship

IMMUNIZATION/INFECTIOUS DISEASE Did you bring your child's immunization record with you today?

☐ Yes ☐ No ☐ Will bring to next appointment ☐ Records with another care provider (name)_____

Has your child had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB) ☐ Hepatitis B

☐ Meningitis ☐ Pneumonia ☐ Influenza (flu) ☐ Other disease _____

PREVENTION/SAFETY

What is your dentist's name? _____ Date of last dental exam: _____

Do you or does anyone in your home:

Use tobacco products?	☐ No	☐ Me	☐ Household member	Type: _____	Amount: _____
Drink alcohol?	☐ No	☐ Me	☐ Household member	Type: _____	Amount: _____
Use illegal drugs?	☐ No	☐ Me	☐ Household member	Type: _____	Amount: _____

Does your home have smoke detectors? ☐ No ☐ Yes

Do you have a gun in your house? ☐ No ☐ If Yes, is it unloaded and out of reach? ☐ No ☐ Yes

Do you regularly use:

Helmets for bikes/boards/ATVs/motorcycles? ☐ No ☐ Yes

Seat belts when riding or driving a car? ☐ No ☐ Yes

OTHER CONCERNS Please review this list and check any concerns you have about the patient

☐ Physical development	☐ Emotional development	☐ Sleep patterns
☐ Weight	☐ Diet/Nutrition	☐ Amount of physical activity
☐ Relationship with parents and family	☐ Choice of friends	☐ Self image/self worth
☐ Excessive moodiness or rebellion	☐ Depression	☐ Lying, stealing, vandalism
☐ Violence/gangs/guns/weapons	☐ School grades/absences	☐ Drug use
☐ Smoking/chewing tobacco	☐ Alcohol use	☐ Sexual behavior
☐ Sexual orientation (heterosexual, gay)	☐ Pregnancy risk	☐ Sexually transmitted diseases (STDs)

What is the greatest challenge for you/your child? _____

What about you/your adolescent makes you proud? _____

Is there anything you would like to discuss in private today? _____

Signature of person completing this form: _____

Reviewed by Provider: _____

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

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 your child. Then, for each statement, check √ the box 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				PN
2. My child gets headaches when he/she am at school.				SH
3. My child doesn't like to be with people he/she does't know well.				SC
4. My child gets scared if he/she sleeps away from home.				SP
5. My child worries about other people liking him/her.				GD
6. When my child gets frightened, he/she fells like passing out.				PN
7. My child is nervous.				GD
8. My child follows me wherever I go.				SP
9. People tell me that my child looks nervous.				PN
10. My child feels nervous with people he/she doesn't know well.				SC
11. My child gets stomachaches at school.				SH
12. When my child gets frightened, he/she feels like he/she is going crazy.				PN
13. My child worries about sleeping alone.				SP
14. My child worries about being as good as other kids.				GD
15. When my child gets frightened, he/she feels like things are not real.				PN
16. My child has nightmares about something bad happening to his/her parents.				SP
17. My child worries about going to school.				SH
18. When my child gets frightened, his/her heart beats fast.				PN
19. He/she child gets shaky.				PN
20. My child has nightmares about something bad happening to him/her.				SP

Screen for Child Anxiety Related Disorders (SCARED)

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

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under instruments.

March 20, 2017

ASEBA

Please print # CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo._____ Date _____ Yr. _____

CHILD'S BIRTHDATE Mo._____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)_____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

6-1-01 Edition - 201

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters)

☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐ **Does not attend school because** _____

_____

	Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
	a. Reading, English, or Language Arts	☐	☐	☐	☐
Other academic subjects–for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.	b. History or Social Studies	☐	☐	☐	☐
	c. Arithmetic or Math	☐	☐	☐	☐
	d. Science	☐	☐	☐	☐
	e. _____	☐	☐	☐	☐
	f. _____	☐	☐	☐	☐
	g. _____	☐	☐	☐	☐

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ **No** ☐ **Yes—kind of services, class, or school:**

3. Has your child repeated any grades? ☐ **No** ☐ **Yes—grades and reasons:**

4. Has your child had any academic or other problems in school? ☐ **No** ☐ **Yes—please describe:**

When did these problems start?_____

Have these problems ended? ☐ **No** ☐ **Yes–when?**

Does your child have any illness or disability (either physical or mental)? ☐ **No** ☐ **Yes—please describe:**

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe):_____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): ____
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

D3

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

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

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

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

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

Comments:

For Office Use Only

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

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

Total Symptom Score for questions 1–18: _____

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

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

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

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

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Name: _____ Grade: _____

Date of Birth: _____ Teacher: _____ School: _____

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

	Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often				
1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting in line	0	1	2	3
18.	Interrupts or intrudes on others (e.g., butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3

(continued on next page)

Vanderbilt ADHD Diagnostic Teacher Rating Scale (continued)

	Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often			
20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

PERFORMANCE

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

PHQ-9 & GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

Over the last 2 weeks, on how many days have you been bothered by any of 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 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

GAD7 – Total Score

Screen for Child Anxiety Related Disorders (SCARED)

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

Screen for Child Anxiety Related Disorders (SCARED)

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

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

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

Screen for Child Anxiety Related Disorders (SCARED)

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

**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.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu