Mary Guardino

308 Seaview Avenue
Staten Island, NY10305

Phone: (718) 351-1717 x.20
Fax: (718) 667-8893
Email: Maryfff@aol.com

Dear Friend,

Thank you for contacting Freedom from Fear about a child or adolescent evaluation. You can visit our website freedomfromfear.org to learn about our organization. It is a big decision to decide to have your child evaluated, so it is important to learn about our work and the mission of the organization. I founded the organization in 1984. Since our humble beginnings, I am pleased to say that FFF has helped tens of thousands of individuals suffering with a variety of mental health issues. FFF also has a national outreach program of public education. This program has a wide range of mental health awareness activities. These efforts have reached many millions of individuals with the message that hope and help are available for those suffering with all types of mental health concerns.

The package that you are receiving contains many important questions. It is vital that it is carefully filled out by the primary care provider with input from the child/adolescent where appropriate. **Prior to completion of the package, please email us a copy of your insurance card, front and back to verify that we accept your insurance. Please return all forms via email: maryfff@aol.com or fax: (718) 667- 8893.**

Once paperwork is received, an intake coordinator will contact you to schedule an appointment. Your intake information will be reviewed and some of it will be analyzed by computer generated programs. You and your child/adolescent will also be asked many more questions during your initial visit. **The first part of the evaluation has a $250 fee, for scoring and interpreting the clinical tests, payable at time of services**. **Insurance will cover the visit with the clinician.** Payment can be paid via cash, check, or credit (we accept Visa, Amex, Discover, and Master Card). If after the intake process your child or adolescent is not found appropriate for our organization, referrals will be provided.

The second part of the evaluation is to meet with the medical doctor. All of our child and adult psychiatrists are board certified. The doctor will review all of the intake information before seeing your child/adolescent. During the visit, the doctor will begin to assess your child's needs and your concerns. It may take more than once session to complete the evaluation process and a treatment plan and/ or diagnosis may or may not be given at the initial appointment. The doctor will discuss this with you, as well as a plan on moving forward. The appropriate insurance will be accepted for this part of the evaluation. Our facility accepts most insurance plans. However, we do not accept Medicaid or related insurances. If interested and deemed appropriate after the evaluation, therapy is available for your child/ adolescent. T**he cost of therapy may not be covered under your insurance.** We will advise if we accept your insurance prior to your first appointment.

If you have any questions please contact me at (718) 351-1717 ext. 20. Be assured that every effort will be made to provide you and your child/adolescent with excellent care.

Sincerely,
Mary Guardino
Founder/Executive Director

CHILD/ADOLESCENT INTAKE INSTRUCTIONS

PLEASE COMPLETE ALL OF THE ENCLOSED INFORMATION TO THE BEST OF YOUR ABILITY.

- ☐ Page 2-13 - General Information - **to be completed by parent**
- ☐ Page 14-16 - CDI (Child Depression Inventory) - **to be completed by child**
- ☐ Page 17-18 - SCARED (Screen for Child Related Anxiety Disorders) - **to be completed by child**
- ☐ Page 19-20 - SCARED (Screen for Child Related Anxiety Disorders) **Parent Report** - **to be completed by parent**
- ☐ Page 21-24 - Child Behavior Checklist- **to be completed by parent**

CHILD/ADOLESCENT INFORMATION FORM

NAME:_____ **DOB:**____/____/____

LAST MIDDLE FIRST

ADDRESS:_____ **APT #:** _____

CITY:_____ **STATE:**_____ **ZIP:** _____

PHONE: HOME: (____)_____ CELL:(_____)_____ **SSN#:**_____

SEX: □ M □ F **SCHOOL**:_____ **GRADE**:_____

CHILD RESIDES WITH: □ PARENTS □ MOTHER □ FATHER □ OTHER _____

PARENTS: □ MARRIED □ SEPARATED □ DIVORCED□ DECEASED□ OTHER _____

LIST SIBLINGS (name, age, sex): _____

REFERRAL SOURCE: _____

EMERGENCY CONTACT:_____

PHONE: HOME: (_____)_____ CELL: (_____)_____

RELATIONSHIP TO PATIENT:_____

PATIENT INSURANCE INFORMATION (NOTE: INSURANCE CARD MUST BE PRESENTED AT FIRST VISIT)

