# CHILD/ADOLESCENT QUESTIONNAIRE

**This questionnaire asks you to respond to a series of questions about your child and your family. This type of information is very helpful in understanding your child. Please complete as best you can. It is also helpful for you to bring copies of your child's recent report cards and any previous educational or neuropsychological testing.**

## IDENTIFYING INFORMATION

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

**Name of Person completing this form and relation to the above child:** _____

_____

**Gender:** - **Pronouns:**_____ **Child's Age:** _____

**School Name:** _____ **Grade:** _____

**Parent's Name:** _____ **Occupation:** _____

**Parent's Name:** _____ **Occupation:** _____

**Biological parents' marital status (circle):** Married

## REASON FOR VISIT

_____

_____

_____

_____

_____

**Has the child received a previous evaluation or intervention for similar reasons? Yes ○ No ○**

**If Yes, when and with whom?** _____

_____

_____

## CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

**Pregnancy: Was your child adopted? Yes ○ No ○ Donor Egg/Sperm? Yes ○ No ○**

*If yes, at what age?*_____ *Please summarize any known biological/donor history:* _____

_____

**Was the pregnancy planned? Yes ○ No ○**

**Pregnancy length in months (or weeks): _____**

**During the pregnancy with this child the following was present: (check all that apply)**

| | | |
|---|---|---|
| ☐ suffer from illness/disease | ☐ excessive vomiting | ☐ maternal anemia |
| ☐ undergo surgery | ☐ excessive blood loss | ☐ smoke tobacco |
| ☐ high blood pressure medication | ☐ threatened miscarriage | ☐ nutrition/weight problem |
| ☐ consume alcohol | ☐ infection(s) | ☐ amniocentesis or CVS |
| ☐ use drugs | ☐ diabetes | ☐ loss of consciousness |

**Please explain any of the above checked difficulties in detail here: _____**

_____

_____

**Delivery and Post-delivery: Duration of labor: _____ hours**

**Type of labor: -** **Type of Delivery: -**

**Delivery Complications: Yes ○ No ○**

**If yes, please describe: _____**

_____

**Birth Weight: _____ lbs _____ oz**

**Child's Condition at birth: Poor ○ Good ○ Excellent ○**

**Neonatal Complications: Yes ○ No ○**

**If yes, please describe: _____**

_____

_____

DEVELOPMENTAL MILESTONES

**The following is a list of infant/preschool/school-age behaviors. Please indicate with a check mark if your child met these developmental milestones on time. Only check "Late Meeting this Developmental Milestone" if your child's Pediatrician indicated there were concerns.**

| Milestones | Met Developmental Milestone | Late Meeting this developmental milestone |
|---|---|---|
| Rolled from stomach to back | ○ | ○ |
| Sat without support | ○ | ○ |
| Crawled | ○ | ○ |
| Walked without assistance | ○ | ○ |
| Babbled | ○ | ○ |

| | | |
|---|---|---|
| **Spoke first word** | ○ | ○ |
| **Gave first and last name** | ○ | ○ |
| **Put several words together** | ○ | ○ |
| **Talked in sentences** | ○ | ○ |
| **Began to read** | ○ | ○ |
| **Wrote first word** | ○ | ○ |
| **Used scissors to cut out pictures** | ○ | ○ |
| **Rode tricycle** | ○ | ○ |
| **Dressed and undressed self** | ○ | ○ |
| **Bladder trained, day** | ○ | ○ |
| **Bladder trained, night** | ○ | ○ |
| **Slept independently in own bed** | ○ | ○ |
| **Upset when separated from caregiver** | ○ | ○ |
| **Understood taking turns** | ○ | ○ |
| **Played with several children** | ○ | ○ |

**Overall, compared with other children, your child's early development was:**

**Normal** ○ **Delayed** ○ **Advanced** ○

**Describe any early indications of delayed or advanced ability:** _____

_____

_____

_____

_____

COORDINATION

**Please indicate whether your child's coordination is good, average or poor.**

| | **Good** | **Average** | **Poor** |
|---|---|---|---|
| **Walking** | ○ | ○ | ○ |
| **Running** | ○ | ○ | ○ |
| **Throwing** | ○ | ○ | ○ |
| **Catching** | ○ | ○ | ○ |
| **Shoelace Tying** | ○ | ○ | ○ |
| **Coloring/Drawing** | ○ | ○ | ○ |
| **Buttoning** | ○ | ○ | ○ |
| **Handwriting** | ○ | ○ | ○ |
| **Athletic Abilities** | ○ | ○ | ○ |

