Intermountain Healthcare

Mental Health Integration

Child & Parent Version
Whole Person Health Baseline Packet

Dear Parent,

Mental health is an important part of a person's overall health. That's why we have an integrated mental health team (MHI) 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.

- **Initial Intake Questionnaire** (4 pages): This form asks about your child's main problems and symptoms. It gives us an overall view of your mental health history, a little physical health history and most importantly, what you want to work on to improve your life.
- **Patient Health Questionnaire** (PHQ-A) (1 page): This form asks questions about your child's recent feelings and behaviors. Your answers help us check for signs and symptoms of depression.
- **Anxiety & Stress Disorder Symptom Rating Scale** (1 page): This form helps us check for problems related to stresses in your child's life.
- **Screening questions about Sleep, Eating Behaviors, and Alcohol or Drug Use (**1 page): This page contains questions about how your child is sleeping, assessing eating concerns and any alcohol or drug use.
- **Screening questions for Abuse and Trauma** (1 page): This screener is to ask about experiences in a child's life that may have a long term impact.
- **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).

Please return these completed forms prior to your next appointment. Hand-completed forms should be written in **black ink** and delivered in person during normal clinics hours. For your convenience, forms can be completed electronically via your MyHealth account. Please ask the clinic front desk for more details about setting up your My Health account.

Additionally, for parents of teenagers, please complete this version as well as passing along the teen's version of this packet for them to give additional insight for the provider.

If you have questions or concerns, please contact the clinic directly at: ______________________________

Thank you

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Patient and Provider Publications MHI005CL (Child & Parent Baseline Cover Letter) - 08/20 *Also available in Spanish.*

MHI Pack 50402

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Mental Health Integration

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Parent/Child

Date: _______________ Patient's name: _____________________________ Date of birth: ________________

Completed by: _____________________________ Relationship to child: Parent Other: ________________

Pediatrician or primary care doctor: ______________________________________

1. What are your main concerns or symptoms that your child is dealing with?
   a. **Physical**: ____
   b. **Emotional**:____
2. What is currently causing your child stress (at home, at school, or in your relationships)?

3. What goals do you and your child hope to achieve with this treatment?

4. Is your child currently being treated for mental health issues? Or has your child been treated for mental health issues in past? Include any type of outpatient or inpatient treatment or therapy your child has received.

Psychiatric Hospitalizations: *Include date, situation, and treatment provided, or write "none" if never.*

Suicide attempt: *Include date, situation, and treatment provided, or write "none" if never.*

Prior experience with therapy: *Include dates and who provided treatment, or write "none" if never.*

Mental health medications my child has been prescribed or is currently taking:

Name and Dose of Medication	Date Started	Response and Side effects	Is your child still on it?
			Yes No
			Yes No
			Yes No

			Yes No
			Yes No
			Yes No

5. Has your child had, or complained about, any of the following: (Select all that apply)

Back pain	Dizziness	Nausea
Change in appetite	Fatigue or lack of energy	Shortness of breath
Chest pain or pressure	Headaches	Stomachache
Constipation	Increased heart rate	
Diarrhea	Joint pain	

6. Does your child have **pain** every day that limits their activities? Yes No
   a. If **yes**, use the pain scale below to rate your child's average daily level of pain. Average pain level (0 to 10): _______
   b. If not daily pain, **how often** does your child have pain that limits activities? ______________________

PAIN ASSESSMENT TOOL

MILD				MODERATE			SEVERE			VERY SEVERE
0	1	2	3	4	5	6	7	8	9	10
No pain	Hardly notice pain It's more like minor discomfort	Slightly aware of pain But mostly don't think about it	Somewhat aware of pain Easy to take mind off it Doesn't get in the way of doing things	Quite aware of pain Not as easy to take mind off it	Very aware of pain May get in the way of doing things Hard to sleep or rest	Hard to take mind off pain Hard to find a comfortable position	Restless, fidgety Can't take mind off pain Can't find a comfortable position	Don't want to talk with people or text Don't want to eat Can hardly sleep or rest	Very hard to talk with people or text Pain is all you can think about Sometimes cry out	Not at all able to talk with people or text Not at all able to eat, sleep or rest May cry out uncontrollably

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7. Has your child been diagnosed with any of the following: (Select all that apply.)
   - Asthma
   - Diabetes
   - Autism spectrum disorder
   - Seizures
   - Developmental disorder
   - Learning disorder
   - Head injury or concussion
   - Other: ____________________________

8. **Serious medical events**: Has your child been in a serious accident, been hospitalized, or had any surgeries?

