Intermountain® Healthcare

Mental Health Integration

Child & Adolescent Baseline Evaluation Packet

Dear Parent,

Mental health is important for overall health. That's why we have an integrated 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.

- **Initial Behavioral Health Intake Questionnaire** (9 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 & Family Rating Scale** (1 page): This form asks questions about you, your family, and your support system. It helps us understand your health, 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:**
  - Patient Health Questionnaire (PHQ-C) (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.
  - Developmental Disorders Symptom Rating Scale (1 page): This form helps us check for problems related to your child's development and to monitor for developmental disorders.
  - Parent–Young Mania Rating Scale (P–YMRS) (2 pages): This form helps us check for signs of a possible mood problem called bipolar disorder.
- **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

Patient and Provider Publications MHI005CL (Child & Adolescent Baseline Cover Letter) - 03/17 *Also available in Spanish.*

Initial Behavioral Health Intake Questionnaire

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

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

Doctor's Name: _____ Child's Primary Care Provider (if different): _____

1. **What are your main concerns about what your child is dealing with at this time and/or symptoms?** _____

   Physical: _____

   Emotional: _____

2. **What is currently causing your child stress (at home, school, or work; in relationships)?**

   _____

   _____

3. **Functional disability rating scale.** In the past 2 weeks, how much has your child's mental health symptoms interfered in the following areas of life?

Area of life	My child's symptoms interfered...										
	Not at all			A little		Pretty much			Very much		Severe
Family life and home responsibilities	0	1	2	3	4	5	6	7	8	9	10
Work or school (includes any volunteer or regularly scheduled activities out of the home)	0	1	2	3	4	5	6	7	8	9	10
Social or leisure activities (includes activities with friends, hobbies, or attending church)	0	1	2	3	4	5	6	7	8	9	10

How would you describe your/your child's overall life functioning?

_____

_____

Notes:

Patient and Provider Publications MHI006 -05/17

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Intermountain® Healthcare

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

4. **Has your child been treated for medical problems in the past?** Complete the table below. Include any type of outpatient or inpatient treatment or therapy your child received. **Be sure to list all medicines that your child has taken.**

Type of illness or concern?	**When** did you seek help?	**What treatment** did your child receive (medicine, counseling)?	**If medicine**, medicine name, number of "mg" from the pill bottle label, and how often (daily, with meals, etc.)	Did it help ? **(Yes or No)**?	Were there side effects? **(Yes or No)** **What kind?** (Use back of page if you need more space.)
Mental Health Problems					
Other Medical Problems					

5. **Does your child have problems sleeping? If yes, answer the following:**

Where does your child sleep?_____ How long has your child had sleep problems?_____

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

Which of the following best describes your child's sleep pattern:

☐ Has trouble falling asleep.

☐ Wakes up frequently at night.

How bad would you say your child's sleep problem is?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
not present		a little bad			pretty bad		very bad			couldn't be worse

Notes:

Mental Health *Integration*

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

6. Abuse and traumatic events: Check any events below that your child has experienced in the past **OR** that are going on now.

- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Emotional neglect
- ☐ Physical neglect
- ☐ Traumatic events
- ☐ Drug abuse in the family

Now, answer the following questions about the items you checked above.

	Yes	No
Are any of the situations either occurring now or still affecting your child?	☐	☐
Do you feel that your child is in any danger or at risk because of any of these issues?	☐	☐
Have you sought help from a professional to deal with any of these issues?	☐	☐

If so, who?_____

7. Alcohol or drug use: To the best of your knowledge, did your child do any of the following in the **past year**?

Yes	No	Substance	If Yes, how often?			
			Once or twice	Monthly	Weekly	Daily or almost daily
☐	☐	Alcohol	☐	☐	☐	☐
☐	☐	Tobacco products (including e-cigarettes)	☐	☐	☐	☐
☐	☐	Prescription medications for non-medical reasons	☐	☐	☐	☐
☐	☐	Prescription medications in amounts greater than prescribed, for reasons other than prescribed, or that weren't prescribed to your child	☐	☐	☐	☐
☐	☐	Drugs (street drugs, marijuana, huffing, and other)	☐	☐	☐	☐

8. Eating behaviors

Yes	No		Yes	No	
☐	☐	Are you concerned with your child's eating patterns?	☐	☐	Does your child's weight affect the way you feel about them?
☐	☐	Does your child ever eat in secret?	☐	☐	Have any members of your family suffered from an eating disorder?

