Intermountain® Healthcare

Mental Health Integration

Child/Adolescent Baseline Evaluation Packet

Dear Parent,

Mental health is important for overall health. That's why we have a mental health team at our clinic. To help us assess this critically important part of your child's health, please fill out the forms in this packet. Your answers will help us best support your child and your family.

- **Child/Adolescent Initial History and Consultation form** (2 pages): This form asks about your child's main problems and symptoms. It includes what's called a "global impairment scale." This scale gives us your view of how much you think your child's problems are affecting his or her life at home or at school.
- **Parental Screen and Family Rating Scale** (1 page): This form asks questions about you, your family, and your support system. It helps us understand your own mental outlook, as well as your family's style of dealing with stress or difficult health problems.
- **Vanderbilt ADHD Parent Rating Scale** (2 pages): This form asks you to identify and rate your child's recent behaviors. Your answers help us evaluate your child for possible attention deficit hyperactivity disorder (ADHD).
- **Symptom Rating Scales** (1 page each): These forms screen for symptoms of the following:
  - Depression
  - Anxiety and stress
  - Developmental disorders
  - Mood problems
- **Home Impairment Scale** (1 page): This form asks which areas of your child's life are most affected by mental health symptoms. This helps in setting goals and tracking treatment progress.

Please bring these completed forms to your child's next appointment. If you're unable to complete them beforehand, please come 20 minutes early so that you'll have time to complete them before your child sees the doctor.

If you have any questions or concerns, please call us here at the clinic at:_____

Thank you

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963
MHI005 (Complete Child/Adolescent Baseline Packet) - 11/13

Mental Health *Integration*

Initial History and Consultation *(page 1 of 2)*

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

Completed by: _____ Relationship to child: ☐ Parent ☐ Other: _____

1. What are the main problems that you're concerned about regarding your child or adolescent?

Physical: 1. _____ 2. _____ 3. _____

Emotional: 1. _____ 2. _____ 3. _____

2. Has your child been treated for mental health disorders in the past? ☐ **YES** ☐ **NO**

IF YES, when? (list all time periods) _____

What treatments were tried? ☐ meds ☐ therapy ☐ hospitalization ☐ other: _____

Was treatment successful? Explain: _____

3. Has your child had, or complained about, any of the following conditions in the past 6 months?

YES	NO		YES	NO		YES	NO	
☐	☐	Chest pain	☐	☐	Shortness of breath	☐	☐	Tension headache
☐	☐	Fatigue	☐	☐	Back pain	☐	☐	Migraine headache
☐	☐	Dizziness	☐	☐	Stomachache	☐	☐	Irritable bowel syndrome

Has your child been diagnosed with a chronic medical condition? ☐ asthma ☐ diabetes ☐ other: _____

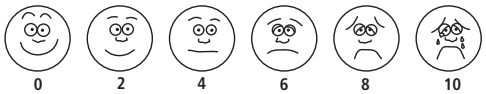
4. Chronic pain assessment

YES NO

☐ ☐ Has your child had pain on a daily basis for the last 6 months or more? If so, please ask your child to choose the face that best describes the average daily level of pain.

_____
Average pain level (0-10)

Wong-Baker FACES Pain Rating Scale



0	2	4	6	8	10
No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst

From Hockenberry-Eaton M, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, Mosby, P. 1259. Used with permission. Copyright, Mosby.

5. Sleep assessment

YES NO

☐ ☐ Does your child have problems sleeping? If **YES**, answer the following:

How long has your child had sleep problems? _____

On average, how many nights each week does your child have sleep problems? _____

On average, how many hours does your child sleep when he/she is having problems? _____

Which of the following best describes your child's sleep problem? _____

- ☐ My child has trouble falling asleep. He/she usually goes to bed at _____ pm/am and gets to sleep by _____ pm/am.
- ☐ My child often wakes up during the night.
- ☐ My child wakes up early and can't go back to sleep.
- ☐ My child sleeps a lot during the day and wants to take naps that I think are inappropriate.

