Packet Returned by:_____ Date Packet Returned: _____

Name & Phone Number of parent/guardian to contact for scheduling:

_____

Packet was given to parent/guardian by: _____
(case manager/crisis/referral coordinator, etc)

(NOTE: This packet can be sent via email to the referral coordinators in outpatient/psychiatry at outpatientreferrals@norcen.org)

Date:

Re: _____ (child name)

As part of the evaluation process, the psychiatrists like to review past medical records and school evaluations as well as request that rating scales and questionnaires be completed.

In this packet that you have received, most of the questionnaires will need to be filled out by the child. If your child cannot understand the forms, please help them complete these. The NICHQ Vanderbilt Assessment Scale-Parent informant and Parent questionnaire will need to be completed by a parent/guardian. There is also a rating scale called the NICHQ Vanderbilt Assessment Scale-Teacher Informant which must be filled out by a teacher. Please ask the teacher to email or fax the form back to our office directly, preferably before the date of the initial evaluation. The email address is: outpatientreferrals@norcen.org or Fax number is: 715-841-5118.

The initial evaluation appointment will be scheduled for 90 minutes. The psychiatrist will have a chance to speak to your child, the parent/guardian as well as the case manager (if your child has one). Follow up appts will range from 30-60 minutes dependent on the amount of time the psychiatrist needs.

Please feel free to contact the office if you have any questions about this packet. You can reach us at the numbers listed below.

Thank you for taking the time to complete these forms.

Sincerely,

Outpatient Psychiatry
North Central Health Care

PARENT QUESTIONNAIRE

Who referred you to our clinic? _____
Name of the person completing this form and relationship to the child: _____
Child's Full Legal Name: _____
If the child prefers being called another name, please list: _____
Date of Birth: _____ Age: _____ Ethnicity: _____
Is the child adopted? _____ Yes _____ No If the child is adopted, is the child aware? _____ Yes _____No
If the biological parents are not the legal guardians, please give the names of the legal guardians: _____
_____

Child Parents' Names	Relationship	Marital Status	Age (or date of death)	Education level	Occupation

List everyone who lives in the same home as the child:

Name	Sex	Age	Relationship to Child

What are the main concerns that you have about your child? How long have you had these concerns? _____
_____
_____

If a crisis led to this request for help, please describe the event: _____
_____
Describe any major changes/stressors that have occurred in the past 6 months: _____
_____
What are your child's favorite activities? _____
What are problem areas for your child? _____
What are your goals for treatment? _____
_____

Traumatic experiences: Has your child even been exposed to actual or threatened death, serious injury, or sexual violence? _____ No _____Yes. If yes, describe the event and circle any of the following symptoms s/he experiences related to the traumatic event:_____
_____

Upsetting or intrusive memories	Feeling like the world/surroundings are not real
Nightmares	Angry Outbursts
Flashbacks (feeling/acting like the vent is happening again)	Recklessness or self-destructive behavior
Avoiding talking or thinking about what happened	Getting startled very easily
Feeling upset by reminders of the event	Often looking around for signs of danger
Having out of body experiences	Trouble remembering some or all of what happened

Please circle all the items below that apply to your child and indicate how long these have been an issue.