Notes:

Intermountain® Healthcare

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

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
great		okay			not so good		bad		very bad	

10. Has your child experienced any of the following medical problems?

Area of illness or concern (examples)	**Age when first began?**	**Describe treatment received, how resolved or if still under treatment**	**Other comments?**
Bones, Muscles (arthritis, joint pain, muscle aches)			
Ear, Nose, Throat (vision problems, hearing problems, ear infection, tubes in ears, speech problems)			
Endocrine (diabetes, metabolic syndrome, thyroid problems, menstruation problems)			
Heart, Blood Vessels (heart murmur, high blood pressure, high cholesterol)			
Lungs (asthma, allergies)			
Nervous System (headache, head injury, seizure)			
Stomach, Intestines (diarrhea, constipation, abdominal pain, vomiting)			
Urinary System (bladder or kidney infection, incontinence, bed wetting)			

11. Has your child been in a serious accident, been hospitalized, or had any surgeries? (Use back if more space needed.)

List any::	**Describe what happened**	**When did this happen?**
Serious accidents:		
Hospitalizations:		
Surgeries:		

12. Current medicines you/your child is taking. List **ALL** medicines prescribed by a physician **AND** any vitamins, supplements, herbal preparations, or other over-the-counter medicines you take:

_____

_____

_____

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

13. Is your child allergic to any medicines? If so, please list the medicine and your child's reaction below:

_____

_____

14. Are your child's immunizations current? ☐ Yes ☐ No

If not, which immunizations are **not** current? _____

15. Chronic Pain Assessment

Does your child have pain every day that limits their activities? ☐ Yes ☐ No

If yes, **use the pain scale below** to rate your child's average daily level of pain. Average pain level (0–10) _____

If not daily pain, how often does your child have pain that limits activities?_____

Wong-Baker FACES Pain Rating Scale

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

Notes:

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

16. Education

Current grade level: _____ Name of school**:** _____

Are you satisfied with your child's performance in school? ☐ Yes ☐ No

If no, please describe:

_____

_____

Has your child been suspended or expelled? ☐ Yes ☐ No

Does your child receive special resources or services at school? ☐ Yes ☐ No

If yes, please describe:_____

_____

17. Other Behaviors.

Does your child have any behaviors that concern you? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do your child's teachers or other adults in their life report behavior concerns? ☐ Yes ☐ No

If yes, please describe:

_____

_____

18. Developmental History

Pregnancy. Were there any problems during pregnancy or delivery with this child? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Mother's health.

Overall health of mother	☐ Good	☐ Fair	☐ Poor
Nutritional status	☐ Good	☐ Fair	☐ Poor
Prenatal vitamins	☐ Yes	☐ No	
Attitude towards pregnancy	☐ Good	☐ Fair	☐ Poor
Social support	☐ Good	☐ Fair	☐ Poor
Drug/alcohol use	☐ Yes*	☐ No	

*If you checked the "yes" box, please describe:

_____

_____

Notes:

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

18. Developmental History *(continued)*

Childhood milestones. Please indicate, to the best of your memory, if the ages for the following milestones were:

D for delayed, **N** for within normal range, and **E** for early

For Infants and Toddlers		
Behavior	**Normal Development**	**Your Child's Development**
Lifts head	1 to 3 months	☐ D ☐ N ☐ E
Smiles	1 to 3 months	☐ D ☐ N ☐ E
Babbling	4 to 11 months	☐ D ☐ N ☐ E
Sits alone	5 to 8 months	☐ D ☐ N ☐ E
Stands	6 to 10 months	☐ D ☐ N ☐ E
Walks	11 to 14 months	☐ D ☐ N ☐ E
First words	11 to 15 months	☐ D ☐ N ☐ E
Pretend play	12 to 24 months	☐ D ☐ N ☐ E
Toilet trained	20 to 36 months	☐ D ☐ N ☐ E

For Preschool		
Behavior	**Normal Development**	**Your Child's Development**
Speaks in full sentences	2 to 3 years	☐ D ☐ N ☐ E
Rides tricycle	2 to 3 years	☐ D ☐ N ☐ E
Plays cooperatively	4 to 6 years	☐ D ☐ N ☐ E
Writes letters and numbers	4 to 6 years	☐ D ☐ N ☐ E
Uses scissors	4 to 6 years	☐ D ☐ N ☐ E

Did your child have behavior problems in preschool? ☐ Yes ☐ No

If so, please describe: _____

Comments: _____

School-age Development. Has your child had problems with any of the following during elementary, middle, and/or high school? Check those that apply. For each item checked, rate how severe the problem is or was.