How bad is your child's sleep problem? 0 1 2 3 4 5 6 7 8 9 10

not present — a little bad — pretty bad — very bad — couldn't be worse

6. Medications

YES NO Has your child taken medications for behavioral or emotional problems (for example, a stimulant or antidepressant)?

☐ ☐ If **YES**, please fill in the information below for each medication. (Use another sheet of paper if you need more room.)

Name of medication	Dose	When Started?	Still Taking?	How well did/does it work?	What side effects?
			Y N		
			Y N		
			Y N		

7. YES NO ☐ ☐ **Family history:** Does your child have any biological relatives who have had behavioral, emotional, or mental problems such as depression, anxiety, bipolar disorder, drug or alcohol abuse, or suicide? **If YES**, list which relatives and what problems:

_____

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI006-11/13

MHI Pack 50402

Intermountain® Healthcare

Mental Health *Integration*

Initial History and Consultation *(page 2 of 2)*

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

8. Abuse and traumatic events: Does your child have a history of any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Physical abuse	☐	☐	Emotional abuse	☐	☐	Drug abuse in the family
☐	☐	Sexual abuse	☐	☐	Traumatic events			

☐ ☐ If **YES** to any of the above, are any of these occurring now, or still affecting your child?

☐ ☐ Is your child in any danger or at risk because of any of these issues?

☐ ☐ Have you sought help from a professional related to these issues? If so, who?_____

9. Adolescent alcohol or drug use: To the best of your knowledge, during the past 12 months did your child do any of the following:

YES	NO		*Clinician interview notes*
☐	☐	Drink any alcohol (more than a few sips)?	_____
☐	☐	Smoke any marijuana or hashish?	_____
☐	☐	Use anything else to get high (illegal drugs, prescription or over-the-counter drugs, things sniffed or huffed)?	_____

10. Eating habits: To the best of your knowledge, does your child have a history with any of the following:

YES	NO	
☐	☐	Showing concern with his or her eating patterns.
☐	☐	Eating in secret.
☐	☐	Weight affecting the way he or she feels about his or herself.
☐	☐	Have any members of your family suffered from an eating disorder?

11. Stress interference

YES NO

☐ ☐ Are your child's physical or emotional problems affecting how he/she deals with others?
If **YES**, briefly describe: _____

☐ ☐ Are there any other present or past life circumstances that you think might negatively affect your child's behavior or emotions?
If **YES**, briefly describe:_____

☐ ☐ In the last 6 months, has your child missed any school days because of mental health problems? **If YES**, how many?_____

☐ ☐ Has your child missed more than 1 continuous week of school for mental health problems?

☐ ☐ Has your child been tested by any member of the resource team at school, or has your child been enrolled in any special education services? (If YES, please bring a copy of test results or individual education plans (IEPs) to your appointment.)

12. Overall impairment. Check the box by the statement that best describes how much you think your child's **mental health symptoms** are impairing his or her life at home, at school, or with friends. (Compare your child to a typical child of the same age/gender in the same situations.)

☐ **1 No impairment.** Symptoms are *not present any more than expected*, and *do not impair* normal functioning at home or school.

☐ **2 Slight impairment.** Symptoms are present *a little more frequently or intensely than expected*, and only *rarely impair* normal functioning at home or school.

☐ **3 Mild impairment.** Symptoms are present *somewhat more frequently or intensely than expected*, and *sometimes impair* normal functioning at home or school.

☐ **4 Moderate impairment.** Symptoms are present *a lot more frequently or intensely than expected*, and *usually impair* normal functioning at home or school.

☐ **5 Severe impairment.** Symptoms are present *a great deal more frequently or intensely than expected*, and *most of the time impair* normal functioning at home or school.

☐ **6 Very severe impairment.** Symptoms are present *so much more frequently or intensely than expected that they almost always impair* normal functioning at home or school.

☐ **7 Maximal (profound) impairment.** Symptoms are present *so frequently or intensely that they produce significant and pervasive impairment*, which creates a crisis requiring immediate action to prevent serious deterioration to avoid or prevent harm.

