CHRISTIE CLINIC | DEPARTMENT *of* PEDIATRICS

1801 West Windsor Road • Champaign, IL 61821
217.366.1257 • 217.366.6110 Fax

INITIAL INFORMATION PACKET

Dear Parent,

Thank you very much for bringing your child to the Christie Clinic Department of Pediatrics. Children come to the Developmental and Behavioral Clinic for many reasons. No single form is appropriate for all children, but the enclosed forms will help us better understand your child's need. Many questions could be inappropriate for your child. We ask you to please complete the sections as best as you can and that you feel pertain to your child.

Please complete the enclosed forms:

____Parent Packet

____Parent Vanderbilt Checklist

Information from the schools is often critical to understand a child's needs. The enclosed school information packet is very helpful in understanding your child's needs:

____Teacher's Report form

____Vanderbilt Teacher's Checklist

Please bring copies of any evaluations:

____IEP or 504 Reports

____School Discipline Reports

____Results of school testing or private testing

____Any other information you think would be useful

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PATIENT INFORMATION

Child's Name: _____

Date of Birth: _____ Age: _____ Grade: _____ Sex: Male / Female / Other

Home Address: _____

Home Phone: _____ Work/Daytime Phone: _____

School: _____ Phone: _____

School Address: _____

Primary Physician: _____ Phone: _____

Physician Address: _____

Referred by: _____ Phone: _____

Child lives primarily with: *(Please be specific as possible – include all adults in the home)*.

_____

_____

Full Sisters in the home: Ages: _____, _____, _____, _____

Full Brothers in the home: Ages: _____, _____, _____, _____

Half-Sisters in the home: Ages: _____, _____, _____, _____

Half-Brothers in the home: Ages: _____, _____, _____, _____

Step-Sisters in the home: Ages: _____, _____, _____, _____

Step-Brothers in the home: Ages: _____, _____, _____, _____

Foster Children in the home: Ages: _____, _____, _____, _____

Custody: Full Joint Visitation

Explanation if needed: _____

_____

_____

Do you want a copy of this evaluation sent to anyone other than the Primary Physician: Yes / No

To whom? _____

_____

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CONCERNS

Please list your concerns: _____

_____

_____

_____

_____

_____

Academic Diagnoses: Has the school diagnosed any of the following problems? Please circle:

Asperger Syndrome	Autism	ADHD	Oppositional Disorder	Behavior Disorder
Mental Retardation	PDD	Learning Disability	Fine/Motor/Dysgraphia	Reading/Dyslexia

My child has the following problems at home or in public. Please circle:

Does not finish chores	Refuses chores	Tantrums at home	Tantrums in stores	
Fights with siblings	Fights with parents	Fights with friends	Fights with neighbors	
Loses belongings	Refuses requests	Loses temper	Deliberately annoys	Is often angry
Is often resentful	Is spiteful	Touchy or easily annoyed	Runs away in public	
Runs from home	Runs from school	Ran away overnight	Often lies	Plays with fire
Sets fires	Steals	Cruel to animals	Often swears	Keeps grudges

Details/Other concerns at home: _____

_____

_____

_____

_____

_____

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MEDICAL HISTORY

Pregnancy. Please circle:

Mother at age of birth:_____ General Health: Good / Poor Bleeding / Threatened loss

Excessive vomiting High blood pressure Toxemia Smoking Alcohol use Infection

Drugs/ Medications Psychological stress Early labor Breech

Details:_____

_____

_____

Delivery. Please circle:

Weeks gestation:_____ Delivery induced: Yes / No Reason:

C-Section: Yes / No Repeat C-Section Emergency C-Section C-Section – Failure to progress

Vaginal Delivery: Yes / No Forceps / Vacuum Complications: Yes / No

Details:_____

_____

_____

Newborn. Please circle:

Premature Birth Normal Nursery NICU Ventilator Oxygen Discharged with mother

Hospitalized for_____Days/Weeks

Infancy. Please circle:

Breastfed Bottle Feeding Problems Vomiting / Spitting Up Colic Poor Sleep

Irritability Weak / Poor Muscle Tone

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GENERAL MEDICAL HISTORY

Chronic Medical Problems: _____

_____

_____

Allergies to Food or Medications: _____

_____

_____

Surgeries – List with age: _____

_____

_____

Hospitalizations – List with diagnosis and age: _____

_____

_____

Medical Problems. Please circle:

Seizure Concussion Loss of consciousness Fainting Tics Headache Asthma

Heart Problems Fast heart rate Abdominal paint Vomiting Constipation Diarrhea

Diet / Feeding. Please circle:

Eats normal diet Has limited food preferences Has very limited diet Chokes when eating

Sensitive to food textures

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GENERAL MEDICAL HISTORY (CONT.)