My child has had problems with (check all that apply):		**If checked,** how severe is or was the problem?										
		Rare					**Occasional**					**Frequent**
☐	Peer relationships	0	1	2	3	4	5	6	7	8	9	10
☐	Classroom behavior	0	1	2	3	4	5	6	7	8	9	10
☐	Academic skills	0	1	2	3	4	5	6	7	8	9	10
☐	Depression	0	1	2	3	4	5	6	7	8	9	10
☐	Anxiety	0	1	2	3	4	5	6	7	8	9	10
☐	Impulsivity	0	1	2	3	4	5	6	7	8	9	10
☐	Short attention span	0	1	2	3	4	5	6	7	8	9	10
☐	High energy	0	1	2	3	4	5	6	7	8	9	10
☐	Truancy	0	1	2	3	4	5	6	7	8	9	10

Notes:

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

19. Family/Caregiver Information

Who does your child live with? _____

If separated, divorced or unmarried, please describe current custody and visition arrangements:

_____

Who are your child's primary caretakers at home?

_____

Is anyone else routinely involved in the care of your child?

☐ Family member ☐ Day care ☐ Neighbor ☐ Others: _____

Is the child involved with DCFS, JJS, or other legal system? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Does child have access to firearms? _____

20. Family History

Where was your child born and raised? _____

Please list your child's/adolescent's brothers and sisters. Use the back for more space if needed.

Brother or sister's name	Alive?		Living in same household?		Relationship?		
	Yes	No	Yes	No	Good	Fair	Poor
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Current religion (optional): _____

Your family's religion growing up (optional): _____

Is spirituality important in your life? ☐ Yes ☐ No

Does your child/adolescent have any biological relatives who have had behavioral, emotional, or mental problems such as depression, anxiety, bipolar disorder, ADHD, drug or alcohol use disorder, or suicide? If yes, complete the table below.

Relative (parent, sibling, child)	Behavioral, Emotional, or Mental Problem

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

20. Family History *(continued)*

Check if any of the following critical events have occurred in your family:

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: _____		

21. Lifestyle, Strengths/Weaknesses, and Goals

On average, how many days per week does your child exercise or do physical activity? _____

On average, how many minutes of physical activity or exercise does your child perform on each of those days? _____

At what intensity (how hard) does your child usually exercise?

☐ Light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)

List your child's strengths and weaknesses. _____

What goals does your child hope to achieve with this treatment? _____

Notes:

Parental Screen and Family Rating Scale *(page 1 of 1)*

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: ____ (3) + ____ (6) + ____ (8) = ____ /30 Style II: ____ (1) + ____ (4) + ____ (9) = ____ /30 Style III: ____ (2) + ____ (5) + ____ (7) = ____ /30

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 the children you are rating* ***in the past 6 months.***

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 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	☐

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Patient and Provider Publications 801-442-2963 ADD003 -10/14

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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): _____

Patient Health Questionnaire (PHQ-C) *(page 1 of 1)*

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

Is your child currently: ☐ *on medication for depression* ☐ *not on medication for depression* ☐ *not sure* ☐ *in counseling*

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/staying asleep, 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 him or herself, — or that he or she is a failure or have let him or herself or family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that he or she has been moving around a lot more than usual	0	1	2	3
9. Thoughts that he or she would be better off dead, or of hurting him or herself in some way	0	1	2	3
Total each column				

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 his or her work, take care of things at home, or get along with other people?

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

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

☐ **Yes** ☐ **No**

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Symptom score *(total # of answers in shaded areas):* _____

Severity score *(total all points from all questions):* _____

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PHQ 50408

Source: Patient Health Questionnaire Modified for Teens (PHQ-9)
(Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

Patient and Provider Publications 801-442-2963 MHI022 (PHQ-C) - 10/14

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: _____

The patient is 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	**Hallucinations:** This can include hearing voices or seeing things that others don't hear or see.	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 ☐ More than 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 (Q 2–5): _____ /40 Hallucinations (Q 6): _____ /10

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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
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	Not at all A little Pretty much Very much Couldn't be worse 0 1 2 3 4 5 6 7 8 9 10
2	**Repetitive or restricted behavior** May include the following symptoms: repeats the same movements, lines up toys, struggles with change, focuses on topics, doesn't notice pain/temperature, smells or touches things a lot	0 1 2 3 4 5 6 7 8 9 10
3	**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
4	**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
5	**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
6	**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
7	**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 (1–5): _____ /50 Impairment score (6–7): _____ /20

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Parent–Young Mania Rating Scale (P–YMRS) *(page 1 of 2)*

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

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

Mark the box that corresponds to how much the described symptoms apply to your child.