HOME INFORMATION/FAMILY HISTORY

**Parent's Name:** _____ **Age:** _____

**Age at the time of child's birth:** _____

**Education:** _____

**Medical Problems:** _____

**Learning/Behavior Problems:** _____

_____

**Personal History of/Family History of: Indicate self with a check mark and Family History with "FH"**

- **Anxiety** - **Drug/Alcohol Abuse** - **Learning Disability** - **ADHD**
- **Depression** - **Heart Arrhythmias** - **Long QT Syndrome** - **Bipolar**
- **Marfan Syndrome** - **Wolf-Parkinson White Syndrome**
- **Death of a relative during exercise of any age** - **Sudden death of a young family member**

**Pertinent Family History on maternal side:** _____

_____

**Parent's Name:** _____ **Age:** _____

**Age at the time of child's birth:** _____

**Education:** _____

**Medical Problems:** _____

**Learning/Behavior Problems:** _____

_____

**Personal History of/Family History of: Indicate self with a check mark and Family History with "FH"**

- **Anxiety** - **Drug/Alcohol Abuse** - **Learning Disability** - **ADHD**
- **Depression** - **Heart Arrhythmias** - **Long QT Syndrome** - **Bipolar**
- **Marfan Syndrome** - **Wolf-Parkinson White Syndrome**
- **Death of a relative during exercise of any age** - **Sudden death of a young family member**

**Pertinent Family History on paternal side:** _____

_____

**What adults live in the home with the child?** _____

**If parents are separated/divorced, who has custody of the child?** _____

**Age of child at separation?** _____

**If parents are separated/divorced, how often does other parent see the child?** _____

_____

**Sibling and/or others living in the home:**

**(Name, Date of Birth, Relationship, and any history of behavior, learning, or psychiatric problems):**

1. _____

   _____

2. _____

   _____

3. _____

   _____

4. _____

   _____

**Describe any stressors that might be affecting your child now or in the past (i.e. death, divorce, trauma):**

_____

_____

**Does your child speak a language other than English in the home? Yes ○ No ○**

**If yes, describe:** _____

**If English is a second language, at what age did your child begin learning English?** _____

## EDUCATIONAL HISTORY

**Did your child attend preschool and/or kindergarten? Yes ○ No ○ At what age?** _____

**Did teachers report anything unusual about his or her early school performance?**

**Yes ○ No ○ If Yes, explain:** _____

_____

**Did your child show significant strength or weaknesses in any academic area at an early age?**

**Yes ○ No ○ If Yes, explain:** _____

_____

**Has your child changed schools for reasons other than normal academic progression?**

**Yes ○ No ○ If Yes, when and for what reason?** _____

_____

**Has your child skipped or repeated any grades in school?**

**Yes ○ No ○ If Yes, explain:** _____

_____

**Does your child have excessive absences from school?**

**Yes ○ No ○** **If Yes, explain:** _____

_____

**Other relevant information related to school performance:** _____

_____

_____

_____

_____

_____

RECENT SCHOOL PERFORMANCE

**Please write the grades (and subjects) on your child's most recent report card or provide a copy of his/her report card:** _____

_____

**What activities or subjects at school does your child most enjoy?** _____

**What activities or subjects at school does your child least enjoy?** _____

**Has your child's school performance in (or attitude toward) school changed in the last two years?**

**Yes ○ No ○** **If Yes, explain:** _____

**Does your child have any special needs or accommodations at school?**

**Yes ○ No ○** **If Yes, explain:** _____

**Do you have any concerns about the quality of your child's school or teachers?**

**Yes ○ No ○** **If Yes, explain:** _____

**Describe any concerns about social or emotional problems, or other matters, that may affect your child's school functioning:** _____

