Fifth Street Family Practice

Pediatric Appointment for Neurodevelopmental Assessment

Parent Questionnaire

(to be completed by parent/ legal guardian in order for referral to be processed)

Patient's Last Name: _____ Today's Date: _____

Patient's First Name: _____ Middle: _____

Name at birth (if different from above): _____

Date of Birth (dd/mm/yy): _____ Sex (at birth): Male / Female

BC Health care number: _____ Gender and preferred pronouns: _____

Is patient covered by extended health care benefits? _____

Does patient have Treaty Status? Yes / No

What are your main concerns about your child? _____

_____

_____

Who suggested this referral and why? _____

_____

_____

Primary care provider/ Family Physician Information:

Name: _____ Address: _____

Phone: _____ Fax: _____

Other physicians involved in patient's care:

Name: _____ Clinic/ location: _____

Name: _____ Clinic/ location: _____

Other allied healthcare professionals involved in patient's care:

Name: _____ Clinic/ location: _____

Name: _____ Clinic/ location: _____

Parent(s)/ Guardian(s) Identification:

Name: 1) _____ 2) _____

Relationship to child*: 1) _____ 2) _____

*please specify: biological, adoptive, foster, step-parent, bio-grandparent etc. along with preferred relationship identified by child.

Marital Status: 1) _____ 2) _____

Address: 1) _____ 2) _____

Phone: 1) _____ 2) _____

If parents are living apart, child mainly lives with: _____

Who has legal custody? _____

List everyone who currently lives at (each) home:

Home 1) _____

Home 2) _____

Language spoken/ understood at (each) home:

Home 1) _____

Home 2) _____

Interpreter required? Yes / No

Social worker Identification (if applicable): _____

Social Worker's Name: _____

District Office: _____

Telephone: _____ Fax: _____

Child's Guardianship Status (if applicable): _____

- ☐ Permanent Guardianship Order (PGO)
- ☐ Temporary Guardianship Order (TGO) Expiry Date: _____
- ☐ Custody Agreement Expiry Date: _____

Child's Prenatal History

List any health (physical and mental) problems during pregnancy: _____

_____

List any psycho-social stressors during the pregnancy: _____

_____

How far into the pregnancy were you when you found out that you were pregnant? ___ weeks

This was mother's ___ (#) pregnancy and ___ (#) child.

Length of pregnancy: ___ weeks

Were any of the following used during the pregnancy?

- ☐ Cigarettes. Approximately ___ pack(s) per day
- ☐ Prescription medications. Names: _____
- ☐ Over the counter medications. Names: _____
- ☐ Vitamins or supplements. Names: _____
- ☐ Alcoholic beverages. Select all that apply:
  - ☐ First 3 months only
  - ☐ Throughout most of the pregnancy
  - ☐ Once per week frequency
  - ☐ Two or more times per week
  - ☐ 1-2 drinks
  - ☐ 3-5 drinks
  - ☐ 6 or more drinks
- ☐ Marijuana. Approximately ___ grams per day
- ☐ Other substances (e.g. cocaine, heroin, LSD, methamphetamines, etc.) _____
  _____

Child's Birth History:

Name of Hospital: _____

City/ Province/ Country: _____

Birth mother's name (at time of birth): _____

Method of delivery:

- ☐ Vaginal vs. C-section. Any forceps or vacuum?

Birthweight: _____

Complications at the time of delivery? E.g. abnormal heart rate, infection, meconium, low oxygen

- ☐ Yes vs. No. If yes, please explain: _____

Did the baby require NICU (Neonatal Intensive Care Unit) care? Observation at the Comox Valley Hospital Nursery? Transfer to another hospital for higher level of care?

- ☐ Yes vs. No. If yes, please explain: _____

Were there any complications post-partum? E.g. jaundice, low blood sugar, breathing issues, feeding issues.

- ☐ Yes vs. No. If yes, please explain: _____

At how many days of life was baby discharged home from the hospital? _____

Child's Past and Present Health Conditions

Please list any pre-existing diagnoses your child has been diagnosed with:

_____

_____

_____

Has your child had any of the following issues previously? *(please denote year of diagnosis and any comments)*

- ☐ Colic
- ☐ Ear Infections
- ☐ Hearing problems
- ☐ Eye/ vision problems/ glasses
- ☐ Feeding/ eating problems
- ☐ Frequent stomach aches
- ☐ Frequent headaches
- ☐ Meningitis
- ☐ Seizure
- ☐ Tics or twitches
- ☐ Sleep problems
- ☐ Bedwetting
- ☐ Soiling pants with stool

Has your child had any Emergency Department visits? *(please denote year and diagnosis)*