NAME OF PRIMARY INSURANCE COMPANY:_____

POLICY OWNER:_____ **RELATIONSHIP TO PATIENT:**_____

DATE OF BIRTH:_____ **POLICY #:**_____

SECONDARY INSURANCE COMPANY:_____ **POLICY #:**_____

PARENT INFORMATION FORM

MOTHER'S NAME:_____ **DOB:**__/____/_____ **AGE:**_____

LAST FIRST

ADDRESS:_____ **APT #:** _____

CITY:_____ **STATE:**_____ **ZIP:** _____

PHONE: HOME: (_____) _____ CELL:(_____) _____ **SSN#:**_____

EMAIL:_____

EMPLOYMENT STATUS: □ EMPLOYED □ STUDENT □ UNEMPLOYED □ OTHER_____

OCCUPATION: _____ **YEARS EMPLOYED:** _____ **ANN. INCOME:** _____

MOTHER'S INSURANCE INFORMATION **(NOTE: INSURANCE CARD MUST BE PRESENTED AT FIRST VISIT)**

NAME OF PRIMARY INSURANCE COMPANY:_____

POLICY OWNER:_____ **POLICY OWNER D.O.B. :**_____

POLICY #:_____

FATHER'S NAME:_____ **DOB:**__/____/_____ **AGE:**_____

LAST FIRST

ADDRESS:_____ **APT #:** _____

CITY:_____ **STATE:**_____ **ZIP:** _____

PHONE: HOME: (_____) _____ CELL:(_____) _____ **SSN#:**_____

EMAIL:_____

EMPLOYMENT STATUS: □ EMPLOYED □ STUDENT □ UNEMPLOYED □ OTHER_____

OCCUPATION: _____ **YEARS EMPLOYED:** _____ **ANN. INCOME:** _____

FATHER'S INSURANCE INFORMATION **(NOTE: INSURANCE CARD MUST BE PRESENTED AT FIRST VISIT)**

NAME OF PRIMARY INSURANCE COMPANY:_____

POLICY OWNER:_____ **POLICY OWNER D.O.B. :**_____

POLICY #:_____

PATIENT INFORMATION RE: CREDIT CARD ON FILE POLICY

To Our Patients:

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. As of January 1, 2024, Clinical Management Consultants has adopted a Credit Card on File Policy. An administrative fee of $3.00 will be included for each credit card transaction.

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored on a secure server.

Payment and co-pays will be processed at the time of visit. If you have any questions about this payment method, please do not hesitate to call our **Billing Office** at **718-351-1717.**

How does credit card on file benefit me?
Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail

Your credit card on file can be used for the following reasons:

-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

Credit Card Type (circle) **Visa** **MasterCard** **Discover** **Amex**

Credit Card Number _____ Security Code _____ Exp Date _____ Printed Name as it appears on card _____

Billing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

I authorize Clinical Management Consultants to charge the credit card above per the terms of this policy. This authorization shall remain in effect until CMC has received written notification from me of its termination.

Signature _____ Date _____

SYMPTOM CHECK LIST

(Please check *all* that apply to your child/adolescent)

□ SLEEPING PROBLEMS □ OVEREATING □ LOSS OF APPETITE □ POOR CONCENTRATION

□ ANXIETY □ DEPRESSION □ NOT ENJOYING THINGS □ RACING THOUGHTS □ PANIC ATTACKS

□ EXCESSIVE WORRYING □ OBSESSIVE BEHAVIORS □ COMPULSIVE BEHAVIORS

□ UNCOMFORTABLE IN SOCIAL SITUATIONS□ SELF ESTEEM□ DRUG OR ALCOHOL ABUSE

□ FAMILY PROBLEMS □ BEHAVIORAL PROBLEMS □ SCHOOL PROBLEMS/ SCHOOL REFUSAL

□ ATTENTION PROBLEMS □ BULLYING □ SUICIDALITY □ ANGER □ OTHER (EXPLAIN BELOW)

PLEASE PROVIDE A DETAILED DESCRIPTION OF THE REASON YOU ARE SEEKING TREATMENT FOR YOUR CHILD/ADOLESCENT

FAMILY HISTORY

Please list *all* of the family members and significant others who reside in the same household as child/adolescent:

NAME	AGE	RELATIONSHIP TO PATIENT	RELATIONSHIP QUALITY (GOOD, POOR, FAIR)

MATERNAL GRANDPARENTS: □ LIVING □ DECEASED □ MARRIED □ SEPARATED/DIVORCED

PATERNAL GRANDPARENTS: □ LIVING □ DECEASED □ MARRIED □ SEPARATED/DIVORCED

FAMILY HISTORY OF EMOTIONAL DISORDERS

	RELATIONSHIP TO (Y/N)	TREATED? PATIENT
SCHIZOPHRENIA		
DEPRESSION		
ANXIETY		
SUBSTANCE ABUSE		
ALCOHOL ABUSE		
PANIC ATTACKS		
OBSESSIVE COMPULSIVE DISORDER		
ATTENTION DEFICIT HYPERACTIVITY		
BEHAVIORAL PROBLEMS		
LEARNING DIFFICULTIES		
TICS		
MENTAL RETARDATION		
SUICIDE or SUICIDE ATTEMPT(S)		
PHYSICAL SELF HARM (IE. CUTTING)		
BIPOLAR DISORDER		
POST TRAUMATIC STRESS DISORDER		
OTHER		

SOCIAL AND DEVELOPMENTAL HISTORY

DEVELOPMENTAL HISTORY

Duration of Pregnancy (in weeks): _____

Labor Duration: _____

Any problems? Specify: _____

Delivery (check one): □ Vaginal □ C-Section

Any problems? Specify: _____

NEWBORN PERIOD (check one): □ Normal □ Any Problems

Specific problems: □ Oxygen □ Incubator □ Infection □ Jaundice □ Other

Provide details: _____

FIRST YEAR – TEMPERAMENT (CHECK ALL THAT APPLY AND PROVIDE EXAMPLES)

- □ **EASY BABY:** _____
- □ **SLOW TO WARM UP:** _____
- □ **DIFFICULT BABY:** _____
- □ **EATING HABITS:** _____
- □ **SLEEPING HABITS:** □Normal □Abnormal _____
- □ **COLIC** (if yes, how long?) _____
- □ **WALKED AT AGE?** _____

EARLY INTERVENTION SERVICES PROVIDED? □ YES □ NO

(IF YES...)

□ SPEECH THERAPY □ OCCUPATIONAL THERAPY □ PHYSICAL THERAPY

□ ABA THERAPY: _____HRS/ WEEK

OTHER MILESTONES

First words at age: _____ **Three word sentences at age: _____**

Toilet training at age: _____ **Bowel: _____** **Bladder: _____**

Any current problems with wetting or soiling (specify): _____

Age at first menses: _____ **Last menstrual period: _____**

Sexually active: □ YES □ NO

SCHOOL HISTORY

	NAME OF SCHOOL	EASILY ADJUSTED? Y/N	SPECIFY DIFFICULTIES
PRESCHOOL			
KINDERGARTEN			
ELEMENTARY SCHOOL			
JUNIOR HIGH SCHOOL			
HIGH SCHOOL			

HOME SCHOOL: □ YES □ NO **WHEN? : _____**

SCHOOL REFUSAL: □ YES □ NO **DETAILS:_____**

DATE OF LAST ATTENDENCE: _____ _____

ACADEMIC PROGRESS:□ SATISFACTORY □UNSATISFACTORY

DETAILS:_____

I.E.P? :□ YES □ NO

DETAILS:_____

_____

ACTIVITIES OF DAILY LIVING:

SOCIAL PROGRESS:

MAKES FRIENDS EASILY? □ YES □ NO **DETAILS:**_____

GOES ON PLAY DATES? □ YES □ NO **DETAILS:**_____

HAS FULFILLING FRIENDSHIPS? □ YES □ NO **DETAILS:**_____

ATTENDS SLEEP OVERS? □ YES □ NO **DETAILS:**_____

HAS BEEN BULLIED? □ YES □ NO **DETAILS:**_____

ENGAGES IN EXTRACIRRICULAR ACTIVITIES? □ YES □ NO **DETAILS:**_____

IMPULSE CONTROL: PHYSICAL OR VERBAL FIGHTS WITH PEERS?