Sleep. Please circle:

Sleeps normally _____ to _____ Has difficulty falling asleep – takes _____ minutes

Sleeps in own bed Sleeps in parent's bed Night roams Has left the house during the night

Creates problems at night Sleeps during the day Snores Chokes

Special Senses. Please circle:

Vision normal – Passed school screen Hearing normal Acts deaf

Overreacts to sounds or noise Overreacts to touch Does not look at faces

Does not pickup on social cues Rocks Self stimulates

Flaps when excited Easily over-stimulated

Coordination. Please circle:

Normal Poor Difficulties throwing Difficulties with sports Poor handwriting

Problems lying

Other fine motor problems: _____

_____

_____

Sports and other activities: _____

_____

_____

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PAST TREATMENT

Please list all other Professionals consulted: ***(Including name, specialty and phone number)***.

_____

_____

_____

_____

_____

_____

_____

_____

Past Medications: ***(Include doses).***

Adderall	Adderall XR	Concerta	Daytrana	Dexidrine	
Focalin	Focalin XR	Intuniv	Metadate CD	Methylphenidate	
Vyvanse	Abilify	Risperdone	Geodon	Seroquel	Zyprexa
Clonidine	Tenex	Depakote	Trileptal	Lithium	

Comments: _____

_____

_____

Age that concerns began: _____

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MOOD AND ANXIETY

School refusal	Yes / No
Unable to participate in activities due to worry or "being scared"	Yes / No
Unable to visit friends due to worry	Yes / No
Avoids being alone in a room in the house	Yes / No
Refuses to sleep alone	Yes / No
Distress anticipating separation	Yes / No
Excessive distress when away from home	Yes / No
Unrealistic and persistent worries about harm to family members	Yes / No
Unrealistic worries about natural events, calamities, storms, etc.	Yes / No
Depressed sad mood often	Yes / No
Unrealistic concerns about past behavior	Yes / No
Intrusive concerns about competence (I'm a loser)	Yes / No
Needs excessive reassurance	Yes / No
Very self-conscious	Yes / No
Unable to relax	Yes / No
Fatigue, loss of energy	Yes / No
Diminished pleasure in daily activities	Yes / No
Suicidal thought or expressions	Yes /No

Details:_____

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SCHOOL HISTORY

Please list schools attended in chronological order – include name of school, city, what ages they were when they attended and grade if applicable:

Problems?

1. _____ Yes / No
2. _____ Yes / No
3. _____ Yes / No
4. _____ Yes / No
5. _____ Yes / No
6. _____ Yes / No
7. _____ Yes / No
8. _____ Yes / No
9. _____ Yes / No
10. _____ Yes / No

Age of first concern:_____

Concerns:_____

_____

_____

To the best of your knowledge, what grade level is your child functioning in the following subject matters?

Reading _____ Spelling _____ Mathematics _____

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SCHOOL HISTORY (CONT.)

Has your child ever received any special help in schools? Please include type of help, what grade your child was in when they received the help and circle if they are currently receiving help at this time.

Title 1 Reading.....Yes / No

Speech and language.....Yes / No

Occupational Therapy.....Yes / No

Physical Therapy.....Yes / No

Resource Room.....Yes / No

Behavioral Plan / Class.....Yes / No

Special Education.....Yes / No

Private Tutoring.....Yes / No

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SCHOOL BEHAVIOR

Are there any other modifications made for your child at school? **Yes / No**

Explain: _____

_____

_____

_____

_____

Has your child ever been suspended, had detentions or been expelled? **Yes / No**

Explain: _____

_____

_____

_____

_____

Has your child ever been retained? **Yes / No**

What grade level? _____

My child has the following behaviors in school. Please circle:

Fidgets	Blurts out answers	Out of seat	Easily distracted	Talks excessively
Does not take turns	Interrupts	Does not listen	Loses work	Loses possessions
Forgets homework	Fights			

Homework Habits. Please circle:

Homework takes too long _____ minutes spent on homework per night

Activities get canceled due to homework	Refuses homework	Cannot do homework	
Excessive homework	Poor handwriting	Cannot organize projects	Dawdles

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TEACHER EVALUATION FORM

Student Name: _____

School: _____

Teacher: _____

Grade Level: _____

Phone number: _____

Fax number: _____

Thank you for your assistance. Your input in essential for accurate diagnosis and management of your student. No single form can cover all children. If you have concerns, please contact us.

PLEASE COMMENT ON ANY OF THE FOLLOWING STATEMENTS:

Needs reminders to work independently: _____

_____

_____

Needs reminders to finish work: _____

_____

_____

Often distracts others: _____

_____

_____

Fidgets often, has a difficult time sitting still: _____

_____

_____

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TEACHER EVALUATION FORM

Does not understand or follow through on directions: _____

_____

_____

Sleepy or tuned out of learning: _____

_____

_____

Impulsive behavior: _____

_____

_____

Learning problems: _____

_____

_____

SOCIAL PROBLEMS

Makes friends: _____

_____

_____

Sensory problems: _____

_____

_____

Overreacts to sound: _____

_____

_____

Acts as if deaf: _____

_____

_____

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TEACHER EVALUATION FORM

SOCIAL PROBLEMS (CONT.)