13. Overall health. How would you rate your child's overall health?

1	2	3	4	5	6	7	8	9	10
great		okay		not so good			bad		very bad

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI006 - 11/13

Intermountain® Healthcare

Parental Screen and Family Rating Scale

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

Completed by: _____ Relation: ☐ Mom ☐ Dad ☐ Other: _____

Parental Screen: Please answer the following questions as they apply to you — the parent.	
During the past 2 weeks, have you been feeling down, depressed, or hopeless?	☐ YES ☐ NO
During the past 2 weeks, have you had little interest or pleasure in your usual activities?	☐ YES ☐ NO
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 hard at all ☐ somewhat hard ☐ very hard ☐ extremely hard

Who do you (the parent) most commonly talk to or go to for help when you do not feel well or you are distressed?

☐ I don't usually talk to anyone ☐ My support is exhausted or burnt out ☐ I talk to a friend, clergyman, church leader, spouse, or partner

Family Rating Scale: There are many definitions of "family," such as people related to you by birth or marriage, the people you live with, or your group of friends. This section is about your family or current support system as you would define it. Each family has their own style for dealing with stress and other health problems. This rating scale may help you — and us — understand your family's style. Please circle the number that best describes how you and your family act when under stress or dealing with a difficult health problem.

	Family style descriptions	Rating Scale										
		Not at all		A little		Pretty much			Very much			Describes my family accurately
1	We are often in crisis. We have many problems and unsolved concerns. The result of our family contact is confusion and chaos. It is hard for us to keep regular appointments.	0	1	2	3	4	5	6	7	8	9	10
2	We have people who can help us in times of stress. We value and ask for experts' (doctors'/nurses') help with our problems.	0	1	2	3	4	5	6	7	8	9	10
3	We are very independent and don't often need to count on others. We like to handle problems on our own. Asking for help is scary and often upsetting, so we may avoid getting the support we need.	0	1	2	3	4	5	6	7	8	9	10
4	Our family and friends are worn out because it is difficult to deal with all our needs. We are grateful for help but not sure it will work.	0	1	2	3	4	5	6	7	8	9	10
5	We think early family relationships are important. Relationships are safe and helpful to us.	0	1	2	3	4	5	6	7	8	9	10
6	We have many friends, but not close friends. We are often alone with our problems.	0	1	2	3	4	5	6	7	8	9	10
7	We are helpful and open when dealing with problems. Our family contacts are direct and caring, even when we disagree with each other or fight.	0	1	2	3	4	5	6	7	8	9	10
8	Our family contacts can be rejecting, distant, and cold. The importance of early family relationships is ignored or forgotten.	0	1	2	3	4	5	6	7	8	9	10
9	We have painful memories of early family relationships. We are still angry with our parents.	0	1	2	3	4	5	6	7	8	9	10

For office use only:

Style I: _____ + _____ + _____ = _____ /30 (3 + 6 + 8)

Style II: _____ + _____ + _____ = _____ /30 (1 + 4 + 9)

Style III: _____ + _____ + _____ = _____ /30 (2 + 5 + 7)

©2004–2013 Intermountain Healthcare. All rights reserved.

Patient and Provider Publications 801-442-2963 MHI009 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Vanderbilt ADHD Parent Rating Scale *(page 1 of 2)*

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

Completed by: _____ Relationship to child: ☐ *Parent* ☐ *Other:* _____

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 staying focused on 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 vindictive (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 (i.e., "cons" others)	0	1	2	3
30. 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 ADHD Diagnostic Parent Rating Scale
Mark L. Wolraich, MD. Oklahoma University Health Sciences Center. Used with permission.

©2004–2013 Intermountain Healthcare. All rights reserved.

Patient and Provider Publications 801-442-2963 ADD003 -11/13

Van ADHD 50407

Intermountain® Healthcare

Continued on next page →

Vanderbilt ADHD Parent Rating Scale *(page 2 of 2)*

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

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/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	Above Average		Average		Problematic
48. **Overall academic performance**	**1**	**2**	**3**	**4**	**5**
a. Reading	1	2	3	4	5
b. Mathematics	1	2	3	4	5
c. Written expression	1	2	3	4	5
49. **Overall Classroom Behavior**	**1**	**2**	**3**	**4**	**5**
a. Relationship with peers	1	2	3	4	5
b. Following directions/rules	1	2	3	4	5
c. Disrupting class	1	2	3	4	5
d. Assignment completion	1	2	3	4	5
e. Organizational skills	1	2	3	4	5