□ YES □ NO **DETAILS:**_____

TO THE BEST OF YOUR KNOWLEDGE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

SUBSTANCE USE:

DOES YOUR CHILD PARTAKE IN ANY DRUG USAGE? □ YES □ NO

IF YES, PLEASE SPECIFY?

□ Marijuana □ Cocaine □ Heroine/ Opioids □ Other _____

HAS YOUR CHILD EVER ATTENDED A REHABILITATION PROGRAM FOR DRUGS OR ALCOHOL?
□ YES □ NO

DOES YOUR CHILD SMOKE CIGARETTES? □ YES □ NO

DOES YOUR CHILD DRINK ALCOHOL? □ YES □ NO

HAS YOUR CHILD BEEN ARRESTED / IN TROUBLE WITH THE POLICE? □ YES □ NO

IF YES, PLEASE EXPLAIN: _____

_____

MAJOR CHANGES OR STRESSES:

Have there been or are there currently any major changes or stressors in the family where your child was brought up? YES NO

If yes, please mark all that apply:

	PAST	CURRENT	PLEASE PROVIDE DETAILS
1. FINANCIAL PROBLEMS			
2. FREQUENT MOVES			
3. JOB CHANGES			
4. DRINKING/DRUG PROBLEMS			
5. ARUGMENTS BETWEEN PARENTS			
6. DIVORCE/SEPARATION OF PARENTS			
7. REMARRIAGE OF PARENTS			
8. SEPARATION OF SIBLINGS			
9. SEPARATION OF FAMILY MEMBERS			
10. SEPARATION FROM SIGNIFICANT NON-FAMILY MEMBERS			
11. FREQUENT PHYSICAL PUNISHMENT			
12. PHYSICAL CONFRONTATION BETWEEN PARENTS			
13. MENTAL ILLNESS IN FAMILY			
14. PHYSICAL ILLNESS IN FAMILY			
15. PSYCHIATRIC HOSPITALIZATION OF PARENT			
16. MEDICAL HOSPITALIZATION OF PARENT			
17. DEATH IN FAMILY			
18. SEXUAL PROMISCUITY/INCESTUOUS			
19. LEGAL PROBLEMS			
20. OTHER FAMILY PROBLEMS			
21. SEXUAL/EMOTIONAL ABUSE			
22. OTHER			

MEDICAL QUESTIONNAIRE

PEDITRICIAN'S NAME:_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:** _____

PHONE:(_____)_____ **FAX:** (___)_____

DATE OF LAST PHYSICAL:_____/_____/_____

HEIGHT: _____ **WEIGHT:** _____

DATE OF LAST BLOODWORK:_____/_____/_____

Please list all medications & dosages your child is *CURRENTLY* taking for their medical conditions including psychiatric medications:

MEDICATION	DOSAGE	PRESCRIBING MD	REASON FOR PRESCRIPTION	HELPFUL: YES/NO

Please list all psychiatric medications & dosages in which your child has *PREVIOUSLY* taken.

MEDICATION	DOSAGE	PRESCRIBING MD	REASON FOR PRESCRIPTION	HELPFUL: YES/NO

PREVIOUS MEDICAL/SURGICAL HISTORY

Any operations? _____

Any hospitalizations? _____

Any allergies? _____

Any other medical problems? _____

Family medical problems? _____

Family history of psychiatric disorders? _____

Any dietary restrictions? _____

Any prosthetics? _____

Any observable ticks? _____

PREVIOUS PSYCHOLOGICALTREATMENT

Therapist Name:_____ **Therapist Name:**_____

Why Consulted?_____ **Why Consulted?**_____

When Consulted?_____ **When Consulted?**_____

Type of Treatment:

☐Individual ☐ Family

☐ Group ☐Other

Type of Treatment:

☐Individual ☐ Family

☐ Group ☐Other

How Long? _____ **How Long?** _____

Was it Helpful? ☐YES ☐NO **Was it Helpful?** ☐YES ☐NO

Please Specify: _____ **Please Specify:** _____

Psychiatrist Name: _____ **Psychiatrist Name:** _____

Why Consulted? _____ **Why Consulted?**_____

When Consulted?_____**When Consulted?**_____

Type of Treatment:

☐Individual ☐ Family

☐ Group ☐Other

Type of Treatment:

☐Individual ☐ Family

☐ Group ☐Other

How Long? _____ **How Long?** _____

Was it Helpful? ☐YES ☐NO **Was it Helpful?** ☐YES ☐NO

Please Specify: _____ **Please Specify:** _____

TREATMENT CONTRACT

1) I agree to pay all and *any co-payments* according to my insurance policy at each visit. Co-payments will not be billed. *They must be paid* at the time of the visit. _____ **(Initial here)**

2) I hereby authorize said assignee to release all information to secure payment._____ **(Initial here)**

3) I understand that I am financially responsible for all charges whether or not paid by said insurance and that payments are due at the times services are rendered for my child._____ **(Initial here)**

4) **I understand there will be a $50 fee for all appointments missed or cancelled without 48 hour notice._____ (Initial here)**

5) **The first part of the evaluation is a $200 fee, payable at time of services**. **Insurance will not be accepted for this appointment.** Payment can be paid via cash, check, or credit (we accept Visa, Amex, Discover, and Master Card). _____ **(Initial here)**

6) **The appropriate insurance will be accepted at the second part of the evaluation.** Our facility accepts most insurance. Return the paper work with a copy of your insurance card, front and back. We do not accept Medicaid or related insurances. We will advise if we accept your insurance. _____ **(Initial here)**

7) **If your child is taking medication:** I understand that no prescriptions will be called in. It is my responsibility to discuss my child's medication with my doctor and make sure he/she will have enough to last until their next visit. _____ **(Initial here)**

8) **I understand that I have to remain a constant participant in my child's treatment._____ (Initial here)**

9) **I understand that I/we will have to partake in sessions, without my child, when requested. These sessions are extremely important so that your child can receive the necessary treatment. One parent must be in attendance of each session with the child. _____ (Initial here)**

10) Care providers need to read through and keep any and all worksheets or reading material given by treatment staff. **_____ (Initial here)**

11) It is highly recommended for you and your child to track progress throughout treatment and write down any questions you may have for your treatment staff. **_____ (Initial here)**

12) **There is an hourly fee for any paperwork or letters completed by the treatment staff and are dependent upon Dr. approval. This paperwork will be completed within 10 business days upon parent/caregiver request. _____ (Initial here)**

13) The first three visits to see your assigned doctor are considered assessment only. After these sessions are complete your child will then be considered admitted as a patient to the clinic. **_____ (Initial here)**

14) We do not initiate contact to your child's school. Contact with a school must be initiated by a parent or school to the treatment provider(s). **_____ (Initial here)**

In order to maintain an orderly, respectful and secure treatment environment for the patients and staff in our facility, it is essential that all parents and visitors to our building be aware of their responsibilities and adhere to an expected level of conduct. Please be respectful and follow all office policies as explained or documented and ask questions if any guideline is unclear. Appropriate language and demeanor is expected at all times when in the building or conversing with staff. Any parent participating in any type of improper conduct will be asked to leave, and clinicians reserve the right to terminate treatment and provide an appropriate referral, should they feel that it is necessary.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND AND AGREE TO THE TERMS OF TREATMENT FOR MY CHILD/ADOLESCENT, _____.
(Name of Patient)

Periodically you will be offered online or live parenting programs:

☐ I AGREE TO PARTICIPATE IN THESE PROGRAMS WHENEVER POSSIBLE

Signature _____ Date: _____

Signature _____ Date: _____

TO BE COMPLETED BY CHILD

Name:_____

Childhood Depression Inventory

Name: _____

Date: _____

INSTRUCTIONS:

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups of three statements. From each group pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, then go on to the next group of three statements.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been feeling recently. Put a mark like this **X** next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example how this form works. Try it, put a mark next to the sentence that describes you best.

EXAMPLE:

- ☐ I read books all the time.
- ☐ I read books once in a while.
- ☐ I never read books.

Remember, pick out the sentences that describe your feelings and thoughts in the past two weeks.

1.
- ☐ I am sad once in a while.
- ☐ I am sad many times.
- ☐ I am sad all the time.

2.
- ☐ Nothing will ever work out for me.
- ☐ I am not sure if things will work out for me.
- ☐ Things will work out for me O.K.

