

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

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:

OK to leave a message with detailed information

Circle one:

OK to leave a message with detailed information

Home Cell Work

Home Cell Work

Other: _____

Leave call back number ONLY

Other: _____

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 FINANCIALLY 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 Deaf/Sign Language
 Non-English 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

7) **Insurance:**

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

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

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.

PEDIATRIC HEALTH HISTORY

(Use from birth to 10 years)

Today's Date: _____

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

PREGNANCY & BIRTH Where was your child born? _____ Vaginal C-Section

Is this child yours by Birth Adoption Stepchild Other _____

Medical problems during pregnancy: None Yes (specify) _____

During pregnancy did you use Tobacco Illegal drugs Alcohol Medications (list): _____

Birth weight _____ Birth length _____ APGAR scores 1 min. ____ / 5 min. ____

Problems during the newborn period: None Premature, how early? _____ Other (list) _____

NUTRITION & FEEDING

Breastfed? No Yes, how long? _____ Bottle No Yes

Has your child had any problems with eating or foods? (list) _____

Intake now: Breast milk Formula Cow's milk (1%, 2%, whole milk) Soy milk Rice milk Juice

Other (water, soda, tea) Average ounces per day (8 ounces= 1 cup) _____

Baby food Table food Meats Fruits Vegetables Whole grains Sweets Junk food

SLEEP Any concerns/problems with sleep? (list) _____

Hours per night: _____ Naps: No Yes, number and length: _____

Where does your child sleep? Bassinette Crib Own bed Parents room Own room Other _____

DEVELOPMENT At what age did your child: Smile _____ Sit alone _____ Walk alone _____ Say words _____

Toilet train _____ Ride a tricycle _____ Read words _____ (females) Have first menstrual period _____

DENTAL HISTORY Has your child been seen by a dentist? No Yes, how often? _____

Date of last dental visit: _____ What type of water does your child drink?: City water Well water

IMMUNIZATIONS/INFECTIOUS DISEASES Did you bring your child's immunization record to their appointment?

No Yes 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)

EXPOSURE/HABITS Does the patient, or do any household members:

Use tobacco? No Yes Use illegal drugs? No Yes Drink alcohol? No Yes

Concern about lead exposure? No Yes Old home Old plumbing Peeling paint Other (list) _____

TV-hours per day _____ Computer-hours per day _____ Video game-hours per day _____

Signature of person completing this form: _____

Reviewed by Provider: _____

PEDIATRIC HEALTH HISTORY

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

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) _____

FAMILY HISTORY Please note family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism _____ Heart attack _____ High cholesterol _____ Stroke _____

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

Sudden/early death _____ Other _____

SOCIAL HISTORY List all household members below:

Name	Age	Relationship	Name	Age	Relationship
------	-----	--------------	------	-----	--------------

Are the child's parents: Married Unmarried Separated Divorced Other _____

If separated/divorced, when? _____

Mother's occupation: _____ Employer: _____

Father's occupation: _____ Employer: _____

Child care situation: Parent(s) Day Care Other (specify) _____

Concerns about your child: Alcohol use Tobacco use Drug use Sexual activity Aggressive behavior Violence at home

SAFETY Check all that apply.

Are there guns in the home? No Yes Uses infant seat/booster/seat belt in the car? No Yes

Smoke detectors in home? No Yes Wears helmet for bike/scooter/skateboard/ATV use? No Yes

SCHOOL HISTORY Does your child attend school? No If Yes, Public Private Home schooled Preschool

Current grade: _____ Name of school: _____

Any problems with school grades, teachers or student relationships? No Yes, _____

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

Signature of person completing this form: _____

Reviewed by Provider: _____

PEDIATRIC HEALTH HISTORY

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

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

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

Signature of person completing this form: _____

Reviewed by Provider: _____

2007-May

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	1	2	
	Not True or Hardly Ever True	Somewhat True or Sometimes True	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 doesn'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 feels 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	1	2	
	Not True or Hardly Ever True	Somewhat True or Sometimes True	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



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

- a. _____
- b. _____
- c. _____

Compared to others of the same age, about how much time does he/she spend in each?

Less Than Average Average More Than Average Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compared to others of the same age, how well does he/she do each one?

Below Average Average Above Average Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- a. _____
- b. _____
- c. _____

Compared to others of the same age, about how much time does he/she spend in each?

Less Than Average Average More Than Average Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compared to others of the same age, how well does he/she do each one?

Below Average Average Above Average Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

None

- a. _____
- b. _____
- c. _____

Compared to others of the same age, how active is he/she in each?

Less Active Average More Active Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- a. _____
- b. _____
- c. _____

Compared to others of the same age, how well does he/she carry them out?

Below Average Average Above Average Don't Know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Behave with his/her parents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Play and work alone? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

VII. 1. Performance in academic subjects.

Does not attend school because _____

Check a box for each subject that child takes

Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., or other nonacademic subjects.

	Falling	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

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 _____

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

Revised - 1102

American Academy
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NICHQ

National Initiative for Children's Healthcare Quality



HE0350

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: _____

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

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

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

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

**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