



PEDIATRIC IN-TAKE

In order to serve you properly, please complete ALL of the following information and bring it with you to your first visit. You may need to ask family members about the family history. If assistance was required in filling this form out, please indicate on form with name and relationship.

CONTACT INFORMATION

Patient Name

Date

Primary Care Physician (PCP)

Primary Care Physician's Number

Primary Care Address

City

State

Zip

Current Therapist/Counselor's Name

Current Therapist/Counselor's Number

Email

Referred by (PCP, ZocDoc, Friend, Etc.)

REASON FOR VISIT

Don't know _____ Evaluation _____ Therapy for Child _____ Family Therapy _____

Medication _____ Testing _____

Please Summarize the concerns that led to this referral:



ABOUT MY CHILD:

Gender _____ Race/Ethnicity _____ Religious Identity _____ Sexual Orientation _____

Interests/Hobbies _____

What do you see as your child's strengths?

SUICIDE RISK ASSESSMENT

Has your child ever expressed or acted in any way that has made you concerned for his/her safety (thoughts of wanting to die, plans to kill self, cutting self, burning self, etc.)?

Yes _____ No _____

If yes, please explain:

REVIEW OF SYMPTOMS		
please check all that apply		
MUSCULOSKELETAL		
Arthralgias	Joint Swelling	
Myalgias	NSAID Use	
Muscle Weakness	Other	
SKIN		
Rash	Nail Changes	
Pruritus	Skin Thickening	
Sores	Other	
NEUROLOGICAL		
Migraines	Tremors	
Numbness	Vertigo	
Ataxia	Other	

ENDOCRINE		
Excess Thirst	Heat Intolerance	
Polyuria	Goiter	
Cold Intolerance	Other	
PSYCHIATRIC		
Depression	Drug Abuse	
Anxiety	Insomnia	
Antidepressants	Other	
Alcohol Abuse		
HEM/LYMPHATIC		
Easy Bruising	Swollen Glands	
Bleeding Diathesis	Lymphedema	
Blood Clots	Others	
ALLERGIC/IMMUNE		
Allergic Rhinitis	Positive PPD	
Hay Fever	Hives	
Asthma	Other	

Please list ALL current prescription medications in reference to your child only

Medication Name	Total Daily Dosage	Estimated Start Date

PATIENT MEDICAL HISTORY

Height/Weight

Please list all allergies

Current over-the-counter medications or supplements



Current medical problems

Past medical problems, non-psychiatric hospitalizations or surgeries

Have you ever had an EKG Yes No If yes, when was the EKG?

Results: Normal Abnormal Unknown

DEVELOPMENTAL HISTORY

Birth History:

Biological Mother's age at time of birth _____ years.

Biological Father's age at time of birth _____ years.

Did Biological Mother smoke while pregnant? Yes__ No__ Drink alcohol Yes__ No__ Use illicit Drugs Yes__ No__

Did Biological Mother take medications during pregnancy? Yes__ No__ Please List: _____

Was Biological Mother under a doctor's care during pregnancy? Yes____ No____ Were there any complications

during pregnancy? Yes____ No____ Please Describe _____

About the delivery: Number of weeks _____ Vaginal _____ Caesarean _____ Forceps _____ Other
Complications _____

What were the APGAR Scores? _____

Was the baby in the hospital or NICU for more than 2 days? Yes____ No____

If YES, please explain _____

DEVELOPMENT As closely as you can remember, please indicate when your child.....

Age of rolling over _____ Age of sitting alone _____ Age of walking _____

Large motor skills developed: Fast _____ Slow _____ Average _____

Fine motor skills developed: Fast _____ Slow _____ Average _____

Did your child seem clumsier than other children? Yes _____ No _____

Did your child point to things? Yes _____ No _____

Age of first words _____ Age of talking in sentences _____

Is your child: Right-handed _____ Left-handed _____ Uses both hands equally _____

Age when child chose one hand more than the other _____

Age when child stayed dry during the day _____

Age when child stayed dry throughout the night ____

Age when child was bowel trained ____

Temperament As an Infant/Toddler did your child establish the following routines normally....

