PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First) :	Date of Birth:	Age:	Sex : M F	Today's Date:
Address: City:		State: Zip:		Phone:
Child's Race (circle) : 8=Don't know 3=White 5=American Indian/ Alaskan Native 2=Black or African American 4=Asian or Pacific Islander 6=Other, specify: _____				
Is your child also Hispanic or Latino (circle) : Yes No	Child's Doctor:			Doctor's Phone:
Name of person completing this form:	Relationship to child:			Phone:

CHIEF CONCERN:

1. **Who** suggested this child be seen by the doctor for attention, school, or behavior problems?

2. What **concerns** do you have about your child?
   a.
   b.
   c.

3. **How long** have you been concerned about this child's behavior?	4. Please circle ONE: Overall, the above concerns are **mild, moderate,** or **severe**?	5. Please circle ONE: My concerns are **improving, staying the same,** or **getting worse**?

6. Please describe this child's **strongest areas at home**:	7. Please describe this child's **weakest areas at home**:
a.	a.
b.	b.
c.	c.

HISTORY: Birth

1. How much did this child weigh at birth? ___pounds ___ounces
2. Biological **Father's age** at birth of this child:_____
3. Biological **Mother's age** at birth of this child:_____
4. Number of **pregnancies prior** to this child:_____
5. Number of **miscarriages prior** to this child:_____

Y	N	6. Were there any **problems during the pregnancy**? Specify:
Y	N	7. Were there any **problems during labor / delivery** or **following the birth**? Specify:
Y	N	8. Was this child born by **Cesarean / C-Section**? If yes, circle appropriate response: **planned** **emergency**
Y	N	9. Was this child born **two or more weeks before** the "due date"? If yes, how many weeks early was this child? _____ weeks
Y	N	10. Were any substances or **medications used by the mother** during the pregnancy? ____Beer / Wine ____Alcohol ____Any prescription medication ____Cocaine ____Tobacco ____Marijuana ____Methamphetamine (Crystal / Ice) ____Other:_____
Y	N	11. Were any substances or **medications used by the father** around the time this child was conceived? ____Beer / Wine ____Alcohol ____Any prescription medication ____Cocaine ____Tobacco ____Marijuana ____Methamphetamine (Crystal / Ice) ____Other:_____

*HISTORY: Developmental Concerns

Y	*N*	1. Did this child **sit up** by 8 months?
Y	*N*	2. Did this child **crawl** by 10 months?
Y	*N*	3. Did this child **walk** by 15 months?
Y	*N*	4. Did this child **speak 2 word sentences** by 2 years?
Y	*N*	5. Could strangers **understand** this child by 3 years?
Y	*N*	6. Did this child **stay dry during the day** by 3 ½ years?
Y	*N*	7. Did this child **read simple words** by 6 years?

(OFFICE USE ONLY) Y=[concern ≥6 months: Y N Birth: Y N] * N=[Development: Y N]

PARENT QUESTIONNAIRE: Child Health (*continued*)

Child's Name:

HISTORY: Behavioral

Y	N	1. Did this child **cry frequently** as an infant?
Y	N	2. Was this child **difficult to calm** down as an infant?
Y	N	3. Did this child **have trouble sleeping** as an infant (e.g., was this child fidgety or overly sleepy)?
Y	N	4. Was this child a **picky or irregular eater** as an infant?
Y	N	5. Did this child have **many temper tantrums** as a toddler?
Y	N	6. Did you have **trouble keeping a babysitter** because of this child's behavior?
Y	N	7. Does this child have **urine accidents**?
Y	N	8. Does this child have **stool / bowel accidents**?
Y	N	9. Does this child often have **nightmares**?
Y	N	10. Has this child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	N	11. Does this child have any **problems falling asleep**? Specify:
Y	N	12. Does this child have any **problems staying asleep** through the night? Specify:
Y	N	13. Does this child have any **problems getting up** in the morning? Specify:
Y	N	14. Does this child have **frequent stomachaches and headaches**? Specify:
Y	N	15. Does this child have **problems with his/her weight**? Specify:

HISTORY: Health

Y	N	1. Has this child had any **major health problems**? Specify:
Y	N	2. Has this child had frequent **ear infections**?
Y	N	3. Has this child had any **vision / eye or hearing** problems? Specify:
Y	N	4. Has this child ever been **hospitalized** or had **surgery**? Specify:
Y	N	5. Has this child lost **consciousness** or had a **serious head injury**? Specify:
Y	N	6. Has this child had **meningitis** or **encephalitis**? Specify:
Y	N	7. Has this child had **seizures**?
Y	N	8. Has this child had any **difficulties with growth**? Specify:
Y	N	9. Does this child have any **birth defects** or **birthmarks**? Specify:

HISTORY: Family Medical Problems: Is there anyone in this child's family with the following:				If yes, how is this person related to this child?
Y	N	Don't Know	1. Neurologic problems	
Y	N	Don't Know	2. Learning or reading difficulty	
Y	N	Don't Know	3. Depression	
Y	N	Don't Know	4. Bipolar Disorder / Manic Depression	
Y	N	Don't Know	5. Schizophrenia	
Y	N	Don't Know	6. History of physical or sexual abuse	
Y	N	Don't Know	7. Alcohol or Drug problems	
Y	N	Don't Know	8. ADHD / ADD (attention problems)	
Y	N	Don't Know	9. Tics or Tourette's disorder	
Y	N	Don't Know	10. Trouble with the law	
Y	N	Don't Know	11. Medications for nerves or emotional problems	
Y	N	Don't Know	12. Thyroid problems	
Y	N	Don't Know	13. Exposure to toxic chemicals	
Y	N	Don't Know	14. Cardiac problems or sudden death?	

