MAHEC Center for Psychiatry and Mental Wellness

WELCOME TO OUR PRACTICE

All of our providers and staff look forward to welcoming you to our practice! We have enclosed the necessary paperwork for you to complete at home and bring with you to your appointment.

PLEASE REMEMBER TO:

1. **Bring your completed paperwork** to your appointment or your appointment may be rescheduled.
2. **Arrive 30 minutes prior** to your appointment time or your appointment may be rescheduled.
3. **Bring current insurance cards** (such as Medicare, Medicaid, etc.) if you are covered by insurance. If you do not bring these to your appointment, you may have to be rescheduled.
4. **Check with your insurance company**, if you are covered by insurance, prior to your appointment to make sure that your provider is participating with your plan.

MAHEC Center for Psychiatry and Mental Wellness
Mary C. Nesbitt Biltmore Campus, 125 Hendersonville Road, Asheville, NC 28803

Phone: 828-398-3601 | **Fax:** 828-333-5465

CENTER FOR PSYCHIATRY AND MENTAL WELLNESS PATIENT REGISTRATION FORM

Please complete the following information using BLACK ink. ****This information is confidential****

Name ____ SS #____________________

Address ______________________________ City________________State_____ Zip________

Home county ____________________E-mail address ________________________________

Home phone __________________Work phone ________________Cell phone ______________________

By providing a phone number, mobile phone number or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Birth Date ____________________ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ In a relationship ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

In case of emergency, contact:

Name______________________________ Relationship _____________ Phone #_____________

IF PATIENT IS CHILD (18 & UNDER): Responsible Party Name:______________________________

Relationship to patient __________________________ Phone #______________________________

Please list: Special hearing needs: _______________________ Special vision needs: ______________________

What is your race / ethnicity? (check all that apply):

❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander

❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Other (please describe):_____________

Preferred Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Other_______________

INSURANCE INFORMATION

Insurance company ____Policy ID# ________________________

Insurance company phone number ______________________________

Policy holder’s name ____ Policy holder’s date of birth _____________

Policy holder’s relationship to patient: ____

Policy holder’s address: ____

____

Policy holder is ❑ male ❑ female

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to MAHEC Family Health Center and I authorize them to file insurance on my behalf. I also authorize them to release medical/and or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand MAHEC Family Health Center:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice

.

I have read and understand the above: ______________________________________ Date___________________
Patient or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient, Parent or Guardian Signature ____________________________________ Date___________________

VERBAL COMMUNICATION CONSENT

MAHEC is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

____ ____

____ ____

Today's Date: _____________________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature ____________________________________ Date__________________

Child's Name ________________
Today's Date ________________
Date of Birth ________________

Record Number ________________
Filled out by ________________

Pediatric Symptom Checklist Ages 4-10

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score ________________

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?____

Pediatric Symptom Checklist - Youth Report (Y-PSC) Ages 11-16

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains...........................	___	___	___
2. Spend more time alone................................	___	___	___
3. Tire easily, little energy...........................	___	___	___
4. Fidgety, unable to sit still.........................	___	___	___
5. Have trouble with teacher………………	___	___	___
6. Less interested in school.…………...	___	___	___
7. Act as if driven by motor............................	___	___	___
8. Daydream too much...................................	___	___	___
9. Distract easily......................................	___	___	___
10. Are afraid of new situations.........................	___	___	___
11. Feel sad, unhappy...................................	___	___	___
12. Are irritable, angry.................................	___	___	___
13. Feel hopeless.......................................	___	___	___
14. Have trouble concentrating...........................	___	___	___
15. Less interested in friends...........................	___	___	___
16. Fight with other children............................	___	___	___
17. Absent from school. ……………………	___	___	___
18. School grades dropping. ………………..	___	___	___
19. Down on yourself....................................	___	___	___
20. Visit doctor with doctor finding nothing wrong........	___	___	___
21. Have trouble sleeping................................	___	___	___
22. Worry a lot...	___	___	___
23. Want to be with parent more than before..............	___	___	___
24. Feel that you are bad................................	___	___	___
25. Take unnecessary risks...............................	___	___	___
26. Get hurt frequently..................................	___	___	___
27. Seem to be having less fun...........................	___	___	___
28. Act younger than children your age...................	___	___	___
29. Do not listen to rules...............................	___	___	___
30. Do not show feelings.................................	___	___	___
31. Do not understand other people's feelings............	___	___	___
32. Tease others..	___	___	___
33. Blame others for your troubles.......................	___	___	___
34. Take things that do not belong to you................	___	___	___
35. Refuse to share.....................................	___	___	___

NEW PATIENTS

New patients need to bring completed paperwork, a picture ID and insurance cards to first appointment. Patients are encouraged to contact their insurance company and verify mental health benefits prior to their first visit. We accept all insurance, but this does not guarantee that we are in network with your plan.

RETURNING PATIENTS

Returning patients should make sure all information is up to date at each visit. This includes name, address, phone number and insurance information.

TELEPHONE CONSULTATIONS

Telephone consultations are generally not available. Please discuss your healthcare needs during your visit. Should issues arise between appointments please contact our office to schedule an earlier appointment.

AFTER HOURS

One of our providers will be on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For medical emergencies, you should call 911.

PRESCRIPTION REFILLS

All medication refill requests need to be made during the patient's appointment. Please bring prescription bottles or a list of medications with you to each appointment. Prescription refill requests at other times will be completed within 3 business days.