Sleep/Wake cycle Yes ____ No ____

Eating Yes ____ No ____

Was your child interested in other people? Yes ____ No ____

Did your child have colic? Yes ____ No ____

Was your child overly sensitive to:

Particular sounds (Sirens, loud noises)? Yes ____ No ____

Particular sensations(tags on clothes, socks, light touch, movement such as swinging)? Yes ____ No ____

Particular smells? Yes ____ No ____

Particular tastes? Yes ____ No ____

Was your child:

Slow to warm up? Yes ____ No ____

Underactive? Yes ____ No ____

Aggressive? Yes ____ No ____

Shy? Yes ____ No ____

Overactive? Yes ____ No ____

PAST PSYCHIATRIC HISTORY

Outpatient Treatment Yes No

If Yes, please list reasons/date(s), treated by whom

Psychiatric Hospitalizations? Yes No

If yes, please list reasons/date(s), treated by whom

Please list if your child has ever taken any of the following medications: Antidepressants, mood stabilizers, antipsychotics, sedatives and hypnotics, ADHD Medications, Anti-Anxiety Medications. If yes, please list:

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or treated for:

	Yes	No	Which Family member
Bipolar Disorder			
Schizophrenia			
Depression			
Post-Traumatic Stress			
Anxiety			
Alcohol Abuse			
Other Substance Abuse			
Suicide			
Anger			
Violence			

Has any family member been treated with a Psychiatric Medication Yes ___ No ___

If yes, who was treated, what medications and how effective was treatment:

PAST PSYCHIATRIC HISTORY

Has your child ever been treated for alcohol or drug use or abuse? Yes ___ No ___

If yes, for which substances?

If yes where was he/she treated?

Any history of complicated withdrawal from substances, including seizures or delirium tremens (DTs)? If yes, explain?

Is your child currently using any alcohol, recreational drug, or misusing prescription medications? Yes ___ No ___

Does your child use any tobacco products such as cigarettes, e-cigarettes, cigars, pipes or chewing tobacco? If yes, how much and how often?



EDUCATIONAL HISTORY

Name of current school _____ Phone Number: _____

Teacher's Name: _____ Grade: _____

Type of school: Public _____ Private _____ Special/Therapeutic _____

Grades repeated: _____ Grades skipped: _____ Suspended/Expelled? Yes ___ No ___ How many times: _____

Does your child have any known learning disabilities? Yes _____ No _____

Does your child have IEP? Yes _____ No _____

Is your child receiving any special education services (speech, reading, etc)? Yes _____ No _____

If yes, please explain:

Describe your child's behavior and academic performance in school over the past month:

Please fill in for current and all previous school years.

Grade	School Name	Academic Performance			Behavior			
		Good	Fair	Poor	Good	Fair	Poor	
Preschool								
Kindergarten								
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

ABOUT THE FAMILY

Are the parents/Caregivers of this child:

Married/Partnered Yes ___ No ___ Date: _____

Separated Yes ___ No ___ Date _____

Divorced Yes ___ No ___ Date _____

Remarried/Re-partnered Yes ___ No ___ Date _____

Is your child adopted Yes _____ No _____

Age of Adoption _____

Does your child know adoption status? Yes _____ No _____

Please briefly describe any changes or disruptions within the family background for your child. (Please include marriages/partnerships, separations, divorces, remarriages/re-partnerships.)

What does each Parent/Caregiver do for work?

1st Parent/Caregiver _____ 2nd Parent/Caregiver _____

What is the highest level of education of each Parent/Caregiver?