1	**Elevated Mood**	*Is your child's mood higher (better) than usual?*	
		☐	0. No
		☐	1. Mildly or possibly increased
		☐	2. Definite elevation — more optimistic, self confident; cheerful; appropriate to their conversation
		☐	3. Elevated but inappropriate to content; joking, mildly silly
		☐	4. Euphoric; inappropriate laughter; singing/making noises; very silly
2	**Increased Motor Activity/Energy**	*Does your child's energy level or motor activity appear to be greater than usual?*	
		☐	0. No
		☐	1. Mildly or possibly increased
		☐	2. More animated; increased gesturing
		☐	3. Energy is excessive
		☐	4. Very excited; continuous hyperactivity; cannot be calmed
3	**Sexual Interest**	*Is your child showing more than usual interest in sexual matters?*	
		☐	0. No
		☐	1. Mildly or possibly increased
		☐	2. Definite increase when the topic arises
		☐	3. Talks spontaneously about sexual matters; gives more detail than usual
		☐	4. Has shown open sexual behavior — touching others or self inappropriately
4	**Sleep**	*Has your child's sleep decreased lately?*	
		☐	0. No
		☐	1. Sleeping less than normal amount by up to 1 hour
		☐	2. Sleeping less than normal amount by more than 1 hour
		☐	3. Need for sleep appears decreased; less than 4 hours
		☐	4. Denies need for sleep; has stayed up one night or more
5	**Irritability**	*Has your child appeared irritable?*	
		☐	0. No more than usual
		☐	2. More grouchy or crabby
		☐	4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
		☐	6. Frequently irritable to point of being rude or withdrawn
		☐	8. Hostile and uncooperative about all the time
6	**Speech (Rate and Amount)**	*Is your child talking more quickly or more than usual?*	
		☐	0. No change
		☐	2. Seems more talkative
		☐	4. Talking faster or more to say at times
		☐	6. Talking more or faster to point he/she is difficult to interrupt
		☐	8. Continuous speech; unable to interrupt

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Parent–Young Mania Rating Scale (P–YMRS) *(page 2 of 2)*

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

Mark the box that corresponds to how much the described symptoms apply to your child.

7	**Language-Thought Disorder**	*Has your child shown changes in his/her thought patterns?*	
		☐	0. No
		☐	1. Thinking faster; some decrease in concentration; talking "around the issue"
		☐	2. Distractible; loses track of the point; changes topics frequently; thoughts racing
		☐	3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
		☐	4. Not understandable; he/she doesn't seem to make any sense
8	**Content**	*Is your child talking about different things than usual?*	
		☐	0. No
		☐	2. He/she has new interests and is making more plans
		☐	4. Making special projects; more religious or interested in God
		☐	6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
		☐	8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs
9	**Disruptive/ Aggressive**	*Has your child been more disruptive or aggressive?*	
		☐	0. No; he/she is cooperative
		☐	2. Sarcastic; loud; defensive
		☐	4. More demanding; making threats
		☐	6. Has threatened a family member or teacher; shouting; knocking over possessions/furniture or hitting a wall
		☐	8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence
10	**Appearance**	*Has your child's interest in his/her appearance changed recently?*	
		☐	0. No
		☐	1. A little less or more interest in grooming than usual
		☐	2. Doesn't care about washing or changing clothes, or is changing clothes more than three times a day
		☐	3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
		☐	4. Refuses to dress appropriately; wearing bizarre styles
11	**Insight**	*Does your child think he/she needs help at this time?*	
		☐	0. Yes; admits difficulties and wants treatment
		☐	1. Believes there might be something wrong
		☐	2. Admits behavior might have changed but denies need for help
		☐	3. Admits possible change behavior, but denies illness
		☐	4. Denies there have been any changes in his/her behavior/thinking

For office use only. Add the highest number in each section for the total score: ***Total Score***: ____ / 60

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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.

	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.
Domain of Functioning	**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

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