Sad or depressed mood Loss of interest in activities Feeling hopeless or worthless Low energy Increased or depressed appetite Tired a lot. Poor self-esteem Poor focus Sleeping problems. If so explain: Thoughts of wanting to die. Trying to kill or hurt him/herself nor or In the past. Please explain: Self-harm behavior. Please explain: Very happy/euphoric for no reason Too confident Dramatic mood swings Very high energy for no reason Going days without needing to sleep Thoughts racing Talking too fast Acting impulsively or recklessly spending, speeding Poor attention. If yes since what age? Hyperactive or fidgety Bed wetting Using the bathroom in clothes during the day. Please explain:	Worrying too much Tense Muscles Feeling or acting restless Panic attacks Feeling awkward in public Fear of looking stupid or being embarrassed. Fear of offending others Thoughts, feelings, or pictures that replay in the child mind even if s/he does not want to think about them. Repetitive or compulsive behaviors or habits Phobias or fears Grunts, ties or jerks Difficulty learning Trouble understanding social cues. Difficulty forming or keeping relationships. Very sensitive to sound, light touch, or smell Hearing voices Seeing things Paranoid Odd thinking Gender Identity Eating too much Eating too little Poor body image Trying to lose weight when not overweight. Making self-throw up after eating.	Alcohol use now or in the past, Please explain: Drug use now or in the past. Please explain: Tobacco use now or in the past, Please explain: Severe Angry Outbursts Irritable Easily loses temper. Easily annoyed. Defiant Argues with authority figures. Annoys others on purpose. Blaming others for her/his mistakes Resentful Lying Stealing Destroying property Skipping school Fire setting Cruelty to people or animals Aggressive or Violence now or in the past. Please explain: Arrests/jail time. Please explain:

PREGNANCY/BIRTH/DEVELOPMENTAL. HISTORY (Place an X **in front of** your selections):

Age of birth mother when child was born: _____ Age of birth father when child was born: _____

How often did mother receive prenatal care during pregnancy? _____ Unknown _____ more than 6 visits to a doctor _____ less than 6 but more than 3 visits to a doctor _____less than 3 visits to a doctor _____ no prenatal care.

Did the birth mother have any illnesses during pregnancy? _____ Unknown _____none _____toxemia (if yes which trimester? _____) _____persistent vomiting _____bleeding _____sexually transmitted diseases _____viral illnesses in the 1st trimester including common cold _____thyroid or any other endocrine disorders. _____ other, please specify: _____
_____

How often did the birth mother use **alcohol** during pregnancy? _____ Unknown _____ none _____less than 1 drink per month _____1 drink per week _____1 drink every day _____2 or more drinks every day.
If the child's mother used alcohol during pregnancy, when did she drink: _____Before being aware of the pregnancy _____1st trimester _____2nd trimester _____throughout the pregnancy.

How often did the birth mother use **tobacco (cigarettes, cigars, or vape)** during pregnancy? _____Unknown _____None. If the birth mother did use tobacco please specify type of tobacco, which trimester, how much, and how often:_____
_____

Did the birth mother use any other substances, supplements, over the counter medications, or prescription medications during pregnancy? _____Unknown _____none _____Decongestants such as medications for cold, flu or allergies _____Anti-seizure medications _____insulin _____birth control pills _____antibiotics _____medication to stop early labor _____street drugs, please specify: _____ _____other, please specify: _____

How long did labor last? ____Unknown ____no labor/planned c-section ____less than 18 hours ____more than 18 hours.
How was the baby delivered? ____normal and spontaneous ____Induced ____C-Section ____use of forceps.
Complications during delivery? ____ unknown ____none ____premature ____late baby ____unusual presentation (breech, etc.) ____Umbilical cord wrapped around child's neck ____other, please specify: _____
_____

Child's birth weight _____ Apgar scores _____

Parents' reaction to the birth of this child? Mother_____ Father_____

Problems occur just after delivery. ____None ____Breathing difficulty ____needed incubator ____sucking difficulty ____jaundice ____cyanotic (blue) ____had to go to Intensive Care Unit ____other, please specify: ___
_____
How old was the baby when s/he left the hospital after birth? _____
Was your baby: ____ Colicky and cried a lot _____cuddly ____easy to get on a schedule ____other _____

Early feeding history: how many months was child breast fed? _____ Bottle fed? _____
Was the child different from siblings? ____No ____Yes, if yes, explain: _____
_____

Rate you child's temperament during **infancy** (birth to 12 months old). Place a check for each item in one box only.

	Not at all	Just a little	Pretty much	Very much
Unusually quiet				
Cried a lot				
Easily excited by sounds and sights				
Easily upset by strangers				
Did not like cuddling				
Fussy				
Irregular sleep				
Did not play with toys				

Rate your child's temperament during **preschool years** (2 to 5 years old). Place a check for each item in one box only.