_____

SOCIAL SKILLS

**About how many close friends does your child have? (circle)**

**None ○** **One ○** **Two or Three ○** **Four or more ○**

**About how many times a week does your child do things with friends outside of regular school hours?** _____

**Compared to others of the same age, how does your child get along with other children?**

Average

**Compared to others of the same age, how does your child interact with adults?**

Average

**Who does your child prefer to play with?**

Preferes to play with Same Age

**Does your child participate in any extracurricular activities or social organizations?**

**Yes** ○ **No** ○ **If Yes, list:** _____

**What are your child's favorite play activities when with friends?** _____

**What are your child's favorite play activities when alone?** _____

**Are there any unusual or repetitive play activities?** _____

## BEHAVIOR

**Do you have any concerns regarding your child's behavior either at home, in public or at school?**

**Yes** ○ **No** ○ **If Yes, please describe:** _____

_____

**Does your child display more anger and aggression compared to other children of his/her age?**

**Yes** ○ **No** ○ **If Yes, please describe:** _____

_____

**Does your child display more sadness or irritability compared to other children of his/her age?**

**Yes** ○ **No** ○ **If Yes, please describe:** _____

_____

**How do you handle discipline in your family?:** _____

_____

**Do you feel these methods are successful in managing you child's behavior?** **Yes** ○ **No** ○

**Please share your child's strengths:** _____

_____

_____

**What is your child's biggest accomplishment?** _____

## MEDICAL INFORMATION / HISTORY

**Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety, or Depression?**

**Yes ○ No ○ If Yes, please specify: _____**

**Is the child on any medication at this time?**

**Yes ○ No ○ If Yes, please list medication, dosage, times per day, and how long they have been on the medication: _____**

_____

_____

**Has your child taken medications for this/these conditions in the past, which have since been discontinued? Yes ○ No ○ If Yes, please list medication along with reason it was discontinued:**

_____

_____

_____

**How many hours per day does your child spend on screens?** 0

**Has your child ever been taken to the emergency room?**

**Yes ○ No ○ If Yes, explain: _____**

_____

**Does your child have any sleeping difficulties (trouble falling asleep, staying asleep, waking)?**

**Yes ○ No ○ If Yes, explain: _____**

_____

_____

**Does your child have any unusual eating patterns or habits?**

**Yes ○ No ○ If Yes, explain: _____**

_____

## SENSORY STIMULATION

**Does your child display unusual sensitivity to things (e. g. sound, light, touch, etc.)**

**Yes ○ No ○ If Yes, explain:**

**Please read the following list and rate your child on each behavior. Indicate how often your child displays that behavior by circling which best describes the frequency of that behavior.**

***Use the following scale: 1 = Never, 2 = Sometimes, 3 = Often.***

| Behavior | Scale | Behavior | Scale | Behavior | Scale |
|---|---|---|---|---|---|
| Poor concentration and attention when it comes to school work | - | Has temper tantrums | - | Plays alone – no enjoyment in interacting with peers | - |
| Has difficulty following directions | - | Blames others for his/her mistakes | - | Lacks confidence in his/her abilities | - |
| Easily distracted | - | Carries a grudge, seems to have "a chip on the shoulder" | - | Seems shy or timid | - |
| Always on the go | - | Doesn't take turns in play | - | Sensitive to criticism | - |
| Has difficulty sitting still | - | Not able to share toys and play space | - | Worries bad things might happen | - |
| Fidgets with hands or feet, squirms in seat | - | Doesn't play with toys as intended (ie. builds with blocks) | - | Needs lots of reassurance | - |
| Fails to complete tasks | - | Has unusual movements (ie. rocking, twitching) | - | Seems fearful and anxious | - |
| Seems disorganized, loses things they need for school | - | Makes noises such as clearing throat or grunting | - | Bites fingernails | - |
| Blurt out answer to questions before they've been completed | - | Has trouble sleeping | - | Talks about hurting himself/herself | - |
| Interrupts or "butts in" to other's games or conversations | - | Seems sad or unhappy | - | Seems withdrawn – "tunes out", seems in own world | - |
| Refuses to follow rules or do chores | - | Loses interest in having fun | - | Unable to tolerate changes in routine | - |
| Argues with parents or teachers | - | Moody | - | Lies | - |
| Gets angry or resentful | - | Cries easily | - | Gets into fights with other children | - |
| Touchy, easily annoyed by others | - | Has poor appetite | - | Has been bullied or bullies other children | - |
| Loses temper | - | Feels badly about himself/herself | - | Cruel to animals | - |

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**Upon completion of this form, please provide a copy to our office. E-mail, fax, portal message, and physical drop-off are all acceptable. Thank you!**


# ADVANCED PEDIATRICS

100 EAST STREET, S.E., SUITE 301 • VIENNA, VA • 22180

PHONE: 703-938-5555 • FAX: 703-319-8580

WWW.ADVANCEDPEDIATRICS.COM

Info@advanced.pcc.com

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## MENTAL HEALTH AGREEMENT

1. Mental Health Providers work closely with our pediatricians to coordinate patient care and may share protected health information with one another. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

    • medication prescription and monitoring
    • counseling session start and stop times
    • the modalities and frequencies of treatment furnished
    • results of clinical tests, summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date

2. Private therapy notes are considered confidential and protected under the law. They will not be shared with parents or pediatricians unless the mental health provider is concerned for the patient's safety or individual consent from the patient is received.