1st Parent/Caregiver _____ 2nd Parent/Caregiver _____

Other children living in the Home:

Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Other Relatives of persons living in the home:

Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Siblings/Half-siblings/Step-Siblings NOT Living in the home

Name and Age: _____ Name and Age: _____

Name and Age: _____ Name and Age: _____

Has your child ever been arrested? Yes _____ No _____

Does he/she have any pending legal problems? Yes _____ No _____



THANK YOU FOR COMPLETING THE FOLLOWING INFORMATION

If there is anything else you would like the provider to know, please indicate below.

SIGNATURE

_____ Signature	_____ Date
_____ Emergency Contact/Relationship	_____ Phone Number

If signed by a patient representative, state relationship to patient



Thank you for choosing Clarity Clinic. In order to serve you properly, we need the following information. Please print. All information will be confidential.

BILLING INFORMATION		
Patient Name		Date
Date of Birth		Sex
Social Security #		
Address		
City	State	Zip
Preferred Telephone Number (Home/Cell/Work)		
Email		
RESPONSIBLE PARTY		
Name of person responsible for this account		
Address		
City	State	Zip
Telephone Number (Home/Cell/Work)		
Drivers License #		
Date of Birth		
Employer	Employer work Phone	
INSURANCE INFORMATION		
Name of insured	Relationship to patient	Date of Birth
Subscriber ID	Group #	
Insurance Company		
Insurance Company Address		

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (or dependents) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the provider. I understand that unless a 24-hour notice of cancellation is given. I may be charged for the time that the provider has set aside



for the appointment. In addition, that if my (or dependent(s)) account requires the services of a collection agency, I may incur charges to cover court and legal fees.

SIGNATURE

Signature (patient, parent or legal guardian)

Date

If signed by a patient representative, state relationship patient



PATIENT EASY PAY CONSENT FORM

(This form is not optional)

I authorize Clarity Clinic to charge my credit/debit card for late fees as outlined in the “Policies and Procedures” Form.

I authorize Clarity Clinic to charge my credit/debit card for all charges and services not paid by my insurance company within 90 days of services rendered including co-pays and no-show fees unless discussed otherwise with the office staff.

BILLING INFORMATION				
Name on Card				
Card Number				
Expiration Date		Type of card		
		VISA	MasterCard	AMEX Discover
CVV Code				
Billing Address				
City		State	Zip	

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Clarity Clinic.

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	



PATIENT TELEPHONE SESSION RATE

I acknowledge that any phone calls made to my therapist or psychiatrist exceeding 15 minutes will be billed as an out-of-pocket expense. The following rates apply:

Phone Call Duration	Therapist Rate	Psychiatrist Rate
15-30 Minutes	\$50	\$75
30-45 Minutes	\$100	\$150
45-60 Minutes	\$120	\$200

AUTHORIZATION AND RELEASE

By signing below I understand and acknowledge these charges are out-of-pocket and will not be billed to my insurance company

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	



CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction(s), they must follow the restriction(s).

Due to the increased frequency and complexity of the medication prior authorization process required by some insurance companies, government, and employers, there will be an administration fee of \$10.00 per page to cover time spent by your doctor on the paperwork and a \$20.00 fee if time is spent by your doctor on phone calls needed to complete a prior-authorization.

I understand that there will be an additional fee of \$30.00 to send or obtain full medical records. Finally, the administrative charges for additional letters and paperwork may apply to cover the time spent by your doctor on paperwork and phone calls needed to complete the authorization.

SIGNATURE

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Signature (patient, parent or legal guardian)		date	
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Witness signature		date	
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POLICIES AND PROCEDURE OVERVIEW

Thank you for choosing Clarity Clinic for your healthcare needs. We are committed to providing high quality, personalized and compassionate, comprehensive patient care. We ask that these policies be reviewed and acknowledged so that we may provide quality service and ensure proper reimbursement. Please sign the policy indicating that you have read the terms and conditions, in agreement to abide by them.