Odd behaviors (rocking, flapping): _____

_____

_____

Special Interests: _____

_____

_____

Obsessive interests: _____

_____

_____

Physically intrusive: _____

_____

_____

Comments / Additional concerns or behaviors you have noticed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please feel free to call the clinic if you have any concerns: 217.366.1257

NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Name: _____

Parent's Phone Number: _____

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

Is this evaluation based on a time when the child

was on medication **was not on medication** **not sure?**

Symptoms	Never	Occasionally	Often	Very Often	
1. Does not pay attention to details or makes careless mistakes with, for example, homework					
2. Has difficulty keeping attention to what needs to be done					
3. Does not seem to listen when spoken to directly					
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)					
5. Has difficulty organizing tasks and activities					
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort					
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)					
8. Is easily distracted by noises or other stimuli					
9. Is forgetful in daily activities					For Office Use Only 2 & 3s: ___/9
10. Fidgets with hands or feet or squirms in seat					
11. Leaves seat when remaining seated is expected					
12. Runs about or climbs too much when remaining seated is expected					
13. Has difficulty playing or beginning quiet play activities					
14. Is "on the go" or often acts as if "driven by a motor"					
15. Talks too much					
16. Blurts out answers before questions have been completed					
17. Has difficulty waiting his or her turn					
18. Interrupts or intrudes in on others' conversations and/or activities					For Office Use Only 2 & 3s: ___/9

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	○	○	○	○	
20. Loses temper	○	○	○	○	
21. Actively defies or refuses to go along with adults' requests or rules	○	○	○	○	
22. Deliberately annoys people	○	○	○	○	
23. Blames others for his or her mistakes or misbehaviors	○	○	○	○	
24. Is touchy or easily annoyed by others	○	○	○	○	
25. Is angry or resentful	○	○	○	○	
26. Is spiteful and wants to get even	○	○	○	○	For Office Use Only 2 & 3s: ___/8
27. Bullies, threatens, or intimidates others	○	○	○	○	
28. Starts physical fights	○	○	○	○	
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	○	○	○	○	
30. Is truant from school (skips school) without permission	○	○	○	○	
31. Is physically cruel to people	○	○	○	○	
32. Has stolen things that have value	○	○	○	○	
33. Deliberately destroys others' property	○	○	○	○	
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	○	○	○	○	
35. Is physically cruel to animals	○	○	○	○	
36. Has deliberately set fires to cause damage	○	○	○	○	
37. Has broken into someone else's home, business, or car	○	○	○	○	
38. Has stayed out at night without permission	○	○	○	○	
39. Has run away from home overnight	○	○	○	○	
40. Has forced someone into sexual activity	○	○	○	○	For Office Use Only 2&3s: ___/14
41. Is fearful, anxious, or worried	○	○	○	○	
42. Is afraid to try new things for fear of making mistakes	○	○	○	○	
43. Feels worthless or inferior	○	○	○	○	
44. Blames self for problems, feels guilty	○	○	○	○	
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	○	○	○	○	
46. Is sad, unhappy, or depressed	○	○	○	○	
47. Is self-conscious or easily embarrassed	○	○	○	○	For Office Use Only 2 & 3s: ___/7

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading	○	○	○	○	○	
49. Writing	○	○	○	○	○	For Office Use Only 4s:_____/3
50. Mathematics	○	○	○	○	○	For Office Use Only 5s:_____/3
51. Relationship with parents	○	○	○	○	○	
52. Relationship with siblings	○	○	○	○	○	
53. Relationship with peers	○	○	○	○	○	For Office Use Only 4s:_____/4
54. Participation in organized activities (eg, teams)	○	○	○	○	○	For Office Use Only 5s:_____/4

Other Conditions

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

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

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

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

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

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

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

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

Comments:

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 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 in questions 48–50: _____

Total number of questions scored 5 in questions 48–50: _____

Total number of questions scored 4 in questions 51–54: _____

Total number of questions scored 5 in questions 51–54: _____

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Caring for Children With ADHD: A Resource Toolkit for Clinicians*, 2nd Edition. Copyright © 2012 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

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QuIIN Quality Improvement Innovation Network
A program of the American Academy of Pediatrics