Comments:

For Office Use Only:

SYMPTOMS:

Number of questions scored 2 or 3 in questions 1–9: _____

Number of questions scored 2 or 3 in questions 10–18: _____

Total symptom score for questions 1–18 (add all scores): _____

Number of questions scored 2 or 3 in questions 19–26: _____

Number of questions scored 2 or 3 in questions 27–40: _____

Number of questions scored 2 or 3 in questions 41–47: _____

PERFORMANCE:

Number of items scored 4 or 5 in questions 48–49: _____

Average performance score (total all scores, then divide by 10): _____

Adapted from the Vanderbilt ADHD Diagnostic Parent Rating Scale
Mark L. Wolraich, MD. Oklahoma University Health Sciences Center. Used with permission.

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 ADD003 - 11/13

Intermountain® Healthcare

Mental Health *Integration*

Depression Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to child: ☐ Self ☐ Parent ☐ Other: _____

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

Circle the number on the rating scale that corresponds to how much the described symptoms apply to your child.

	Symptoms	Rating Scale										
		Not at all		A little		Pretty much		Very much		Couldn't be worse		
1	**Depressed mood** May include the following symptoms: sad, tearful, hopeless, isolates from others, feels down	0	1	2	3	4	5	6	7	8	9	10
2	**Irritable mood** May include the following symptoms: intense anger, temper tantrums, aggression, inability to deal with frustration, rage episodes	0	1	2	3	4	5	6	7	8	9	10
3	**Loss of pleasure** May include the following symptoms: loss of interest in activities they once found pleasurable, has stopped participating in previous activities (sports, dance, etc.), nothing is fun	0	1	2	3	4	5	6	7	8	9	10
4	**Sleep problems** May include the following symptoms: trouble getting to sleep, wakes frequently, naps during day, gets to sleep late and wakes early, sleeps all the time	0	1	2	3	4	5	6	7	8	9	10
5	**Appetite** May include the following symptoms: loss of appetite, significant weight loss (_____ lbs), increased appetite, significant weight gain (_____lbs)	0	1	2	3	4	5	6	7	8	9	10
6	**Agitation** May include the following symptoms: restless, hyperactive, can't relax	0	1	2	3	4	5	6	7	8	9	10
7	**Loss of energy** May include the following symptoms: tired all the time, doesn't feel up to doing anything, less active than usual, slow speech, seems slowed down	0	1	2	3	4	5	6	7	8	9	10
8	**Feelings of worthlessness** May include the following symptoms: inappropriate guilt, excessive guilt, poor self-esteem, makes negative statements about self	0	1	2	3	4	5	6	7	8	9	10
9	**Poor concentration** May include the following symptoms: can't focus, short attention span, poor listening, easily distracted, can't think, indecisive	0	1	2	3	4	5	6	7	8	9	10
10	**Thoughts of death** May include the following symptoms: suicidal gestures, self-harm, thoughts of suicide, suicide plan, suicide attempt	0	1	2	3	4	5	6	7	8	9	10
11	**Impairment at home caused by the symptoms on this sheet:** symptoms impair child's overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
12	**Impairment at school caused by the symptoms on this sheet:** symptoms impair child's overall functioning at school	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ☐ YES ☐ NO

For office use only: Symptom score (1–10): _____ /100 Impairment score (11–12): _____ /20

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI011 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Mental Health *Integration*

Child/Adolescent and Adult

Anxiety/Stress Disorder Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to patient: ☐ Self ☐ Parent ☐ Other: _____

Is the patient currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure? ☐ in counseling

Over the last 2 weeks, *how often have the problems below bothered you/your child? Circle a number for each item.*

	General Anxiety Disorder (GAD-7)	How Often			
		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge?	0	1	2	3
	Not being able to stop or control worrying?	0	1	2	3
	Worrying too much about different things?	0	1	2	3
	Trouble relaxing?	0	1	2	3
	Being so restless that it is hard to sit still?	0	1	2	3
	Becoming easily annoyed or irritable?	0	1	2	3
	Feeling afraid as if something awful might happen?	0	1	2	3

Circle the number on the rating scale that corresponds to how much the symptoms below apply to you/your child.

