Introduction to Your First Behavioral Consult

To provide quality behavioral health care to our patients, we have developed a streamlined intake process for scheduling your First Behavioral Consult. These appointments address ADHD, depression, anxiety, school difficulties, developmental concerns and other mental/behavioral health concerns.

- We require that your child be an established patient at Peak Pediatrics, and your child is up to date on his well child check.
- We require that you submit all previous medical and mental health records prior to the appointment (from previous primary care provider, mental health specialist, emergency room visits or inpatient stays related to mental health)
- Submit any information from the school, including a 504/IEP plan
- We require you to complete this "First Behavioral Consult Intake packet" prior to the appointment. This packet will ask more detailed questions about your child at home and school to better understand your concerns. You (guardian), your child and one of your child's teacher will be filling out specific parts of the packet.
- Please email completed packet to the Behavioral Health Intake Coordinator, at bhc@peakpediatrics.com. Once we receive the completed packet, you will receive a call to schedule the first behavioral visit.
- These visits are in person visits, but we can accommodate families virtually on a case by case basis.

We schedule First Behavioral Consults on a first come first serve basis, so it is your responsibility to gather all the required documentation prior to scheduling. We will not make contact to schedule until we receive all required documentation.

Please be aware that if you need to reschedule, you must reschedule your First Behavioral Consult more than 48 hours in advance to avoid a No Show. If you must reschedule, following a Cancellation or a No Show, we may not be able to see your child for upwards of 1-3 months following the initial appointment date. If there is more than one No Show for a First Behavioral Consult, we may not be able to reschedule your child for our Behavioral Health Care Services.

We look forward to serving your child's Behavioral Health Care needs!

Sincerely,
Peak Pediatrics

Parent Copy

Checklist for Your Child's First Behavioral Consult

First Behavioral Consults are longer visits that address the following concerns: ADHD, depression, anxiety, school difficulties, and other mental/behavioral health concerns. Due to the complexity of these visits, we require the following information **prior to scheduling** a First Behavioral Consult:

- ☐ Well Child Check within the last 12 months (scheduled with Peak Pediatrics or proof of well child check and transfer of care to Peak Pediatrics initiated).
- ☐ Records from previous behavioral health treatment including therapy, psychiatry, mental health related emergency department or inpatient visits, or another primary care office visits.
- ☐ Completed Behavioral Health intake forms from parents/caregivers and the school (located on our website)
- ☐ Signed Peak Pediatrics Behavioral Health Care Agreement (located on our website)
- ☐ Educational/school evaluation or 504/ IEP documentation, if available

Please send the above information to Peak Pediatrics via MyChart (see instructions on our website and introduction letter)

You may also use fax or email you information to our Behavioral Health Intake Coordinator.

Fax 303-420-8831, Attention: Behavioral Health Intake Coordinator
Email: bhc@peakpediatrics.com

We will notify you once we have received all required information and are ready to schedule your child's First Behavioral Consult. These appointments are booked out 1-3 months ahead of time, so it is important to get all needed information to us as soon as possible.

Peak Pediatrics does not see patients for First Behavioral Consults who are 18 years and older

Should your child require mental health services prior to your First Behavioral Health Consult, please contact Colorado Crisis Services for immediate assistance at 1-844-493-8255

Parent Copy

Patient Name:________________________
Date of birth:__________________
Phone #:______________________

Behavioral Health Care Agreement

By signing below I consent to the treatment of myself/my child by the Licensed Medical Providers of Peak Pediatrics, LLC for mental and behavioral health services.

1) I understand that when a new medication is started or restarted, my child may need to have monthly visits to obtain refills until my child is doing well on his/her medications.
Initial_______

2) Once my child is doing well on their current medications, I understand that I am responsible for ensuring that I/my child is seen **every 3 months for a medication check**. Please attempt to schedule follow up med check appointment before leaving the office to ensure available appointments. If unable to schedule before leaving clinic, **parents/patients are responsible for calling 5-6 weeks ahead of time to schedule next med check appointment**.
Initial________

3) I understand that I may receive 3 months of prescription refills for my child at the end of the appointment. These are **my responsibility** and should I lose them, **these will not be replaced**.
Initial________

4) I understand that if I cancel an upcoming med check appointment or No-Show for a scheduled appointment, the prescribed medication **may not be refilled** and a rescheduled appointment will need to be made in order to receive refills. **Med check appointments will be scheduled for the next available slot, which may be 1-2 months from original appointment date.**
Initial________

5) I understand that Peak Pediatrics only sees established patients for Med Checks appointments. If you would like for your child to be seen for mental/behavioral health reasons, **you must transfer all routine care to us and receive yearly well child care with us**. No exceptions will be made for this.
Initial________

6) I understand that **annual Well Child Visits** are an important part of caring for myself/my child and understand that if annual Well Child Visits are not completed, mental/behavioral health medications may not be refilled.
Medication Checks and Well Child Visits are both necessary yet separate visit types. Should you like to have a Medication Check combined with a Well Child Visit, it must be clearly expressed to the scheduler to provide adequate time for both.
Initial________

7) I understand if my child is in a mental health crisis or there are concerns that my child may hurt themselves or someone else that I am to call the **Colorado Crisis Line at 1-844-493-8255, dial 988, or go to my closest Emergency Department**. Peak Pediatrics is not equipped to support in crisis and your child will need a full evaluation at the above support services.
Initial________

By signing below, I agree to the terms of the Peak Pediatrics Behavioral Health Care Agreement.