	Not at all	Just a little	Pretty much	Very much
Overly active				
Irregular bowel habits				
Easily upset by strangers				
Easily upset by changes				
Withdrew from new situations				
Could not finish 1 activity				
Often unhappy				

Were there any delays in development? ____No ____Yes: Please specify: _____

Please write the age in **months** at which your child was able to do the following:
____ Sat alone ____ Walk alone ____1st Words ____1st sentence ____finished toilet training. Any problems with accidents after toilet training? If yes, please explain: _____
Pointed to basic colors_____ Tied own shoes _____ Ride a two-wheel bicycle_____ Began to read _____

Any major events occur during the child's development years? ____No ____Yes, please explain: _____
_____

PAST MEDICAL HISTORY:

Does your child have any history of the following medical conditions? *(Circle all that apply)*

Allergies (describe):	Loss of Consciousness
Asthma	Heart problems
Other Breathing Problems	High Blood Pressure
Diabetes	Low Blood Pressure
Convulsions/Seizures/Epilepsy	Gastrointestinal (Stomach/gut) Problems
Head Injury	Vision Problems
Dizziness or Fainting	Hearing problems

Any other serious illness or injuries? ____No ____Yes, if yes, please specify: _____
_____
Hospitalized for physical health problems? ____No ____Yes, if yes, please explain: _____
_____
Any medical complications in the 1st year of life? ____No ____Yes, if yes please explain: _____
_____
Has your child ever had surgery? ____No ____Yes, if yes, describe and give dates: _____
_____
Is your child up to date on immunizations? ____Yes ____No, If No, please explain why not: _____

Seeing other medical specialists for ongoing treatment (neurologist, gastroenterologists, etc.,) ____No ____Yes. If yes, please list: _____
_____
_____

Biological females:
Has your child started her period? ____No ____Yes. If yes, at what age? ____ Are periods regular? ____Yes ____No
What was the first day of the last period? ____/____/____
Are there any changes in symptom severity with periods? ____No ____Yes. If yes, please describe: _____
_____

Has your child ever seen a **Psychiatrist or Therapist/Counselor** before? If yes, please give details below:

Name of Provider	Dates seen	Reason

Has your child ever been admitted to a **Psychiatric Hospital?** If yes, please give details below:

Hospital	Dates	Reason

TESTING HISTORY:

Did the child ever have IQ or achievement testing? ____No ____Yes, if yes, what were the results? _____

_____

Has the child been tested for hearing abnormalities? ____No ____Yes, if yes what were the results? _____

Has the child been testing for speech/language abnormalities? ____No ____Yes, if yes what were the results? _____

_____

Has the child ever received occupational or physical therapy? ____No ____Yes, if yes, please describe: _____

_____

FAMILY HISTORY:

Please list **blood relatives** of the child that have the following problems:

Psychiatric Illness	**Child's Mother**	**Child's Father**	**Mother's family (explain how they are related)**	**Father's family (explain how they are related)**
Depression				
Anxiety				
Bipolar Disorder				
Schizophrenia				
ADHD				
Intellectual disability				
Learning disability				
Autism				
Eating disorder				
Alcohol problems				
Drug problems				
Suicide				
Heart defects or arrhythmias				
Thyroid disease				

Psychiatric Illness -cont.	Child's Mother	Child's Father	Mother's family	Father's family
Died at a young age.				
Legal problems				

MEDICATIONS: Please list all medications or supplements your child is **currently taking**:

Name of medication or supplement	Dose of medication and frequency	Who prescribes it

Please circle any medications your child has **taken in the past**:

Alprazolam (Xanax)	Desipramine (Norpramin)	Lamotrigine (Lamictal)	Quetiapine (Seroquel)
Amitriptyline (Elavil)	Desvenlafaxine (Pristiq)	Levomilnacipran (Fetzima)	Risperidone (Risperdal)
Amphetamine (Adderall)	Dexmethylphenidate (Focalin)	Lisdexamfetamine (Vyvanse)	Sertraline (Zoloft)
Aripiprazole (Abilify)	Amphetamine (Adderall, Adzenys, Evekeo, Dynavel, Dexedrine, Vyvanse, Desoxyn)	Lithium	Topiramate (Topamax)
Asenapine (Saphris)	Diazepam (Valium)	Lorazepam (Ativan)	Trazodone (Desyrel)
Atomoxetine (Strattera)	Duloxetine (Cymbalta)	Loxapine (Loxitane)	Valproic Acid (Depakote)
Bupropion (Wellbutrin)	Escitalopram (Lexparo)	Lurasidone (Latuda)	Venlafaxine (Effexor)
Buspirone (BuSpar)	Fluoxetine (Prozac)	Methylphenidate (Aptensio, Concerta, Daytrana, Metadate, Methylin, Ritalin, Quillivant)	Vilazodone (Viibryd)
Carbamazepine (Tegretol)	Fluphenazine (Prolixin)	Mirtazapine (Remeron)	Vortioxetine (Brintellix)
Citalopram (Celexa)	Fluvoxamine (Luvox)	Nortriptyline (Pamelor)	Ziprasidone (Geodon)
Clomipramine (Anafranil)	Guanfacine (Intuniv)	Olanzapine (Zyprexa)	Other:
Clonazepam (Klonopin)	Haloperidol (Haldol)	Oxcarbazepine (Trileptal)	
Clonidine (Kapvay)	Iloperidone (Fanapt)	Paliperidone (Invega)	
Clozapine (Clozaril)	Imipramine (Tofranil)	Paroxetine (Paxil)	

SOCIAL HISTORY:

If this child is not your biological child, how old was the child when s/he joined your family? _____

Describe the child's adjustment to the family: _____

_____

Did you or other family members have strong reactions to the child's birth or placement? ____No ____Yes, if yes please explain: _____

How is the child's relationship with siblings? _____

Does this child share a bedroom? ____No ____Yes, if yes please list who else sleeps in the same room? _____

_____

Does this child sleep somewhere other than his/her own room? ____No ____Yes, if yes please describe: _____

_____

Who has been the primary caretaker(s) for this child? _____

Please list other caretakes (including babysitters or daycares) that the child has and how often this child is with each of them. Were there any problems with any of them? _____

_____

Has the child been separated from the **primary** caretaker for over 2 weeks? If yes, please describe: _____

_____

Who usually disciplines your child? _____
How do you discipline your child? _____Spankings/physical discipline ____Discussion ____Time-out ____ Loss of privileges ____other, please specify: _____
How many times has this child moved during his or her life? If there were many moves, please explain: _____
_____
Have social services been involved with this child or other family members? ____No ____Yes, if yes, please explain and provide the name of the case manager and the county: _____
_____

Name of School: _____Current grade: _____
Did the child attend the Birth to Three program? ____Yes ____No
Did the child attend preschool or Head start? ____Yes ____No
Describe your child's reaction to going to school: _____
How many schools has this child attended? If there were multiple school changes, please explain: _____
_____
Has your child been fearful or reluctant to go to school? _____No ____Yes, if yes, which grade? _____
Child's performance in school? ____Excellent ____Above Average ____Average ____Below Average ____Failing
Any recent changes in your child school performance? ____No ____Yes, if yes, please explain: _____
_____
Did your child skip school? ____No ____Yes
Did your child repeat any grades? ____No ____Yes
Does your child have a 504 plan or IEP? ____No ____Yes
Is your child in ESE or special needs classes? ____No ____Yes
Has your child ever been suspended or expelled? ____No ____Yes, if yes, please explain: _____
Has your child ever been bullied? ____No ____Yes, if yes, please explain: _____
Has your child ever been the victim of abuse? ____No ____Yes, if yes, please review your answer in the **Traumatic experiences** section on page 1.
Has the child been arrested? ____No ____Yes, if yes, please explain: _____
_____

Are there weapons/guns in your home? ____No ____Yes, if yes, does your child have access to them? ____No ____Yes
Has this child even been involved with the police or court system? ____No ____Yes, if yes, please explain: _____
_____

OTHER: Has the child experience any of the difficulties below? (Please circle all that apply and give details.)