_____

_____

Has your child had any overnight hospital admissions? *(please denote year and diagnosis)*

_____

_____

Has your child had any surgeries? *(please denote year and diagnosis)*

_____

List your child's current medications (and dose):

_____

_____

List any other medications, special diets, herbal remedies, or vitamins that your child has used for > 2 week in the past:

Name: _____ When: _____

Name: _____ When: _____

Name: _____ When: _____

Name: _____ When: _____

Name: _____ When: _____

Child's Developmental History:

During the first years of life, was this child:

- ☐ Cuddly
- ☐ A poor/ restless sleeper
- ☐ Easily calmed by holding/ stroking
- ☐ Accident prone

Overall mood in the first year of life:

- ☐ "Easy"
- ☐ "Variable"
- ☐ "Challenging"
- ☐ "Other". Please explain:

Early Childhood Development: At what age did you child first accomplish the following?

- Sitting up independently ___ months
- Crawling on hands and knees ___ months
- Walking 10-15 steps independently ___ months
- Riding a tricycle with pedals ___ years

- Use fingers to feed self: ___ months
- Use a spoon to feed self: ___ months
- Toilet-trained (day): ___ years
- Toilet-trained (night): ___ years

- Say his/ her first word: ___ months
- Put 2-3 words together: ___ years
- Use sentences: ___ years

Were there any concerns with your child's early childhood development? Yes / No

If yes, please explain: _____

_____

_____

How was/ is Preschool? _____

_____

_____

How was/ is elementary school? _____

_____

_____

How was/ is high school? _____

_____

_____

<u>Education / Intervention</u> (if child is in a program, e.g. school)

Name of Current Program (e.g. school):

Type of Program: _____ Level/ Grade: _____ Teacher: _____

Phone: _____ Is the program aware of this referral? Yes / No

Are there homework issues? Yes / No _____

Please list any school / program your child has attended in the past:

Name	Years	Grade	Any Problems (learning, behavior)	Special Program?
1.				
2.				
3.				
4.				

<u>Child's Previous Assessments and/or Therapy</u>

	Date	Name and Agency	Still Involved
Psychology			Yes / No
Speech Language Pathology			Yes / No
Occupational Therapy			Yes / No
Physical Therapy			Yes / No
Behavioral Therapy			Yes / No
Hearing (Audiology)			Yes / No
Vision			Yes / No
Other			Yes / No

Are you aware of any assessments planned in the next 6-12 months other than this one? Yes / No

If yes, please explain when, where, and by whom: _____

Please attach any previous assessments which have been completed.

Biological Family History

	Birth Mother	Birth Father
Name	_____	_____
Date of Birth (dd/mm/yy)	_____	_____
Present Occupation	_____	_____
Education (highest grade completed)	_____	_____
Any learning/ attention/ behavior problems?	_____	_____
Attended a special class?	_____	_____

Are birth mother and birth father related: Yes / No Relationship: _____

Health Conditions in the Birth Family

- ☐ Hyperactive Relationship: _____
- ☐ Genetic syndrome or birth defect Relationship: _____
- ☐ Learning problem with:
  - reading/ spelling Relationship: _____
  - writing Relationship: _____
  - arithmetic Relationship: _____
- ☐ Repeated a grade Relationship: _____
- ☐ Intellectual disability / developmental delay Relationship: _____
- ☐ Cerebral palsy Relationship: _____
- ☐ Migraine headaches Relationship: _____
- ☐ Epilepsy Relationship: _____
- ☐ Involuntary tics or Tourette's disorder Relationship: _____
- ☐ Thyroid problems Relationship: _____
- ☐ Speech problem Relationship: _____
- ☐ Hearing difficulties Relationship: _____
- ☐ Visual problems Relationship: _____
- ☐ Behavioral problem in childhood Relationship: _____
- ☐ Drinking problem Relationship: _____
- ☐ Drug abuse Relationship: _____
- ☐ Emotional/ psychiatric disorder (e.g. depression) Relationship: _____
- ☐ Other problems Relationship: _____

Please indicate any recent or current family events or problems that could be influencing your child's functioning (e.g. at home, at work, housing, finances): _____

_____

Sibling History

Sibling(s) Name	Age	Gender	Relationship	Any behavior/ health/ learning problems?

Behavior/ Discipline

Do you have concerns about your child's behavior? Yes / No

If yes, please explain which specific behaviors concern you: _____

Describe how you parent your child (e.g. rewards, consequences, limits, expectations, structured, flexible): _____

Describe your child's morning routine: _____

Describe your child's night-time routine: _____

Describe your child's responsibilities at home: _____

Describe your child's typical weekday evening: _____

What is your child's favorite activities: _____

What types of activities or play does your child avoid? _____

What are your child's strengths? _____

Any additional information that may help us better understand your child? _____

_____

How concerned are you about your child's functioning?