____ ________________

Legal Guardian Date

DATE: ___________________________

To Whom It May Concern:

Please forward all medical records of the person/persons listed below to:

Peak Pediatrics, LLC.
3555 Lutheran Parkway, Suite 340
Wheat Ridge, CO 80033
Phone: (303) 996-6005
Fax: (303) 420-8831

NAME_____________________________________ BIRTHDATE_________________

NAME_____________________________________ BIRTHDATE_________________

NAME_____________________________________ BIRTHDATE_________________

NAME_____________________________________ BIRTHDATE_________________

NAME_____________________________________ BIRTHDATE_________________

____
SIGNATURE OF PARENT OR GUARDIAN

____
PRACTICE NAME

____
PRINTED NAME OF PARENT OR GUARDIAN

____
FAX & PHONE #

Please DO NOT send: Any records from The Children's Hospital Colorado or from the EPIC System. We already have access to them, thank you!

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME: ______________________________ **Date of Birth:** ____________

Address (Mailing): ______________________________ **Phone:** ________________

I authorize: Peak Pediatrics

Phone: 303-996-6005
Fax: 303-420-8831

Address: Wheat Ridge: 3555 Lutheran Pkwy, STE 340 Wheat Ridge, CO 80033

Thornton: 2900 E 136TH Ave, STE 201, Thornton, CO 80241

To use or disclose information from my medical and/or mental health record, which may include information about diagnosis and treatment issues to:

Name: ______________________________ **Phone:** ________________

Address: ______________________________ **Fax:** ________________

Dates of Treatment: All______________________________

Information to be released: All______________________________

Purpose of Disclosure: Coordination of Care______________________________

1. **I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.**
2. **I understand that I may revoke this authorization at any time by notifying the HIPAA Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.**
3. **I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.**
4. **I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.**
5. **My health care and payment for my health care at Peak Pediatrics will not be affected if I do not sign this form.**
6. **I understand that I can request a copy of this form after I sign it.**

By signing below, I acknowledge that I have read and understand this Authorization.

______________________________ **OR** ______________________________

Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

____

Relationship to Patient

Behavioral Health Intake Form

Thank you for your time and thought in completing this form. This will help us greatly in addressing your concerns. We look forward to meeting your family soon.

Sincerely,

Peak Pediatrics Behavioral Health Team

General Information

1) Name of Child: ________________________________ Age: __________ DOB: ______________

2) Home Address: ____

(Street) (City) (State) (Zip)

3) Parent/Guardian # 1

Name: ____

Home Phone: ____________________________________

Cell phone: ______________________________________

Work Phone: _____________________________________

Email address: ___________________________________

Exact Relation to Child: _________________________

Occupation: ______________________________________

Parent/Guardian #2

Name: ____

Home Phone: ____________________________________

Cell phone: ______________________________________

Work Phone: _____________________________________

Email address: ___________________________________

Exact Relation to Child: _________________________

Occupation: ______________________________________

4) Person Filling out Form: ____

5) List other children living in the home: Name/Age/Relation to patient

____

____

____

____

6) List other adults living in the home: Name/Age/Relation to patient

____

____

____

____

7) Marital Status of parents: If separated, how does the child split time?

____

School Information:

Current School ____

Grade Level: ____________

Performance (honors, good, average, poor, failing): ________________________________

IEP/504/Additional services at school: ____

Reason you made this appointment:

1) What brings you here? Please briefly describe your concerns regarding your child.

2) When did the problems begin?

3) What treatments or interventions have been tried? (Medication, therapists, OTC treatment)

4) Describe what effects the problems have had on family relationships and family functioning? How does your child get along with each parent and other family members?

5) How do you discipline your child?

6) Describe your child at school. Are there any problems? What does s/he like at school? What does s/he dislike at school?

7) Has your child experienced any significant trauma or stress in his/her lifespan? Including exposure to violence. If so, please explain

8) Do you have any concerns about any substance use, including tobacco, marijuana, alcohol or other drugs in your child?

9) Do you have any concerns about suicidal or harmful thoughts in your child?

Child's Past Psychological/Psychiatric History:

1) Has your child ever been treated for any psychological or psychiatric problems at any time? Please describe past interventions (therapy, hospitalizations, ED visits)

2) Is there anything else I should know about your child's mental health?

Child's Social History:

1) How does your child get along with other children? What do they do together?

2) What are your child's hobbies and what is your child best at doing?