(OFFICE USE ONLY) **Behavior:** Y N **Health:** Y N **Family Medical History:** Y N

Baseline: Tics: Y N **Sleep Problems:** Y N **Stomachache/Headache:** Y N **Weight:** Y N

PARENT QUESTIONNAIRE: Child Information

Child's Name:

HISTORY: Child's Past/Current Treatment

Y	N	
		1. Has this child **ever been diagnosed with ADHD or ADD in the past?** If yes: Year____ Month____
		2. Has this child **ever taken medication for ADHD or ADD in the past?** If yes, do you know the **name, dose,** and **time(s) of day** the medication was given?

a. **Name**	**Dose**	**Time(s) of Day**
b.		

c. Were you **satisfied** with the medication's effect on this child's symptoms? (circle) Yes No

Y	N	
		3. Has this child **ever received psychological counseling** for any problems? Specify:
		4. Has this child ever been on any **long-term medications**? Specify:
		5. Does this child have any **allergies**? Specify:
		6. Is this child currently taking any **medications?**
		7. Is this child currently taking any **vitamins or herbal supplements?**

8. **What medication(s), including vitamins or herbal supplements, is this child currently taking?**

Name	**Dose**	**Time(s) of Day**
a.		
b.		
c.		

9. **Are there any professionals** (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) **currently involved in this child's care? Please list them and their role in your child's care:**

HISTORY: Social

Y	N	
		1. Have there been any **major changes or stresses** in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time: Is this stress still occurring? (circle) Yes No
		2. Has there been a **serious illness or death** in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
		3. Has this child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? (circle) Yes No
		4. Are any **major changes or stresses** expected in the future? If yes, please specify:

(OFFICE USE ONLY) **Adhd Dx:** Y N **Adhd Tx:** Y N **Medications:** Y N **Professionals:** Y N **Social:** Y N

PARENT QUESTIONNAIRE: Child Information *(continued)*

Child's Name:

HISTORY: Child's Living Arrangement

1. This child is currently living with (please check one)

- ☐ Biological mother **and** biological father
- ☐ Biological mother
- ☐ Biological father
- ☐ Relative (specify relationship):
- ☐ Adoptive parent(s), relative
  Does this child know that he / she is adopted? (circle) Yes No
- ☐ Adoptive parent(s), non-relative
  Does this child know that he / she is adopted? (circle) Yes No
- ☐ Foster parent(s)
  How long has this child been in foster care? Year_____ Month_____
  How long has this child been living in your household? Year_____ Month_____
- ☐ Other (specify):

2. The **biological** parents of this child are currently (please check one):

- ☐ Married to each other Year____ Month____
- ☐ Divorced from each other Year____ Month____
- ☐ Separated from each other Year____ Month____
- ☐ Never married to each other
- ☐ Other (please specify):
- ☐ Not Applicable (please specify):
- ☐ Don't Know

3. How would you describe the **current relationship** between this child's **biological parents**:

- ☐ Friendly / Amicable
- ☐ Unfriendly / Conflict ridden
- ☐ No relationship
- ☐ Not Applicable (please specify):
- ☐ Don't Know

Y	N	**4.** Are there any **immediate family members** who do not live with this child (biological mother, biological father, or siblings)? If yes, please specify relationship to child:
Y	N	**5.** Is there anything unusual about this child's **living arrangement** that you would like to discuss with the child's doctor? If yes, please specify:
Y	N	**6.** Are the parent(s)/guardian(s) of this child **working outside of the home**?
Y	N	**7.** Do you have family or social **support locally**?

8. Please list all people who are currently living in this child's household.

Name	Relationship to Child	Age	Name	Relationship to Child	Age

HISTORY: Military Family

Y	N	**1.** Are you or another parent/guardian of your child currently in the Military?
Y	N	**2.** What Branch: Navy Marine Air Force Army Other (specify):
Y	N	**3.** Are any of this child's parent(s)/guardian(s) Active Duty Military? If yes, who (circle): Mother Father Both Other:
Y	N	**4.** Are they deployed or deployable?
		5. When did you PCS/Move to this Location? Date:
		6. When are you due to PCS / Move? Date:
Y	N	**7.** Do you live in military housing?
Y	N	**8.** Is this child or other members of this family in the Exceptional Family Member Program?