1. Consent for Treatment
 - a. I hereby authorize and acknowledge to work with the authorities of Clarity Clinic, and the physician(s)/therapist(s) in charge of my/the case, to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.
2. Pre-Authorization for Benefits
 - a. I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered. I understand that a quote of benefits is not a guarantee of payment.
3. Payment Guarantee
 - a. Co-payments are due in FULL at the time of each visit.
 - b. Full payment is due at the time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement is made with Clarity Clinic Billing Department.
 - c. Sessions shortened by the patient will still be charged at the full reserved fee.
 - d. Checks written and returned NSF/Account Closed will be charged an additional \$35.00.
 - e. In the event that a check has been returned NSF/Account Closed, all future payments must be made via Cash, Credit, or Debit Card.
 - f. If you do not have insurance, payment is due in full at the time of each visit. Services may be turned away at the discretion of the provider.
 - g. Responsibility of an account balance is always the Patient's, NOT the insurance company.
4. Release of Insurance-Related Information
 - a. I authorize Clarity Clinic to release any information about me to insurance carriers needed to process claims.
5. Delinquent Accounts
 - a. Patients must settle past due balances prior to scheduling future appointments.
 - b. All outstanding balances are due in full at the time of service unless payment arrangements have been made with Clarity Clinic Billing Department.
 - c. Non-payments of delinquent balances will be grounds for termination of services rendered by Clarity Clinic until the delinquent balance is resolved in its entirety.
 - d. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorneys fees, court costs and filing fees will be the responsibility of the patient/guarantor.
6. Late Cancellation/Missed Appointment Charge
 - a. We understand that occasionally life can get in the way, causing you to miss an appointment with us. In order for us to effectively care for all of our patients, it is important we are notified in advance when you must miss a scheduled appointment. Giving advance notice when you cannot attend your scheduled appointment permits us an opportunity to care for others.
 - b. Fees apply for failure to provide 24-hour advanced notice. When a patient cancels/misses an appointment with less than 24-hour advance notice, the patient will be charged \$50.
7. Therapy



- a. Patients who are under the care of a prescribing psychiatrist are encouraged to keep regular therapy appointments, unless directed otherwise.
- 8. Prescriptions
 - a. Please notify your pharmacy 5 days before you run out of a medication, and have them fax the request to our office during regular business hours. Prescriptions are not refilled when our office is closed. Missing appointments may result in your doctor's inability to refill your prescription.
 - b. Refill and prescribing of controlled substances MUST ALWAYS be done at the appointment and will not be able to be called in. No exceptions.
 - c. In the event a physician changes, discontinues, or adjusts a patient's medication the patient will be required to make any follow up appointment in the timeframe the physician deems necessary.
- 9. Follow-up Appointments by Phone
 - a. Clarity Clinic clinicians charge for clinical phone consultations with patients. Charges are according to the individual clinician's specific fee schedule. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultations charges are solely the patient's responsibility.
- 10. Medical Records Change
 - a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee of \$20 for any released Medical Records.
 - b. Medical Record releases take a minimum of 10 business days from the date Clarity Clinic receives a signed release form. Medical Records will be released once the processing fee has been paid in full.
- 11. Completion of Forms/Letters
 - a. The charge for the completion of forms/letters can typically range from \$30-\$150 (\$15 per page). However, please note that depending upon the length of the forms or documentation being requested this charge could be higher.
- 12. Discharge from Care
 - a. You have control over your care, and you have the right to eliminate your care with us at any time. We reserve the right to discharge any patient from this practice at any time for failure to comply with office policies or treatment recommendations. We will provide referral suggestions, if requested, in this event.