Death of a parent, Death of other loved ones/close friend, Separation from parent or family, Parent separation/divorce, Loss of Home, Family financial problems, Family member with substance abuse problem, Conflicts with parents, Removal of child from home, Victim of crime or violence, Unwanted pregnancy, School problems, Serious Illness, Serious Illness in a family member, Other:

Please provider any other information you think would help us better understand and help your child and or your family:

Thank you for your cooperation in completing this questionnaire!

The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

_____

Length of time since the event:

_____

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	0	1	2	3	Having bad dreams or nightmares
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8.	0	1	2	3	Not being able to remember an important part of the upsetting event
9.	0	1	2	3	Having much less interest or doing things you used to do
10.	0	1	2	3	Not feeling close to people around you
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)

12.	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

13.	0	1	2	3	Having trouble falling or staying asleep
14.	0	1	2	3	Feeling irritable or having fits of anger
15.	0	1	2	3	Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class)
16.	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17.	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

	Yes	No	
18.	Y	N	Doing your prayers
19.	Y	N	Chores and duties at home
20.	Y	N	Relationships with friends
21.	Y	N	Fun and hobby activities
22.	Y	N	Schoolwork
23.	Y	N	Relationships with your family
24.	Y	N	General happiness with your life

CRAFFT Screening Tool for Adolescent Substance Abuse

The following questions concern information about your potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Then mark in the appropriate box beside the question. Please answer every question. If you cannot decide, then choose the response that is mostly right.

When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used in excess of the directions and any non-medical use of drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).

Part A: During the PAST 12 MONTHS, did you:		No	Yes
1.	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2.	Smoke any marijuana or hashish?		
3.	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
Part B: CRAFFT		No	Yes
1.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?		
4.	Do you ever **FORGET** things you did while using alcohol or drugs?		
5.	Do your **FAMILY or FRIENDS** ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?		

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

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

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

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

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: _____

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

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

Revised - 1102

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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: _____

Child's name: _____ D.O.B. _____ Date: _____

Completed by: _____

Child and Adolescent Strengths

(Please circle the categorized action item below that describes any of the child's levels)

Family Strengths

1. Has strong positive relation with at least 1 parent
2. Has strong positive relation with 1 adult relative
3. Has strong positive relation with at least 1 sibling
4. Strong positive relations exist among relatives
5. Family has reliable communication

School/vocational Strengths

1. Excels in at least 1 subject
2. Likes to write (e.g., keeps a diary)
3. Reads for pleasure
4. Has done well for at least 1 year during school
5. Has a particular vocational skill
6. Is articulate in speech
7. Has identified career goals for adulthood

Psychological Strengths

1. Has a sense of humor
2. Has the ability to adapt to stressful life circumstances
3. Has the ability to enjoy positive life experiences
4. Is able to express emotions accurately
5. Has the ability to trust others

Peer Strengths

1. Has close friend(s)
2. Negotiates appropriately with peers
3. Is well liked by peers

Moral/Spiritual Strengths

1. Has developed values/morals
2. Has expressed religious/spiritual beliefs
3. Attends religious services regularly
4. Participates in church youth groups

Extracurricular Strengths

1. Has artistic/creative talent
2. Has a hobby or hobbies
3. Participates in a community services youth group
4. Participates in organized sports

CHILD MANIA RATING SCALE, PARENT VERSION (CMRS-P)

Child's name _____ Date of Birth (mm/dd/yy) ___ ___ ___ Case # / ID # _____

INSTRUCTIONS

The following questions concern your child's mood and behavior ***in the past week***. Please place a check mark or an 'x' in a box for each item. Please consider it a problem if it is causing trouble and is beyond what is normal for your child's age. For example, check 'rare or never' if the behavior is not causing trouble.