Serious accidents: *What happened? When? Or write "none."*

Hospitalizations: *Why hospitalized? What happened? When? Or write "none."*

Surgeries: *For what? When? Or write "none."*

9. **Family History and Important Events**

   a. **Family history of mental health challenges**: Does your child have any biological relatives who have had problems with depression, anxiety, bipolar disorder, schizophrenia, ADHD, drug or alcohol use disorder, or suicide? If yes, complete the table below.

Relative (include relation to child)	Diagnosis or Condition

   b. **Important Events**. Fill out this section if any of the following events have happened and are **having an impact** on your child and your family currently:

Event	Age of Child	Comments
Parent or sibling illness		
Parental separation		
Parental divorce		
Family move		
Financial stress		

Out-of-home placement		
Death in family		
Death of close friend		
Other:		

10. **Education:**
    a. What school does your child attend? ____
    b. What grade is your child in? _______________
    c. Does your child receive special resources or services at school such as a **504 plan or an IEP**? If yes, please describe:____

11. **Developmental History:**
    a. Were there any problems during the pregnancy or delivery of this child? If **Yes,** describe:
    b. Were there any delays in developmental milestones such as walking, talking, toilet training, writing letters, or playing cooperatively? If **Yes,** describe:

12. **Lifestyle, strengths, and challenges**:
    a. On average, **how many days per week does your child exercise, play sports, or do physical activity**? _____________
    b. On average, **how many minutes does your child spend doing physical activity on these days**?________
    c. At **what intensity (how hard) does your child usually exercise?**

       Light (casual walk) Moderate (brisk walk) Vigorous (jog or run)

    d. List your child's **strengths and challenges**:

       (What is your child good at? What are some things that are difficult for your child?)

My child's strengths	My child's challenges

Depression screening for children under 11 (PHQ C):

Over the last 2 weeks, how often has your child been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about himself or herself, or feeling like a failure who lets people down	0	1	2	3
7. Trouble concentrating on things, such as schoolwork, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed, or the opposite: being very fidgety, restless, or moving around so much that others have noticed	0	1	2	3
9. Thoughts that he or she would be better off dead, or of hurting himself or herself in some way	0	1	2	3

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

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

In the past year, has your child seemed depressed or sad most days, even if he or she seems to feel OK sometimes?

Yes **No**

Access to Firearms: Does your child have **access to firearms**? Yes No

If yes, how are the firearms locked up or secured?___________________________________

Anxiety and stress disorder symptoms:

Over the last 2 weeks, how often have the problems below bothered your child? Check the number for each item.

Generalized 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
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If your child is experiencing any of the above problems, how difficult have these problems made it for them to attend school, take care of things at home, or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Other Symptoms	Not at all	Several days	More than half the days	Nearly every day
Panic: This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, or feeling lightheaded.	0	1	2	3
Obsessions and compulsions: This can include repeated or persistent thoughts that your child can't control (about germs, schoolwork, being perfect, neatness, safety, or death). It can also include repeated behaviors or extreme routines that your child can't control (such as repeated hand-washing, checking locks, cleaning, or personal hygiene).	0	1	2	3
Hallucinations: This can include seeing or hearing things that others don't see or hear.	0	1	2	3

Symptom duration: Symptoms have been a serious concern for (check the most appropriate time period):

2 to 4 weeks 1 to 3 months 3 to 6 months 6 months to 1 year 1 to 2 years More than 2 years

Have 2 or more of these symptoms lasted longer than 1 year? Yes No

Sleep screening questions (pediatric insomnia severity index):

Mark the number of nights per week that your child has any of the following problems. **Select the appropriate box.**

	Never or 0 nights	**Once in a while or 1 to 2 nights**	**Sometimes or 2 to 3 nights**	**Quite often or 4 to 5 nights**	**Frequently or 5 to 6 nights**	**Always or 7 nights per week**
My child takes longer than 30 minutes to fall asleep after going to bed.						
My child has trouble falling asleep at bedtime.						
My child wakes up more than once during the night.						
After waking during the night, my child has trouble returning to sleep.						
My child appears or acts sleepy during the day.						