Please sign below to authorize treatment indication that you acknowledge these stated policies and your full financial responsibility for services rendered.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date

CONTROLLED SUBSTANCE AGREEMENT

Part 1: I UNDERSTAND

- Part of my treatment may include prescriptions for benzodiazepines, stimulants, and narcotics to improve my ability to function. These medications are only part of my treatment.
- Treatment with these medications may have side effects including nausea, sleepiness, difficulty breathing (if taken in excess), itching, difficulty concentrating, constipation, and difficulty urinating.
 - Additional side effects for men include low testosterone levels.
 - Additional side effects for women include changes in menstrual cycles.
- If I take these medicines for more than a few weeks, I may become used to them and could develop physical dependence and/or addiction. I could experience withdrawal if I stop taking them suddenly, which could lead to death. The risks of dependence, tolerance, and side effects specific to the medication have been explained to me.
- If I do not reach my treatment goals from use of these medications, my provider may gradually discontinue them or may adjust my dose.
- Medication will not be refilled on weekends or holidays.
- Psychiatric symptoms can be improved by good health habits such as exercise, healthy diet, and abstinence from tobacco, alcohol, and illicit drugs.

I WILL

- Tell my provider if I have been diagnosed with, treated, or arrested for drug dependence or abuse prior to starting treatment with the prescribed medications.
- Tell my provider if I have been involved in the sale, illegal possession, or transport of controlled substances prior to starting treatment.
- Take my controlled medication as prescribed, taper the medication if recommended by my provider at any time, and reduce the medication only under the supervision of my provider.
- Tell my other provider(s) and any emergency department I may visit that I am taking controlled medication and have an agreement with Clarity Clinic.
- Tell my provider about ALL of the medications (over-the-counter herbs, vitamins, those ordered by other providers, legal, illegal) that I am taking because this medication can interact with other substances, which could potentially lead to death.
- Only ask for refills during clinic hours (8:00am-5:00pm, Monday-Friday).
- Provide at least three (3) days notice for refills of medications
- Tell my provider if I get the prescribed medications or other controlled substances from any other provider.
- Keep my controlled medications in a safe place, locked away from children and to prevent theft.
- Attend my appointments regularly and call my provider's office at least 24 hours in advance if I need to cancel my appointment.
- Submit to random tests of my urine or blood and pill counts within 48 hours of request.
- Actively participate in therapy and other non-medication treatment if I am recommended to do so by the provider as part of my treatment plan.

I WILL NOT

- Share, sell, or trade my medications with anyone.
- Use someone else's medications.

- Use any illegal drugs (crystal meth, marijuana, cocaine, etc.)
- Change how I take my medications without asking my provider.
- Ask my provider for extra refills if I use up my supply or lose or misplace my medications before my next refill is due. Looking after my medications and complying with my prescription are my responsibility.

Part 2: I UNDERSTAND

If I do not do all of the things listed in Part 1, my provider:

- May no longer prescribe the medications for me.
- May stop giving me medical care.
- May send me to drug abuse treatment

PART 3: CLARITY CLINIC CONTROLLED SUBSTANCE POLICIES

- Each patient is allowed up to 1 early refill per year.
- If a patient loses a script, they must come in for an appointment. Prescriptions cannot be left at the front desk or issued without an appointment.
- Newly prescribed patients must come in for an appointment once a month for the 1st year. After the 1st year, prescribed patients must come for at least follow-ups every two months.
- Patients prescribed a dosage that exceeds the FDA approved dosage must come in monthly
 - Vyvanse - 70mg/day
 - Adderall - 60mg/day
 - Concerta/Methylphenidate - 72mg/day
- Patients should receive EKG and blood pressure reading after increasing stimulant dose greater than FDA approved dose and at least once a year.
- Patients on disability and not currently working will not receive Adderall.
- If a prescribed patient is away at college, the patient must come in at least every 3 months. If this is not possible, the patient must find a doctor nearby to manage their medication.
- Patients with blood pressure greater than 160/100 must receive either primary care or cardiology clearance before receiving refills at the next appointment. Failure to do so will result in medication not being refilled.
- Patients with congenital heart, valve issues, Sickle Cell Anemia require cardiology clearance before beginning stimulants.
- Patients with a history of drug addiction on stimulants will be subject to random drug screens. If patient is positive, inferring any potential for drug abuse, the patient will be sent a termination letter.
- Patients on more than 4mg of Xanax, Lorazepam, or Clonazepam must come to clinic at least every 2 weeks until patient is tapered down to 4mg of respective medication. Patients on greater than 2mg and less than 4mg will not receive greater than a 30-day script and will have to come each month to refill medication.