BILLING

You are responsible for your annual deductible, co-pay/co-insurance, and any balance that your insurance does not pay. Co-pays are expected at the time of service. Please be aware that some services are not covered by insurance and you will be billed. We accept cash, check, and credit card payments. A service fee is assessed for returned checks. The billing office phone number is (828) 257-4725, option 3. If you have a billing question, please call the billing office and we will do our best to help you or direct you to someone who can.

I have read and agree to the above policy:

____	___/____/____	____________________
Printed Name	Date of Birth	Today's Date

____

Signature

Thank you for choosing us for your healthcare!

INCOMING TO MAHEC

MAHEC Center for Psychiatry
Centralized Medical Records Department
125 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: ____**Date of Birth:**__________________

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	**MAHEC Center for Psychiatry Centralized Medical Records Dept.**
ADDRESS:	**125 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

- ❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- ❑ Only information related to *(specify)*: ____
- ❑ Only the period of events from: ______________________________ to ________________________________
- ❑ Entire medical record
- ❑ Exclusions
  - __ AIDS/HIV test results, diagnosis, treatment, and related information
  - __ Drug screen results and information about drug and alcohol use and treatments
  - __ Mental health notes
  - __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. ____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

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

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE ***(State relationship to Patient)***	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

OUTGOING FROM MAHEC

MAHEC Center for Psychiatry

125 Hendersonville Road, Asheville, NC 28803
Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

Patient Account#:____________

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ALL SECTIONS of this form MUST be complete before your request can be processed.
Don't forget to sign and date at bottom before submitting.

Patient Legal Name: ____**DOB:**______________________________

I authorize the use or disclosure of the above named individual's health information as described below. **If the request is for more than 50 pages, the documents will be mailed and not faxed. Please confirm mailing address below.**

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY **MAHEC Center for Psychiatry**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **125 Hendersonville Road**	ADDRESS
CITY/STATE/ZIP **Asheville, NC 28803**	CITY/STATE PHONE #: FAX #:

The purpose or need for this disclosure is:

____

I would like to receive my records via: ☐ Fax ☐ Mail ☐ In-Person (___ paper or ___ CD)

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

☐ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
☐ Only information related to *(specify)*: ____
☐ Only the period of events from: ______________________________ to ______________________________
☐ Entire medical record
☐ Exclusions __ AIDS/HIV test results, diagnosis, treatment, and related information
__ Drug screen results and information about drug and alcohol use and treatments
__ Mental health notes
__ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. ____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

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

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

MOOD AND FEELINGS QUESTIONNAIRE: Short Version

This form is about how you might have been feeling or acting **recently**.

For each question, please check (✓) how you have been feeling or acting ***in the past two weeks***.

If a sentence was not true about you, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about you most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. I felt miserable or unhappy.			
2. I didn’t enjoy anything at all.			
3. I felt so tired I just sat around and did nothing.			
4. I was very restless.			
5. I felt I was no good anymore.			
6. I cried a lot.			
7. I found it hard to think properly or concentrate.			
8. I hated myself.			
9. I was a bad person.			
10. I felt lonely.			
11. I thought nobody really loved me.			
12. I thought I could never be as good as other kids.			
13. I did everything wrong.			

Copyright Adrian Angold & Elizabeth J. Costello, 1987; Developmental Epidemiology Program; Duke University

MOOD AND FEELINGS QUESTIONNAIRE: Short Version

This form is about how your child might have been feeling or acting **recently**.

For each question, please check (✓) how s/he has been feeling or acting ***in the past two weeks***.

If a sentence was not true about your child, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about your child most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. S/he felt miserable or unhappy.			
2. S/he didn't enjoy anything at all.			
3. S/he felt so tired that s/he just sat around and did nothing.			
4. S/he was very restless.			
5. S/he felt s/he was no good anymore.			
6. S/he cried a lot.			
7. S/he found it hard to think properly or concentrate.			
8. S/he hated him/herself.			
9. S/he felt s/he was a bad person.			
10. S/he felt lonely.			
11. S/he thought nobody really loved him/her.			
12. S/he thought s/he could never be as good as other kids.			
13. S/he felt s/he did everything wrong.			

Copyright Adrian Angold & Elizabeth J. Costello, 1987; Developmental Epidemiology Program; Duke University

PHQ-9 modified for Adolescents (PHQ-A)

Name: ______________________ **Clinician:** ____________________ **Date:** ________

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

	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

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

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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

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 to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

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	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
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	**SC**
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	**SC**
41. I am shy.	O	O	O	**SC**

SCORING:

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

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

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

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

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

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

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.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.
"

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

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

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ___________________________________ Date of Birth: ______________

Parent's Name: ___________________________________ Parent's Phone Number: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ______________

Total number of questions scored 2 or 3 in questions 10–18: ______________

Total Symptom Score for questions 1–18: ______________

Total number of questions scored 2 or 3 in questions 19–26: ______________

Total number of questions scored 2 or 3 in questions 27–40: ______________

Total number of questions scored 2 or 3 in questions 41–47: ______________

Total number of questions scored 4 or 5 in questions 48–55: ______________

Average Performance Score: ______________

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

Today's Date: ________ Child's Name: ______________________ Grade Level: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: ________.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

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

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

Consumer & Specialty Pharmaceuticals

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: ____________

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

11-20/rev0303