- ☐ Extremely
- ☐ Very
- ☐ A little
- ☐ Not really concerned

Signature: _____ Relationship: _____ Date: _____

Thank you for completing this questionnaire. With this, please also include the following:

- ☐ Vanderbilt Parent Assessment Scale
- ☐ SCARED Parent Questionnaire
- ☐ SCARED Child Questionnaire (if > 6yo)
- ☐ Age-appropriate MCHAT questionnaire (if <6yo)
- ☐ Columbia Depression Scale (Teen) (if >10yo)
- ☐ Columbia Depression Scale (Parent) (if >10yo)
- ☐ Record of any prior assessments (e.g. vision, hearing, speech, physiotherapy, etc.)
- ☐ School Questionnaire and Vanderbilt Teacher Assessment Scale

Once the above documentation is received, your referral will be processed, and you will be informed of approximate wait times or an appointment time and date.

Please return completed questionnaire to:

Fifth Street Family Practice
c/o Dr. Gunaratnam
519G 5th Street
Courtenay, BC
V9N 1K2
Fax: 250-703-1431

Using the above methods, your health information and privacy will be protected.

Email: clinicfsfp@gmail.com (*please note that this is a non-confidential method of communication, and the privacy of your health information may be compromised if you choose to use this method).*

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

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

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

Revised - 1102

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: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date**: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

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

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

Fifth Street Family Practice

Pediatric Appointment for Neurodevelopmental Assessment

School Questionnaire

(To be completed by teacher or school-based team and returned for referral to be processed.)

Student's Name: _____

Date of Birth (dd/mm/yy): _____ Today's Date (dd/mm/yy): _____

Present Grade Level: _____ Size/ Type of Class: _____

Name of School: _____

Phone: _____ Fax: _____

Address of School: _____

School Board: _____

Principal's Name: _____ Classroom Teacher's Name: _____

Contact Person: _____ Information provided by: _____

Who initiated this referral? _____

What are your main concerns about this student regarding school progress?_____

_____

_____

What questions would you like answered? _____

_____

_____

For each of the following academic skills, compared to other students the same age, this student is:

	Behind grade level	At grade level	Beyond grade level
Reading	☐	☐	☐
Writing	☐	☐	☐
Math	☐	☐	☐

School History:

How long has this student been attending your school? _____

Which of the following assessments/ therapies has this student received?

	Dates	Name and Agency	Still Involved
Psychoeducational Assessment	_____	_____	Yes / No
Counselling	_____	_____	Yes / No
Speech Language Pathology	_____	_____	Yes / No
Occupational Therapy	_____	_____	Yes / No
Physical Therapy	_____	_____	Yes / No
Behavioral Therapy	_____	_____	Yes / No
Hearing (Audiology)	_____	_____	Yes / No
Vision	_____	_____	Yes / No
Other	_____	_____	Yes / No

Are you aware of any pending assessments which have already been requested? What is the anticipated date? Yes / No Anticipated Date: _____

If yes, please provide details: _____

Please attach any previous assessments which have been completed.

Which of the following services are available in your school?

- ☐ Individualized Educational/ Learning Plan
- ☐ Slow starts
- ☐ Psychoeducational testing
- ☐ Learning Support Teacher
- ☐ Educational Assistants
- ☐ Speech and language therapists
- ☐ Occupational therapists
- ☐ Physiotherapists
- ☐ Counsellors
- ☐ Resource room
- ☐ Other services for children with special learning needs: _____

Describe any current programming, assistance, or therapy given to this student: _____

_____

Please provide any general observations in the following areas:

Peer relationships and social interactions: _____

_____

_____

Any restricted interests or repetitive behaviors? _____

_____

_____

Attention and Impulsivity: _____

_____

_____

Behavior around new experiences or transitions: _____

_____

_____

Behavior (in groups vs. individually): _____

_____

_____

Attitude towards learning: _____

_____

_____

Work style: _____

_____

Self-Concept: _____

_____

Coping style for academic or social difficulties: _____

_____

Emotional style/ temperament: _____

_____

Strengths: _____

_____

Challenges: _____

_____

_____

Any additional information that may help us better understand this student? _____

_____

How concerned are you about your child's functioning?

- ☐ Extremely
- ☐ Very
- ☐ A little
- ☐ Not really concerned

Signature: _____ Professional Role: _____ Date: _____

Thank you for completing this questionnaire. With this, please also include the following:

- ☐ Vanderbilt Teacher Assessment Scale
- ☐ Record of any prior school-based assessments
- ☐ Formal Individualized Education/ Learning Plan if available

Once the above documentation is received, this student's referral will be processed.