PART 4: SIGN THE FORM

The decision to use controlled substances (benzodiazepines, stimulants, narcotics) has been made between my provider and me because of my specific condition. When I sign this form, I acknowledge that I understand and agree to the above conditions to make my treatment as safe and successful as possible. A copy of this agreement will be maintained in my medical record. I



can cancel this agreement at any time, except to the extent my provider has already acted in reliance on it. If not canceled before, this agreement will end on my last dose of the medications prescribed by my provider. If I cancel this agreement, my provider may take any or all of the actions described above.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date



AUTHORIZATION TO RELEASE OUTPATIENT RECORDS

I, _____, hereby request and authorize Clarity Clinic to release the information which is contained in any outpatient psychiatric, psychotherapy, alcohol and/or substance abuse records, including any & all information gained in interviewing & examining including, but not limited to, any outpatient treatment.

The persons or entities, including oneself, authorized to receive the information and records covered by this consent are: (Please provide relationship, name, address, and telephone number).

Name	Relationship	Phone
Address		
Name	Relationship	Phone
Address		
Name	Relationship	Phone
Address		

- The information and records which may be released are limited to all medical records or other information obtained by **Clarity Clinic**, through interviews or inquiries concerning or obtained from other persons, and will include all outpatient psychiatric, psychotherapy, alcohol and/or substance abuse records which are in the possession of control of **Clarity Clinic**.
- The purpose of such disclosure is for use in connection with Coordination of Care purposes. The information and records released pursuant to this consent will not be used for any other purposes.
- I understand that I may refuse to sign this authorization to release information.
- I understand that I receive a copy of this authorization to release information.
- I understand that this release automatically expires within ninety days unless I authorize it to ask to authorize the expiration to be sooner.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date



NICHQ VANDERBILT ASSESSMENT SCALE
PARENT

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 ___unsure

Symptoms	Never	Occasionally	Often	Very Often	
Does not pay attention to details or makes careless mistakes with, for example, homework					
Has difficulty keeping attention to what needs to be done					
Does not seem to listen when spoken to directly					
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)					
Has difficulty organizing tasks and activities					
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort					
Loses things necessary for tasks or activities (toys, assignments, pencils, or books.)					
Is easily distracted by noises or other stimuli					
Is forgetful in daily activities					
Fidgets with hands or feet or squirms in seat					
Leaves seat when remaining seated is expected					
Runs about or climbs too much when remaining seated is expected					

Has difficulty playing or beginning quiet play activities					
Is "on the go" or often acts as if "driven by a motor"					
Talks too much					
Blurts out answers before questions have been completed					
Has difficulty waiting his or her turn					
Interrupts or intrudes in others' conversations and activities					
Argues with adults					
Loses temper					
Actively defies or refuses to go along with adult's' requests or rules					
Deliberately annoys people					
Blames others for his or her mistakes or misbehavior					
Is touchy or easily annoyed by others					
Is angry or resentful					
Is spiteful and wants to get even					
Bullies, threatens, or intimidates others					
Starts physical fights					
Lies to get out of trouble or to avoid obligations (i.e. "cons" others)					
Is truant from school (skips school) without permission					
Is physically cruel to people					
Has stolen things that have value					
Deliberately destroys others' property					
Has used a weapon that can cause serious harm (bat, knife, brick, gun)					
Is physically cruel to animals					
Has deliberately set fires to cause damage					