3. Patients receiving AP Mental Health services ***must*** stay up to date on their routine medical care (check-ups, asthma tune ups, etc.). If you are not compliant with your routine medical care, mental health services will be paused and/or terminated.

4. Intake evaluations will be scheduled after any anticipated trips. We cannot hold reoccurring appointments for those who will not be present on a consistent basis.

5. I acknowledge that my/child's Mental Health Provider with work with us to develop a recommended treatment plan. If I fail or refuse to follow through on their recommendations, the Mental Health provider reserves the right to discontinue their services and/or dismiss from the Mental Health Department entirely (in this event, I would still be able to continue seeing AP for Primary Care, but would have to seek Mental Health care outside of the practice.)

**I understand the above information and will stay up to date with my (child's) routine medical care and communicate any anticipated trips with my provider**

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***Patient/Parent's Name*** ***Patient/Parent's Signature*** ***Date***

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## FINANCIAL RESPONSIBILITY FORM

We are currently credentialed with the most major private insurance companies. Your visit will be subject to specialist copays, deductibles, and/or coinsurance per your individual policy. Practice policies regarding copays and deductible deposits due at the time of service will apply. Please note that we cannot guarantee benefit coverage for primary care mental health services, and it is your responsibility to verify if your policy offers mental health benefits, and what your financial responsibilities are.

Please be advised that some plans have a specific behavioral health network associated with their benefits. We cannot guarantee that our mental health providers will be considered in-network. If your claim is processed out of network, you will be responsible for the balance due per your out of network benefits. Patients who do not have mental health benefits will be considered self-pay and payment will be due upon check-in.

Some plans require pre-authorization for mental health or nutrition appointments. It is your responsibility to verify your plan requirements and communicate those to us prior to scheduling an appointment. If you do not and as a result your plan denies coverage for the appointment(s), it will be your out of-pocket responsibility for the service rendered.

***I acknowledge the fact that I am responsible for any copayment, coinsurance, pre-authorization, or deductible as it applies to my individual insurance plan and benefits***

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***Patient/Parent's Name*** ***Patient/Parent's Signature*** ***Date***

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## CANCELLATION POLICY

Appointments that are canceled with less than 24 business hours advanced notice or no showed will be subject to a $100 fee.

We only have a limited number of appointments available and need to maximize our efforts to actively help as many of our patients as we can. Should you cancel with less than 24 hours' notice or miss 3 therapy appointments for any reason we will terminate therapy services in our office and refer you to other providers in the community for continued care. Please be advised that many community resources are not insurance credentialed and often have extensive waitlists.

**I acknowledge and agree to the information above**

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***Patient/Parent's Name*** ***Patient/Parent's Signature*** ***Date***

# ADVANCED PEDIATRICS

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## TELEHEALTH INFORMED CONSENT

I, _____, hereby consent to participate in telehealth with Advanced Pediatrics. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a patient who are located in two different locations.

**Telehealth Requirements & Coverage:**

Due to the COVID-19 pandemic, out of state telehealth regulations and insurance coverage for telehealth varies by individual states and policies. By signing this consent form, I agree to the following:

- *I will physically be in the state of Virginia at the time of my telehealth appointment. If I sign on to my telehealth session from another state where my provider is not licensed, I recognize that the appointment will be cancelled, and I will be charged a missed appointment fee of $100.*
- *It is my responsibility to verify my telehealth coverage with my individual insurance plan. If I fail to verify my telehealth coverage and my insurance denies coverage, I recognize that I am 100% responsible for the charges for the appointment.*

**I understand the following with respect to telehealth:**

- *I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.*
- *I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.*
- *I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions*

*are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.*

- *I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).*
- *I understand that if the patient is having acute symptoms or experiencing a crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.*
- *I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 703-938-5555 to discuss since we may have to re-schedule.*
- *I understand that my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.*

I have read the information provided above and discussed it with the office staff. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Patient Printed Name Date of Birth

