

**Psychiatry Intake Form (Under Age 18)**

Child's Full Name \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

Who is completing this form and what is your relationship to the child?

Who lives at home with the child, including adults and other children?

Who are the child's legal guardians?

Is the child adopted or in foster care?      **Yes**   **No**

Are there any firearms or other weapons in the home?      **Yes**   **No**

What are the problems or concerns for which you are seeking help?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

What mental health conditions has your child previously been diagnosed with?

Has your child ever stayed overnight in the hospital for mental health reasons?      **Yes**   **No**

Has your child ever been to the emergency room for mental health reasons?      **Yes**   **No**

Has your child ever attempted suicide or self-harmed?      **Yes**   **No**

Does your child have concerns about their sexual orientation or gender identity?      **Yes**   **No**

Has your child ever been in therapy or counseling for mental health concerns?      **Yes**   **No**

Current Therapist/Counselor (if applicable) \_\_\_\_\_

Current Therapist/Counselor Phone or Email \_\_\_\_\_

Has your child ever had testing completed by a psychologist or through their school, including IQ testing, achievement testing, or testing for autism spectrum disorder?      **Yes**   **No**

If so, where was the testing done? \_\_\_\_\_

Has anyone related to your child ever been treated for mental health conditions or substance abuse? Examples include depression, anxiety, OCD, ADHD/ADD, autism, learning disabilities, bipolar disorder, schizophrenia, suicide attempts, alcoholism, or drug use.      **Yes**   **No**

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

List all **current** prescriptions, other medications, and supplements your child is taking:

Medication Name	Dose	Estimated Start Date

List any **past** medications that your child has tried for behavioral or mental health concerns:

Medication Name	Dose	Estimated Dates Taken

What school does your child attend? \_\_\_\_\_

Current Grade: \_\_\_\_\_ Has your child ever repeated a grade? **Yes No**

Does your child have an IEP, 504 plan, or any other extra help at school? **Yes No**

Who should we contact at your child's school if needed, including their phone or email?

\_\_\_\_\_

In the past, has your child ever:

- |                                     |            |           |
|-------------------------------------|------------|-----------|
| Been neglected                      | <b>Yes</b> | <b>No</b> |
| Been physically abused              | <b>Yes</b> | <b>No</b> |
| Been emotionally or verbally abused | <b>Yes</b> | <b>No</b> |
| Been sexually abused or assaulted   | <b>Yes</b> | <b>No</b> |
| Been bullied                        | <b>Yes</b> | <b>No</b> |
| Witnessed domestic violence         | <b>Yes</b> | <b>No</b> |
| Experienced another traumatic event | <b>Yes</b> | <b>No</b> |

Radiology	Special	Labs	Letters	Old Records
Hospital	ER/UC	Screens	Reports	Forms/Orders
Visit Date/Order	_____			OR
Date of Document	_____			
Label	Psych Intake			
Result/Notes	_____			
				Initials <b>TM</b>

To your knowledge, has your child ever used nicotine products (including vaping), alcohol, or illicit drugs (including marijuana)? **Yes No**

Has your child received physical therapy, occupational therapy, or speech therapy? **Yes No**

Were there any problems during the pregnancy or birth of your child? **Yes No**

Was your child exposed to any nicotine, alcohol, or drugs during the pregnancy? **Yes No**

*I grant permission for Pediatric Associates of Mt. Carmel to obtain information from and maintain contact with any of the persons listed above about my child's mental health history, if it is felt to be necessary to provide optimal care for my child. **Yes No***

Guardian's Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

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

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

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

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

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

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American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

**McNeil**  
Consumer & Specialty Pharmaceuticals

## 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	Somewhat of a			
		Above Average	Average	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: \_\_\_\_\_

Radiology    Special    Labs    Letters  
 Hospital DC    ER/UC    Screens    Reports  
 Forms/Orders                      Old Records  
 Link to Visit Date/Lab \_\_\_\_\_ OR  
 Date of Document \_\_\_\_\_  
 Label Vanderbilt-Parent  
 (Result/Notes) \_\_\_\_\_  
 \_\_\_\_\_ Initials



## Screen for Child Anxiety Related Disorders (SCARED)

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

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

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
2. My child gets headaches when he/she am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
3. My child doesn't like to be with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
4. My child gets scared if he/she sleeps away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. My child worries about other people liking him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When my child gets frightened, he/she feels like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. My child is nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. My child follows me wherever I go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that my child looks nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. My child feels nervous with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. My child gets stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. My child worries about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. My child worries about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When my child gets frightened, he/she feels like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. My child has nightmares about something bad happening to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. My child worries about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When my child gets frightened, his/her heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. He/she child gets shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. My child has nightmares about something bad happening to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP

## Screen for Child Anxiety Related Disorders (SCARED)

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

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

### SCORING:

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

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

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

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

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

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

*The SCARED is available at no cost at [www.wpic.pitt.edu/research](http://www.wpic.pitt.edu/research) under tools and assessments, or at [www.pediatric bipolar.pitt.edu](http://www.pediatric bipolar.pitt.edu) under instruments.*