Has broken into someone else's home, business or car					
Has stayed out at night without permission					
Has run away from home overnight					
Has forced someone into sexual activity					
Is fearful, anxious or worried					
Is afraid to try new things for fear of making mistakes					
Feels worthless or inferior					
Blames self for problems, feels guilty					
Feels lonely, unwanted or unloved, complains that "no one loves him or her"					
Is sad, unhappy or depressed					
Is self-conscious or easily embarrassed					
Performance	Excellent	Above Average	Average	Somewhat a problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with parents					
Relationship with siblings					
Relationship with peers					
Participation in organized activities (i.e. teams)					



COLUMBIA IMPAIRMENT SCALE

Directions: This survey asks questions about how you think your child is doing overall. Please answer the question on a scale from 0 to 4, with “0” being “no problem” and “4” being a “very bad problem.” If the question does not apply to your child, please indicate with N/A.

In general, how much of a problem do you think that your child has with:					
	No Problem 0	1	2	3	Very bad Problem 4
Getting into trouble					
Getting along with his/her mother?					
Getting along with his/her father?					
Feeling unhappy or sad?					
Behavior at school/on the job					
Having fun?					
Getting along with adults other than his/her parents?					
Feeling nervous or worried?					
Getting along with brothers/sisters?					
Getting along with other kids his/her age?					
Getting involved in activities like sports or hobbies?					
School/work/job?					
Behavior at home?					



SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDER (SCARED)
CHILD FORM (8 YEARS AND OLDER*)

*For children ages 8 to 11, it is recommended that the child answer the questionnaire sitting with an adult in case they have any questions

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 you. Then for each statement, indicate which statement corresponds to the response that seems to describe you **now or within the past 6 weeks**. Please respond to all statements as well as you can, even if some do not seem to concern you.

	0	1	2
	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
When I feel frightened, it is hard to breathe			
I get headaches when I am at school			
I don't like to be with people I don't know well			
I get scared if I sleep away from home			
I worry about other people liking me			
When I get frightened I feel like passing out			
I am nervous			
I follow my mother or father wherever they go			
People tell me that I look nervous			
I feel nervous with people I don't know well			
I get stomach aches at school			
When I get frightened I feel like I am going crazy			
I worry about sleeping alone			
I worry about being as good as other kids			
When I get frightened, I feel like things are not real			
I have nightmares about something bad happening to my parents			
I worry about going to school			

When I get frightened, my heart beats fast			
I get shaky			
I have nightmares about something bad happening to me			
I worry about things working out for me			
When I get frightened, I sweat a lot			
I am a worrier			
I get really frightened for no reason at all			
I am afraid to be alone in the house			
It is hard for me to talk with people I don't know well			
When I get frightened, I feel like I am choking			
People tell me that I worry too much			
I don't like to be away from my family			
I am afraid of having anxiety (or panic) attacks			
I worry that something bad might happen to my parents			
I feel shy with people I don't know well			
I worry about how well I do things			
I worry about what is going to happen in the future			
When I get frightened, I feel like throwing up			
I worry about how well I do things			
I am scared to go to school			
I worry about things that have already happened			
When I get frightened, I feel dizzy			
I feel nervous when I am with other children or adults and I have to do something while they watch me (ex: read aloud, speak, play a game, play a sport)			
I am shy			

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)
(PARENT FORM)

Below is a list of items that describe how people feel. For each item, please darken the circle that best describes your child's feelings **now or in the past 2 weeks**. Please answer all items 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
When my child feels frightened, it is hard for him/her to breathe			
My child gets headaches when he/she is at school			
My child doesn't like to be with people he/she doesn't know well			
My child gets scared if he/she sleeps away from home			
My child worries about other people liking him/her			
When my child gets frightened, he/she feels like passing out			
My child is nervous			
My child follows me wherever I go (he/she is like my shadow)			
People tell my child that he/she looks nervous			
My child feels nervous with people he/she doesn't know well			
My child gets stomach aches at school			
When my child gets frightened, he/she feels like he/she is going crazy			
My child worries about sleeping alone			
My child worries about being as good as other kids			
When my child gets frightened, he/she feels like things are not real			
My child has nightmares about something bad happening to his/her parents			
My child worries about going to school			
When my child gets frightened, his/her heart beats fast			