_____

Signature of Patient or Parent/Guardian Date

Practice Support Program

# SCARED – Child and Teen Version

(Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

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

| | | 0 Not True Or Hardly Ever True | 1 Somewhat True or Sometimes True | 2 Very True or Often True | For Office Use Only | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 1 | 2 | 3 | 4 | 5 |
| 21. | I worry about things working out for me. | ○ | ○ | ○ | | | | | |
| 22. | When I get frightened, I sweat a lot. | ○ | ○ | ○ | | | | | |
| 23. | I am a worrier. | ○ | ○ | ○ | | | | | |
| 24. | I get really frightened for no reason at all. | ○ | ○ | ○ | | | | | |
| 25. | I am afraid to be alone in the house. | ○ | ○ | ○ | | | | | |
| 26. | It is hard for me to talk with people I don't know well. | ○ | ○ | ○ | | | | | |
| 27. | When I get frightened, I feel like I am choking. | ○ | ○ | ○ | | | | | |
| 28. | People tell me that I worry too much. | ○ | ○ | ○ | | | | | |
| 29. | I don't like to be away from my family. | ○ | ○ | ○ | | | | | |
| 30. | I am afraid of having anxiety (or panic) attacks. | ○ | ○ | ○ | | | | | |
| 31. | I worry that something bad might happen to my parents. | ○ | ○ | ○ | | | | | |
| 32. | I feel shy with people I don't know well. | ○ | ○ | ○ | | | | | |
| 33. | I worry about what is going to happen in the future. | ○ | ○ | ○ | | | | | |
| 34. | When I get frightened, I feel like throwing up. | ○ | ○ | ○ | | | | | |
| 35. | I worry about how well I do things. | ○ | ○ | ○ | | | | | |
| 36. | I am scared to go to school. | ○ | ○ | ○ | | | | | |
| 37. | I worry about things that have already happened. | ○ | ○ | ○ | | | | | |
| 38. | When I get frightened, I feel dizzy | ○ | ○ | ○ | | | | | |
| 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.) | ○ | ○ | ○ | | | | | |
| 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. | ○ | ○ | ○ | | | | | |
| 41. | I am shy. | ○ | ○ | ○ | | | | | |
| | | | | | 1 | 2 | 3 | 4 | 5 |

Practice Support Program

# SCARED – Parent Version

(Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

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

## SCARED – Parent Version

| | | 0 Not True Or Hardly Ever True | 1 Somewhat True or Sometimes True | 2 Very True or Often True | For Office Use Only | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 1 | 2 | 3 | 4 | 5 |
| 21. | My child worries about things working out for him/her. | ○ | ○ | ○ | | | | | |
| 22. | When my child gets frightened, he/she sweats a lot. | ○ | ○ | ○ | | | | | |
| 23. | My child is a worrier. | ○ | ○ | ○ | | | | | |
| 24. | My child gets really frightened for no reason at all. | ○ | ○ | ○ | | | | | |
| 25. | My child is afraid to be alone in the house. | ○ | ○ | ○ | | | | | |
| 26. | It is hard for my child to talk with people he/she doesn't know well. | ○ | ○ | ○ | | | | | |
| 27. | When my child gets frightened, he/she feels like he/she is choking. | ○ | ○ | ○ | | | | | |
| 28. | People tell me that my child worries too much. | ○ | ○ | ○ | | | | | |
| 29. | My child doesn't like to be away from his/her family. | ○ | ○ | ○ | | | | | |
| 30. | My child is afraid of having anxiety (or panic) attacks. | ○ | ○ | ○ | | | | | |
| 31. | My child worries that something bad might happen to his/her parents. | ○ | ○ | ○ | | | | | |
| 32. | My child feels shy with people he/she doesn't know well. | ○ | ○ | ○ | | | | | |
| 33. | My child worries about what is going to happen in the future. | ○ | ○ | ○ | | | | | |
| 34. | When my child gets frightened, he/she feels like throwing up. | ○ | ○ | ○ | | | | | |
| 35. | My child worries about how well he/she does things. | ○ | ○ | ○ | | | | | |
| 36. | My child is scared to go to school. | ○ | ○ | ○ | | | | | |
| 37. | My child worries about things that have already happened. | ○ | ○ | ○ | | | | | |
| 38. | When my child gets frightened, he/she feels dizzy. | ○ | ○ | ○ | | | | | |
| 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.) | ○ | ○ | ○ | | | | | |
| 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. | ○ | ○ | ○ | | | | | |
| 41. | My child is shy. | ○ | ○ | ○ | | | | | |
| | | | | | 1 | 2 | 3 | 4 | 5 |

**Patients Name:**_____ **Date of Birth:**_____

Beck's Depression Inventory

**Select Answer:**

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I have almost no interest in sex.

3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

| Total Score | Levels of Depression |
|---|---|
| 1-10 | These ups and downs are considered normal |
| 11-16 | Mild mood disturbance |
| 17-20 | Borderline clinical depression |
| 21-30 | Moderate depression |
| 31-40 | Severe depression |
| over 40 | Extreme depression |