Number of hours per night	**11 to 13**	**9 to 11**	**8 to 9**	**7 to 8**	**5 to 7**	**Less than 5**
How many hours of sleep does your child get on most nights?						

Alcohol or drug use screening questions:

	Yes	**No**
Are you aware of your child drinking any alcohol?		
Are you aware of your child using any **tobacco products** (including e-cigarettes)?		
Are you aware of your child using any **prescription medications that were not prescribed to them or illegal drugs (including marijuana)?**		

Eating behaviors:

Questions	**Yes**	**No**	**Questions**	**Yes**	**No**
Are you concerned with your child's eating patterns?			Does your child's weight affect the way he or she feels about himself or herself?		
Does your child ever eat in secret?			Have any family members ever had an eating disorder?		

Abuse and traumatic events:

Read the following, then answer the first two questions:

Sometimes people have violent or very scary or upsetting things happen to them. This could be something that happened to your child or something your child saw. It can include being badly hurt, someone doing something harmful to your child or to someone else, or a serious accident or illness.

Has something like this happened to your child **RECENTLY**? Yes No

If yes, what happened?

Has something like this happened to your child **IN THE PAST**? Yes No

If yes, what happened?

If you answered **YES** to either question above, please continue. *Select how often the event caused problems for your child in the past month, even if the bad thing happened a long time ago. Use the Frequency Rating Calendar on the right to help you decide how often your child has been affected.*

Frequency Rating Calendar

NONE	LITTLE	SOME	MUCH	MOST
NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES A WEEK	ALMOST EVERY DAY

	HOW OFTEN DURING THE PAST MONTH...	None	Little	Some	Much	Most
1	My child has bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	My child has trouble going to sleep, wakes up often, or has trouble getting back to sleep.	0	1	2	3	4
3	My child has upsetting thoughts, pictures, or sounds of what happened that come to mind when they don't want them to.	0	1	2	3	4
4	When something reminds my child of what happened, they have strong feelings in their body (examples: a rapid heartbeat, headaches, or stomachaches).	0	1	2	3	4
5	When something reminds my child of what happened, they get very upset, afraid, or sad.	0	1	2	3	4
6	My child has trouble concentrating or paying attention.	0	1	2	3	4
7	My child gets upset easily or gets into arguments or physical fights.	0	1	2	3	4
8	My child tries to stay away from people, places, or things that remind them of what happened.	0	1	2	3	4
9	My child has trouble feeling happiness or love.	0	1	2	3	4
10	My child tries not to think about or have feelings about what happened.	0	1	2	3	4
11	My child has thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	My child feels alone even when he or she is around other people.	0	1	2	3	4

Vanderbilt ADHD parent rating scale:

What grade (year of school) is your child in?

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are evaluating and based on behavior over the past 6 months.

Is this evaluation based on a time when the child: Was on medication Was not on medication Unsure

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes (for example, makes mistakes on their homework)	0	1	2	3
2.	Has difficulty keeping their attention 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 staying seated is expected	0	1	2	3
12.	Runs around or climbs too much when staying 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 on others' conversations 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.	Purposely annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehavior	0	1	2	3
24.	Is easily offended or 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

	Symptoms	Never	Occasionally	Often	Very Often
29.	Lies to get out of trouble or to avoid obligations (tricks or cons others)	0	1	2	3
30.	Misses school without permission	0	1	2	3
31.	Is physically cruel to people (for example: hits, pinches, or slaps others)	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
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 (for example: kicks a dog or pulls a tail)	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, or complains that "no one loves" them	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. Math	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 (for example: team sports)	1	2	3	4	5

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