3) How long does your child watch TV/tablet/play video games/use a smartphone in a day?

4) How much physical activity does your child get in a day?

5) Have there been any recent stresses in the family? (death, new family, changes in jobs, money stressors) Please explain.

Child's Medical History:

1) Please list any chronic or serious medical concerns:

2) Current Medications (including vitamins/Herbals):

3) Please describe your child's sleep. What time does s/he go to bed, fall asleep, and wake up? What time do screens (TV/iPad/video games/computer) go off? Any sleep concerns (trouble falling asleep, frequent waking, restless sleep or snoring)?

Child's Developmental history:

1) Were there any problems during pregnancy or around the birth?

2) Was your child born early/on time/late?

3) Have you ever been told your child has any developmental problems? Do you have any concerns about your child's development?

Family Health, Home Safety and Mental Health History:

Please include any blood relatives, including great grandparents, grandparents, parents, great aunts and uncles, aunts and uncles, cousins of any degrees, siblings, nieces, nephews, etc

	Yes	No	Relation	Comments
School Problems				
Learning Disabilities or dyslexia				
Gifted				
ADHD/ADD				
Trouble with law				
Depression				
Anxiety				
Obsessive Compulsive Disorder				
Suicide				
Psychiatric Hospitalization				
Drug/Alcohol Abuse				
Bipolar Depression				
Post Traumatic Stress				
Eating disorder				
Difficulty holding job				
Autism/Asperger's Syndrome				
Thyroid Disease				
Tic/Tourette's Disorder				
Sudden Death (unclear cause)				
Heart problem				
Birth defects				
Other ____________				

Has any family member ever taken any psychiatric or mental health medication? If so, what medication?

How do you store guns and medications in your home?

Is there anything else you would like us to know about your child or family for your behavioral consult visit?

For parent to fill out about your child

Screen for Child Anxiety Related Disorders (SCARED)

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

Name: ______________________________

Date: ______________________________

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

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

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Screen for Child Anxiety Related Disorders (SCARED)

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

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

SCORING:

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

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

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

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

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

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

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

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ___________________________ Date of Birth: ___________

Parent's Name: ___________________________ Parent's Phone Number: ___________________________

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

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

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

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 of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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: ______________

This form is for children age 7 or older. For ages 7-11, please have child sit with adult in case they have questions.
For ages 12 and older, they can fill out alone.

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: ______________________ **Date:** __________________________

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

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

This form is for children age 7 or older. For ages 7-11, please have child sit with adult in case they have questions.
For ages 12 and older, they can fill out alone.

Screen for Child Anxiety Related Disorders (SCARED)

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

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

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

Please have your CHILD fill out this survey. (only if your child is 12 years old or older)

Part of routine screening for your health includes considering mood and emotional concerns. Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling or staying asleep or sleeping too much?				
Poor appetite, weight loss, or overeating?				
Feeling tired or having little energy?				
Feeling bad about yourself –or feeling that you are a failure, or have let yourself or your family down?				
Trouble concentrating on things, like school work, reading or watching TV?				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the ***past year*** have you felt depressed or sad most days, even if you felt OK sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

PHQ-9 Modified for Teens, www.teenscreen.org

For Office Use Only: Score ______

For CHILD to fill out if older than age 12

Screening to Brief Intervention Tool (modified)

Circle the answer that best fits you.

1) In the PAST YEAR, how many times have you used tobacco?

Never | Once or twice | Monthly | Weekly or More

2) In the PAST YEAR, how many times have you used alcohol?

Never | Once or twice | Monthly | Weekly or More

3) In the PAST YEAR, how many times have your used marijuana?

Never | Once or twice | Monthly | Weekly or More

If you answered NEVER to the questions above, please stop now.

Otherwise, continue to the following questions.

In the PAST YEAR, how many times have you used the following:

4) Prescription drugs that were not prescribed for you (such as pain medication or Adderall)

Never | Once or twice | Monthly | Weekly or More

5) Illegal drugs: (such as cocaine or ecstasy)

Never | Once or twice | Monthly | Weekly or More

6) Inhalants: (such as nitrous oxide)

Never | Once or twice | Monthly | Weekly or More

7) Herbs or synthetic: (such as salvia, K2, or bath salts)

Never | Once or twice | Monthly | Weekly or More

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: ______________

Today's Date: ________ Child's Name: ______________________ 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: ________.

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. 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 instructions 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 sustained 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 (eg, butts into conversations/games)	0	1	2	3	
19. Loses temper	0	1	2	3	
20. Actively defies or refuses to comply with adult's 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 (eg, "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	

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

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Teacher's Name: ______________ Class Time: ______________ Class Name/Period: ______________

Today's Date: __________ Child's Name: ______________ Grade Level: ______________

Symptoms (continued)	Never	Occasionally	Often	Very Often
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 or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	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 Symptom Score for questions 1–18: ______________

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 or 5 in questions 36–43: ______________

Average Performance Score: ______________

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