Does your child . . .	NEVER	SOMETIMES	OFTEN	VERY OFTEN	
1. Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0	1	2	3	____
2. Feel irritable, cranky, or mad for hours or days at a time	0	1	2	3	____
3. Think that he or she can be anything or do anything (e.g., leader, best basket ball player, rap singer, millionaire, princess) beyond what is usual for that age	0	1	2	3	____
4. Believe that he or she has unrealistic abilities or powers that are unusual, and may try to act upon them, which causes trouble	0	1	2	3	____
5. Need less sleep than usual; yet does not feel tired the next day	0	1	2	3	____
6. Have periods of too much energy	0	1	2	3	____
7. Have periods when she or he talks too much or too loud or talks a mile-a-minute	0	1	2	3	____
8. Have periods of racing thoughts that his or her mind cannot slow down , and it seems that your child's mouth cannot keep up with his or her mind	0	1	2	3	____
9. Talk so fast that he or she jumps from topic to topic	0	1	2	3	____
10. Rush around doing things nonstop	0	1	2	3	____
11. Have trouble staying on track and is easily drawn to what is happening around him or her	0	1	2	3	____
12. Do many more things than usual, or is unusually productive or highly creative	0	1	2	3	____
13. Behave in a sexually inappropriate way (e.g., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3	____
14. Go and talk to strangers inappropriately, is more socially outgoing than usual	0	1	2	3	____

Does your child . . .	NEVER	SOMETIMES	OFTEN	VERY OFTEN	
15. Do things that are unusual for him or her that are foolish or risky (e.g., jumping off heights, ordering CDs with your credit cards, giving things away)	0	1	2	3	____
16. Have rage attacks, intense and prolonged temper tantrums	0	1	2	3	____
17. Crack jokes or pun more than usual, laugh loud, or act silly in a way that is out of the ordinary	0	1	2	3	____
18. Experience rapid mood swings	0	1	2	3	____
19. Have any suspicious or strange thoughts	0	1	2	3	____
20. Hear voices that nobody else can hear	0	1	2	3	____
21. See things that nobody else can see	0	1	2	3	____

TOTAL SCORE _____

Please send comments to:
PavuluriMD@Brainandwellness.com

Severity Measure for Depression

*PHQ-9

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	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?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Screen for Child Anxiety Related Disorders (SCARED)

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

Name: _____ **Date:** _____

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

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

Screen for Child Anxiety Related Disorders (SCARED)

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

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

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

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

What's Your ACE Score?

There are 10 types of childhood trauma measured in the ACE Study, and each type of trauma counts as one. The most important thing to remember is that the ACE score is meant as a guideline. If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? OR Act in a way that made you afraid that you might be physically hurt?

No ___ If Yes, enter 1 ____

2. Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured?

No ____ If Yes, enter 1 ____

3. Did an adult or person at least five years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? OR Attempt or actually have oral, anal, or vaginal intercourse with you?

No ____ If Yes, enter 1 ____

4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? OR Your family didn't look out for each other, feel close to each other, or support each other?

No ____ If Yes, enter 1 ____

5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No ____ If Yes, enter 1 ____

6. Were your parents ever separated or divorced?

No ____ If Yes, enter 1 ____

7. Was your mother or stepmother ... Often or very often pushed, grabbed, slapped, or had something thrown at her? OR Sometimes, often, or very often, kicked, bitten, hit with a fist, or hit with something hard? OR Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No ____ If Yes, enter 1 ____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No ____ If Yes, enter 1 ____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

No ____ If Yes, enter 1 ____

10. Did a household member go to prison?

No ____ If Yes, enter 1 ____

This instrument and additional resources are available at **acestoohigh.com**.

Now add up your "Yes" answers: _____ is your ACE score.