	Other Symptoms	Rating Scale										
		Not at all		A little			Pretty much			Very much		Couldn't be worse
2	**Panic:** This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, getting lightheaded	0	1	2	3	4	5	6	7	8	9	10
3	**Physical symptoms:** This can include stomachache, headache, tight muscles, shaking, muscle twitching, sweats	0	1	2	3	4	5	6	7	8	9	10
4	**Obsessions and/or compulsions:** This can include repeated or persistent thoughts that they can't control (about germs, schoolwork, being perfect, neatness, safety, death); repeated behaviors or extreme routines that they can't control (such as repeated handwashing, checking locks, cleaning, personal hygiene)	0	1	2	3	4	5	6	7	8	9	10
5	**Post-traumatic stress:** This can include repeated, disturbing thoughts or dreams about a traumatic experience from the past, having physical reactions when reminded of the traumatic experience, avoiding situations that are reminders of the experience, feeling distant or emotionally numb, feeling jumpy or easily startled Check if post-traumatic symptoms have lasted **more than 4 weeks:** ☐	0	1	2	3	4	5	6	7	8	9	10
6	**Impairment at home caused by the symptoms listed on this sheet:** Symptoms impair overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
7	**Impairment outside the home caused by the symptoms listed on this sheet:** Symptoms impair overall functioning outside the home (school, work, church, with friends, etc.)	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ☐ YES ☐ NO

For office use only: GAD-7 score (item 1): _____ / 21 Other symptoms (2-5): _____ /40 Impairment score (6-7): _____ /20

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI013 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Developmental Disorders Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to child: ☐ Self ☐ Parent ☐ Other: _____

Is your child currently: ☐ on medication for developmental symptoms ☐ not on medication ☐ not sure? ☐ in counseling

Circle the number on the rating scale that corresponds to how much the described symptoms apply to your child.

	Symptoms	Rating Scale										
		Not at all		A little			Pretty much			Very much		Couldn't be worse
1	**Language** May include the following symptoms: speech overly precise or formal, talks like a walking dictionary, monotone voice, talks like he has a foreign accent, forgets to take turns in a conversation, interprets things literally, has trouble understanding figures of speech Did your child have normal language development by age 3? ☐ yes ☐ no ☐ don't know	0	1	2	3	4	5	6	7	8	9	10
2	**Emotional sensitivity** May include the following symptoms: lacks empathy, over- or under-reacts to stress, difficulty understanding feelings of others, trouble managing emotions, intense emotional reactions, emotionally unresponsive, displays little emotion, not in tune with others' emotions	0	1	2	3	4	5	6	7	8	9	10
3	**Social awareness** May include the following symptoms: not aware of peer pressure, not aware of social norms, expects others to know his or her thoughts, not interested in group activities, poor team member, avoids social contact, not interested in your side of the conversation	0	1	2	3	4	5	6	7	8	9	10
4	**Sensory integration** May include the following symptoms: overly sensitive or not sensitive enough to sound, light, pain, touch	0	1	2	3	4	5	6	7	8	9	10
5	**Impairment at home caused by the symptoms on this sheet:** Symptoms interfere with child's overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
6	**Impairment at school caused by the symptoms on this sheet:** Symptoms interfere with child's overall functioning at school	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

For office use only: Symptom score (1–4): _____ /40 Impairment score (5–6): _____ /20

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI010 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Mental Health *Integration*

Child/Adolescent and Adult

Mood Regulation Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ ☐ Self ☐ Parent ☐ Other: _____

Is the patient currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure? ☐ in counseling

Circle the number on the rating scale that corresponds to how much the described symptoms apply to you or your child.