3.
- ☐ I do most things O.K.
- ☐ I do many things wrong.
- ☐ I do everything wrong.

4.
- ☐ I have fun in many things.
- ☐ I have fun in some things.
- ☐ Nothing is fun at all.

5.
- ☐ I am bad all the time.
- ☐ I am bad many times.
- ☐ I am bad once in a while.

Name:_____

6. ☐ I think about bad things happening to me once in a while.
☐ I worry that bad things will happen to me.
☐ I am sure that terrible things will happen to me.

7. ☐ I hate myself.
☐ I do not like myself.
☐ I like myself.

8. ☐ All bad things are my fault.
☐ Many bad things are my fault.
☐ Bad things are not usually my fault.

9. ☐ I do not think about killing myself.
☐ I think about killing myself but would not do it.
☐ I want to kill myself.

10. ☐ I feel like crying everyday.
☐ I feel like crying many days.
☐ I feel like crying once in a while.

11. ☐ Things bother me all the time.
☐ Things bother me many times.
☐ Things bother me once in a while.

12. ☐ I like being with people.
☐ I do not like being with people many times.
☐ I do not want to be with people at all.

13. ☐ I can not make up my mind about things.
☐ It is hard to make up my mind about things.
☐ I make my mind about things easily.

14. ☐ I look O.K.
☐ There are some bad things about my looks.
☐ I look ugly.

15. ☐ I have to push myself all the time to do my schoolwork.
☐ I have to push myself many times to do my schoolwork.
☐ Doing schoolwork is not a big problem.

16. ☐ I have trouble sleeping every night.
☐ I have trouble sleeping many nights.
☐ I sleep pretty well.

17. ☐ I am tired once in a while.
☐ I am tired many days.
☐ I am tired all the time.

Name:_____

18. ☐ Most days I do not feel like eating.
☐ Many days I do not feel like eating.
☐ I eat pretty well.

19. ☐ I do not worry about aches and pains.
☐ I worry about aches and pains many times.
☐ I worry about aches and pains all the time.

20. ☐ I do not feel alone.
☐ I feel alone many times.
☐ I feel alone all the time.

21. ☐ I never have fun at school.
☐ I have fun at school only once in a while.
☐ I have fun at school many times.

22. ☐ I have plenty of friends.
☐ I have some friends but I wish I had more.
☐ I do not have any friends.

23. ☐ My school work is alright.
☐ My school work is not as good as before.
☐ I do very poorly in subjects I used to be good in.

24. ☐ I can never be as good as other kids.
☐ I can be as good as other kids if I want to.
☐ I am just as good as other kids.

25. ☐ Nobody really loves me.
☐ I am not sure if anybody loves me.
☐ I am sure that somebody loves me.

26. ☐ I usually do what I am told.
☐ I do not do what I am told most times.
☐ I never do what I am told.

27. ☐ I get along with people.
☐ I get into fights many times.
☐ I get into fights all the time.

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

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

Please print # CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo._____ Date _____ Yr. _____

CHILD'S BIRTHDATE Mo._____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent

☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)_____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

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Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

❒ None ❒ 1 ❒ 2 or 3 ❒ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters)

❒ Less than 1 ❒ 1 or 2 ❒ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	❒	❒	❒	❒ Has no brothers or sisters
b. Get along with other kids?	❒	❒	❒	
c. Behave with his/her parents?	❒	❒	❒	
d. Play and work alone?	❒	❒	❒	

VII. 1. Performance in academic subjects. ❒ **Does not attend school because** _____

_____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	❒	❒	❒	❒
b. History or Social Studies	❒	❒	❒	❒
c. Arithmetic or Math	❒	❒	❒	❒
d. Science	❒	❒	❒	❒
e. _____	❒	❒	❒	❒
f. _____	❒	❒	❒	❒
g. _____	❒	❒	❒	❒

Other academic subjects–for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?

❒ No ❒ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ❒ No ❒ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ❒ No ❒ Yes—please describe:

When did these problems start?_____

Have these problems ended? ❒ No ❒ Yes–when?

Does your child have any illness or disability (either physical or mental)? ❒ No ❒ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe):_____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): ____
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Be sure you answered all items. Then see other side.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.