NICHQ
National Initiative for Children's Healthcare Quality

NICHQ Vanderbilt Assessment Scale: Teacher Informant

Child's Name: _____

Child's Date of Birth: _____

Teacher's Name: _____

Today's Date: _____

Class Time: _____

Class Name/Period: _____

Grade Level: _____

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

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

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Loses temper	○	○	○	○	
20. Activity defies or refuses to comply with adults' requests or rules	○	○	○	○	
21. Is angry or resentful	○	○	○	○	
22. Is spiteful and vindictive	○	○	○	○	
23. Bullies, threatens, or intimidates others	○	○	○	○	
24. Initiates physical fights	○	○	○	○	
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	○	○	○	○	
26. Is physically cruel to people	○	○	○	○	
27. Has stolen items of nontrivial value	○	○	○	○	
28. Deliberately destroys others' property	○	○	○	○	For Office Use Only 2 & 3s: ___/10
29. Is fearful, anxious, or worried	○	○	○	○	
30. Is self-conscious or easily embarrassed	○	○	○	○	
31. Is afraid to try new things for fear of making mistakes	○	○	○	○	
32. Feels worthless or inferior	○	○	○	○	
33. Blames self for problems; feels guilty	○	○	○	○	
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	○	○	○	○	
35. Is sad, unhappy, or depressed	○	○	○	○	For Office Use Only 2 & 3s: ___/7

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

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
39. Relationship with peers	○	○	○	○	○	
40. Following directions	○	○	○	○	○	
41. Disrupting class	○	○	○	○	○	
42. Assignment completion	○	○	○	○	○	For Office Use Only 4s:_____/5
43. Organizational skills	○	○	○	○	○	For Office Use Only 5s:_____/5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

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 number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 in questions 36–38: _____

Total number of questions scored 5 in questions 36–38: _____

Total number of questions scored 4 in questions 39–43: _____

Total number of questions scored 5 in questions 39–43: _____

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Caring for Children With ADHD: A Resource Toolkit for Clinicians*, 2nd Edition. Copyright © 2012 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

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QuIIN Quality Improvement Innovation Network
A program of the American Academy of Pediatrics

NICHQ National Initiative for Children's Healthcare Quality

Screen for Child Anxiety Related Disorders (SCARED)

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP

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

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

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.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

Screen for Child Anxiety Related Disorders (SCARED)

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

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, 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	PN
2. My child gets headaches when he/she am at school.	O	O	O	SH
3. My child doesn't like to be with people he/she does't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she fells like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomachaches at school.	O	O	O	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	PN
13. My child worries about sleeping alone.	O	O	O	SP
14. My child worries about being as good as other kids.	O	O	O	GD
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	PN
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	SP
17. My child worries about going to school.	O	O	O	SH
18. When my child gets frightened, his/her heart beats fast.	O	O	O	PN
19. He/she child gets shaky.	O	O	O	PN
20. My child has nightmares about something bad happening to him/her.	O	O	O	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.	O	O	O	GD
22. When my child gets frightened, he/she sweats a lot.	O	O	O	PN
23. My child is a worrier.	O	O	O	GD
24. My child gets really frightened for no reason at all.	O	O	O	PN
25. My child is afraid to be alone in the house.	O	O	O	SP
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	SC
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	PN
28. People tell me that my child worries too much.	O	O	O	GD
29. My child doesn't like to be away from his/her family.	O	O	O	SP
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. My child worries that something bad might happen to his/her parents.	O	O	O	SP
32. My child feels shy with people he/she doesn't know well.	O	O	O	SC
33. My child worries about what is going to happen in the future.	O	O	O	GD
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	PN
35. My child worries about how well he/she does things.	O	O	O	GD
36. My child is scared to go to school.	O	O	O	SH
37. My child worries about things that have already happened.	O	O	O	GD
38. When my child gets frightened, he/she feels dizzy.	O	O	O	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).	O	O	O	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.	O	O	O	SC
41. My child is shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

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A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect often-occurring behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other comorbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ▪ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 **AND** ▪ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ▪ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 **AND** ▪ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ▪ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 **AND** ▪ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Hyperactive/Impulsive subtype** ▪ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 **AND** ▪ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ▪ Requires the above criteria on both inattention and hyperactivity/impulsivity	**ADHD Combined Inattention/Hyperactivity** ▪ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional/Defiant Disorder Screen ▪ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 **AND** ▪ Score a 4 or 5 on any of the Performance questions 48–55	**Oppositional/Defiant Disorder Screen** ▪ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 **AND** ▪ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ▪ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 **AND** ▪ Score a 4 or 5 on any of the Performance questions 48–55	**Anxiety/Depression Screen** ▪ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 **AND** ▪ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ▪ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 **AND** ▪ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up

- Calculate **Total** Symptom Score for questions 1–18.
- Calculate **Average** Performance Score for questions 19–26.

Teacher Assessment Follow-up

- Calculate **Total** Symptom Score for questions 1–18.
- Calculate **Average** Performance Score for questions 19–26.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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