My child gets shaky			
My child has nightmares about something bad happening to him/herself			
My child worries about things working out for him/herself			
When my child gets frightened, he/she sweats a lot			
My child is a worrier			
My child gets really frightened for no reason at all			
My child is afraid to be alone in the house			
It is hard for my child to talk with people he/she doesn't know well			
When my child gets frightened, he/she feels like he/she is choking			
People tell my child that he/she worries too much			
My child doesn't like to be away from his/her family			
My child is afraid of having anxiety (or panic) attacks			
My child worries that something bad might happen to his/her parents			
My child feels shy with people he/she doesn't know well			
My child worries about what is going to happen in the future			
When my child gets frightened, he/she feels like throwing up			
My child worries about how well he/she does things			
My child is scared to go to school			
My child worries about things that have already happened			
When my child gets frightened, he/she feels dizzy			
My child feels nervous when he/she is with other children or adults and has to do something while they watch him/her (ex: reading aloud, speak, play a game, play a sport)			
My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she does not know well			
My child is shy			

MOOD AND FEELINGS QUESTIONNAIRE
(PARENT VERSION)

Please indicate next to the statement that best describes your child in the past two weeks.

	No true	Sometimes	TRUE
S/he felt miserable or unhappy			
S/he didn't enjoy anything at all			
S/he was less hungry than usual			
S/he ate more than usual			
S/he felt so tired that s/he just sat around and did nothing			
S/he was moving and walking more slowly than usual			
S/he was very restless			
S/he felt s/he was no good anymore			
S/he blamed her/himself for things that weren't his/her fault			
It was hard for her/him to make up her/his mind			
S/he felt grumpy and cross with you			
S/he felt like talking less than usual			
S/he was talking more slowly than usual			
S/he cried a lot			
S/he thought there was nothing good for her/him in the future			
S/he thought that life wasn't worth living			
S/he thought about death or dying			
S/he thought her/his family would be better off without her/him			
S/he thought about killing her/himself			
She didn't want to see her/his friends			
S/he found it hard to think properly or concentrate			

S/he thought bad things would happen to her/him			
S/he hated him/herself			
S/he felt s/he was a bad person			
S/he thought s/he looked ugly			
S/he worried about aches and pains			
S/he felt lonely			
S/he thought nobody really loved her/him			
S/he didn't have any fun at school			
S/he thought s/he could never be as good as other kids			
S/he felt s/he did everything wrong			
S/he didn't sleep as well as s/he usually sleeps			
S/he slept a lot more than usual			
S/he wasn't as happy as usual, even when you praised or rewarded her/him			

MOOD AND FEELINGS QUESTIONNAIRE
(CHILD VERSION)

Please indicate next to the statement that best describes you in **in the past two weeks.**

	0	1	2
	No true	Sometimes	TRUE
I feel awful or unhappy			
I didn't enjoy anything at all			
I was less hungry than usual			
I ate more than usual			
I felt too tired. I just sat around and did nothing			
I was moving and walking more slowly than usual			
I was very restless			
I felt I was no good anymore			
I blamed myself for things that weren't my fault			
It was hard for me to make up my mind			
I felt grumpy and upset with my parents			
I felt like talking less than usual			
I was talking more slowly than usual			
I cried a lot			
I thought there was nothing good for me in the future			
I thought that life wasn't worth living			
I thought about death and dying			
I thought my family would be better off without me			
I thought about killing myself			
I didn't want to see my friends			
I found it hard to pay attention or concentrate			
I thought bad things would happen to me			
I hated myself			

I felt I was a bad person			
I thought I looked ugly			
I worried about aches and pains			
I felt lonely			
I thought nobody really loved me			
I didn't have any fun at school			
I thought I could never be as good as other kids			
I felt I did everything wrong			
I didn't sleep as well as I usually sleep			
I slept a lot more than usual			