	Symptoms	Rating Scale										
		Not at all		A little			Pretty much			Very much		Couldn't be worse
1	**Elevated mood** May include the following symptoms: driven, high energy, never stops, silliness, unusual happiness	0	1	2	3	4	5	6	7	8	9	10
2	**Irritable mood** May include the following symptoms: intense anger, temper tantrums, aggression, inability to deal with frustration, rage episodes	0	1	2	3	4	5	6	7	8	9	10
3	**Self-centered** May include the following symptoms: grandiose, bossy, entitled, unaware of others feelings, believes they are always right, believes nothing can hurt them, believes they are better than others	0	1	2	3	4	5	6	7	8	9	10
4	**Sleep problems** May include the following symptoms: trouble getting to sleep, wakes frequently, naps during the day, gets to sleep late and wakes early	0	1	2	3	4	5	6	7	8	9	10
5	**Talkative** May include the following symptoms: talks constantly, interrupts others, chatterbox	0	1	2	3	4	5	6	7	8	9	10
6	**Racing thoughts** May include the following symptoms: thinks faster than can speak, goes from topic to topic, mind is going 100 miles per hour	0	1	2	3	4	5	6	7	8	9	10
7	**Poor concentration** May include the following symptoms: can't focus, short attention span, poor listening, easily distracted	0	1	2	3	4	5	6	7	8	9	10
8	**Agitation** May include the following symptoms: restless, hyperactive, can't relax	0	1	2	3	4	5	6	7	8	9	10
9	**Increased involvement in high-risk activities** May include the following symptoms: fascination with sex, alcohol/drug use, excessive gambling, reckless driving	0	1	2	3	4	5	6	7	8	9	10
10	**Impulsivity** May include the following symptoms: suicidal gestures, self-harm, running away, poor judgment, sneaky, acting without thinking, not learning from consequences	0	1	2	3	4	5	6	7	8	9	10
11	**Impairment at home caused by the symptoms on this sheet:** symptoms impair overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
12	**Impairment outside the home caused by the symptoms on this sheet:** symptoms impair overall functioning outside the home (school, work, church, with friends, etc.)	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

For office use only: Symptom score (1–10): _____ /100 Impairment score (11–12): _____ /20

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 MHI012 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Mental Health *Integration*

Child/Adolescent

Home Impairment Scale *(page 1 of 1)*

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

Directions: For each of the **Domains of Functioning** listed in the left column, please circle the number (1–7) that best describes your child's degree of impairment. Remember — the higher the number, the greater the impairment.

Domain of Functioning	Your child has symptoms that are appropriate to age/gender. Your child shows **no** signs of impairment at home.	Your child has symptoms **a little more** frequently or intensely than expected of children of similar age/gender. Symptoms only **rarely** interfere with normal functioning at home.	Your child has symptoms **somewhat more** frequently or intensely than expected of children of similar age/gender. Symptoms **sometimes** interfere with normal functioning at home.	Your child has symptoms **a lot more** frequently or intensely than expected of children of similar age/gender. Symptoms **usually** interfere with normal functioning at home.	Your child displays symptoms **a great deal more** frequently or intensely than expected of children of similar age/gender. **Most of the time,** symptoms interfere with normal functioning at home.	Your child has symptoms **so much more** frequently or intensely than expected of children of similar age/gender that symptoms **almost always** interfere with normal functioning at home.	Your child's symptoms are **so frequent or intense** that they completely impair normal functioning. The symptoms **may create a crisis** that needs action right away to prevent serious danger or harm.
	No impairment	**Slight impairment**	**Mild impairment**	**Moderate impairment**	**Severe impairment**	**Very severe impairment**	**Profound impairment**
Behavior How much do your child's symptoms interfere with (impair) the ability to follow home rules, parents' commands, or general behavioral expectations?	1	2	3	4	5	6	7
Interpersonal Relationships How much do your child's symptoms interfere with (impair) the ability to form and maintain positive peer relationships?	1	2	3	4	5	6	7
Emotions How much do your child's symptoms interfere with (impair) the ability to express or control emotions?	1	2	3	4	5	6	7
Responsibilities How much do your child's symptoms interfere with (impair) the ability to perform daily home responsibilities and tasks?	1	2	3	4	5	6	7

©2004–2013 Intermountain Healthcare. All rights reserved.
Patient and Provider Publications 801-442-2963 ADD009-11/13

MHI Pack 50402

Intermountain® Healthcare