Please return completed questionnaire to:

Fifth Street Family Practice
c/o Dr. Gunaratnam
519G 5th Street
Courtenay, BC
V9N 1K2
Fax: 250-703-1431

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

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 Health Quality

McNeil Consumer & Specialty Pharmaceuticals

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

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 Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY PARENT OF FEMALE CHILD

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions about your daughter (female child) as honestly as possible.

In the last four weeks ...	No	Yes
1. Has she often seemed sad or depressed?	0	1
2. Has it seemed like nothing was fun for her and she just wasn't interested in anything?	0	1
3. Has she often been grouchy or irritable and often in a bad mood, when even little things would make her mad?	0	1
4. Has she lost weight, more than just a few pounds?	0	1
5. Has it seemed like she lost her appetite or ate a lot less than usual?	0	1
6. Has she gained a lot of weight, more than just a few pounds?	0	1
7. Has it seemed like she felt much hungrier than usual or ate a lot more than usual?	0	1
8. Has she had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Has she slept more during the day than she usually does?	0	1
10. Has she seemed to do things like walking or talking much more slowly than usual?	0	1
11. Has she often seemed restless ... like she just had to keep walking around?	0	1
12. Has she seemed to have less energy than she usually does?	0	1
13. Has doing even little things seemed to make her feel really tired?	0	1
14. Has she often blamed herself for bad things that happened?	0	1
15. Has she said she couldn't do anything well or that she wasn't as good looking or as smart as other people?	0	1
16. Has it seemed like she couldn't think as clearly or as fast as usual?	0	1
17. Has she often seemed to have trouble keeping her mind on her [schoolwork/work] or other things?	0	1
18. Has it often seemed hard for her to make up her mind or to make decisions?	0	1
19. Has she said she often thought about death or about people who had died or about being dead herself?	0	1
20. Has she talked seriously about killing herself?	0	1
21. Has she EVER, in her WHOLE LIFE, tried to kill herself or made a suicide attempt?	0	1
22. Has she tried to kill herself in the last four weeks?	0	1

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

PARENT-COMPLETED FORM

Add up "1"s ("yes") on items 1 to 21.

Score	Chance of Depression	How often is this seen?
0–4	Very Unlikely	in 2/3 of teens
5–9	Moderately Likely	in 1/4 of teens
10–12	Likely	in 1/10 of teens
13 and Above	Highly Likely	in 1/50 of teens

October 11, 2007

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY TEEN

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions as honestly as possible.

In the last four weeks ...	No	Yes
1. Have you often felt sad or depressed?	0	1
2. Have you felt like nothing is fun for you and you just aren't interested in anything?	0	1
3. Have you often felt grouchy or irritable and often in a bad mood, when even little things would make you mad?	0	1
4. Have you lost weight, more than just a few pounds?	0	1
5. Have you lost your appetite or often felt less like eating?	0	1
6. Have you gained a lot of weight, more than just a few pounds?	0	1
7. Have you felt much hungrier than usual or eaten a lot more than usual?	0	1
8. Have you had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Have you slept more during the day than you usually do?	0	1
10. Have you often felt slowed down ... like you walked or talked much slower than you usually do?	0	1
11. Have you often felt restless ... like you just had to keep walking around?	0	1
12. Have you had less energy than you usually do?	0	1
13. Has doing even little things made you feel really tired?	0	1
14. Have you often blamed yourself for bad things that happened?	0	1
15. Have you felt you couldn't do anything well or that you weren't as good looking or as smart as other people?	0	1
16. Has it seemed like you couldn't think as clearly or as fast as usual?	0	1
17. Have you often had trouble keeping your mind on your [schoolwork/work] or other things?	0	1
18. Has it often been hard for you to make up your mind or to make decisions?	0	1
19. Have you often thought about death or about people who had died or about being dead yourself?	0	1
20. Have you thought seriously about killing yourself?	0	1
21. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	0	1
22. Have you tried to kill yourself in the last four weeks?	0	1

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

YOUTH-COMPLETED FORM

Add up "1"s ("yes") on items 1 to 21.

Score	Chance of Depression	How often is this seen?
0–6	Very Unlikely	in 2/3 of teens
7–11	Moderately Likely	in 1/4 of teens
12–15	Likely	in 1/10 of teens
16 and Above	Highly Likely	in 1/50 of teens

October 11, 2007

Screen for Child Anxiety Related Disorders (SCARED)

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

Name: _____ **Date**: _____

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

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

Screen for Child Anxiety Related Disorders (SCARED)

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

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

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

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