(OFFICE USE ONLY) Living Arrangement: Y N

SANDAP

PARENT QUESTIONNAIRE: Child Behavior

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior **NOT** on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. **Fails to give close attention** to detail or **makes careless mistakes** (e.g., homework).				
2. Has **difficulty attending** to what needs to be done.				
3. **Does not seem to listen** when spoken to directly.				
4. **Does not follow through** when given directions.				
5. Has **difficulties organizing** tasks and activities.				
6. **Avoids, dislikes**, or does not want to start tasks.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by noises or other things.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** when he/she is supposed to stay in seat.				
12. **Runs about or climbs** too much when he/she is supposed to stay seated.				
13. Has **difficulty playing** or starting quiet games.				
14. Is "**on the go**" or acts as if "driven by a motor".				
15. **Talks too much.**				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting his/her turn.**				
18. **Interrupts** or bothers others when they are talking or playing games.				
19. **Argues** with adults.				
20. **Loses temper.**				
21. Actively **disobeys or refuses** to follow adult's request or rules.				
22. **Bothers people** on purpose.				
23. **Blames others** for his or her mistakes or misbehaviors.				
24. Is **touchy or easily annoyed** by others.				
25. Is **angry or bitter.**				
26. Is **hateful** and wants to get even.				
27. **Bullies**, threatens, or scares others.				
28. **Starts physical fights.**				
29. **Lies** to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. **Skips school** without permission.				
31. Is **physically unkind** to people.				
32. Has **stolen things** that have value.				
33. **Destroys others' property** on purpose.				

(OFFICE USE ONLY) **1—9:** ___/9 Inattentive: ☐ ≥ 6 / 9 DuPaul: **10—18:** ___/9 Hyperactive: ☐ ≥ 6 / 9 DuPaul: **19—26:** ___/8 Oppositional Defiant Disorder ☐ ≥ 4 / 8

Modifed from the DuPaul ADHD Rating Scale and the Vanderbilt ADHD Diagnostic Parent Rating Scale by the Child and Adolescent Services Research Center (CASRC) in collaboration with the Children's Hospital and Health Center (CHHC) Committee on Guidelines for ADHD in Pediatrics (C-GAP) for use in the San Diego ADHD Project 2003

Children's CASRC

SANDAP

PARENT QUESTIONNAIRE: Child Behavior *(continued)*

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior **NOT** on medication.*	Never Rarely 0	Occa-sionally 1	Often 2	Very often 3
34. Is physically **mean to animals.**				
35. Has **set fires** on purpose to cause damage.				
36. Has **broken into** someone else's home, business, or car.				
37. Has **stayed out all night** without permission or **runaway** from home overnight.				
38. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is **fearful, anxious, or worried.**				
40. Is **afraid to try new things** for fear of making mistakes.				
41. Feels **useless or inferior.**				
42. **Blames self** for problems, feels at fault.				
43. Feels **lonely, unwanted, or unloved;** complains that "no one loves me."				
44. Is **sad or unhappy**.				
45. Feels **different and easily embarrassed.**				
46. Is **overly concerned about health/body**.				
47. Has problems getting along with **you.**				
48. Has problems getting along with **others his/her own age.**				
49. Has problems getting along with **his / her own siblings.**				
50. Has problems in **group activities** such as games or team play.				
51. **Decreased interest or pleasure in all,** or almost all, activities of the day.				
52. Has **said things like "I wish I were dead"** or has tried to hurt self.				
53. **Recurrent excessive distress** when separation from home or caretakers.				
54. Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).				
55. Has **prolonged temper tantrums** (greater than 20-30 minutes).				
56. **Hears voices** others do not hear.				
57. Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear).				
58. Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has **recurrent recollections or dreams** of a traumatic event.				
60. Seems to **avoid or have phobias** of specific people, animals, things or situations.				
61. Seems **unaware of others existence,** is **uninterested in interacting with others**.				
62. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness)				
63. Appears **uninterested in activities** children his or her age usually like or participate in.				
64. Has experimented with or abused **drugs or alcohol.**				

(OFFICE USE ONLY) 27—38: ___/ 12 Conduct Disorder☐ ≥ 3 / 12 39—46: ___/ 8 Anxiety/Depression:☐ ≥ 3 / 8 47—50: ___/ 4 Social Functioning: ☐≥ 1 / 4 51—64: ___/ 14 Mental Health Concerns

Children's

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PARENT QUESTIONNAIRE: School History

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe this child's **strongest** areas in his/her **schoolwork**:	2.Please describe this child's **weakest** areas in his/her **schoolwork**:
a.	a.
b.	b.
c.	c.

HISTORY: School Intervention

Y	N	
Y	N	1. Has this child been in an **Early Intervention program or Special Day Care/Preschool**?
Y	N	2. Has this child had **speech, occupational or physical therapy**?
Y	N	3. Has this child ever **attended summer school**? If Yes, specify subject(s) / grade(s)?
Y	N	4. Has the school ever **discussed this child attending summer school** with you? Specify:
Y	N	5. Has this child ever **repeated a grade**? If Yes, specify subject(s) / grade(s)?
Y	N	6. Has the school ever **discussed this child repeating a grade** with you? Specify:
Y	N	7. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	N	8. Has this child ever received any **special education services** (like a 504 Plan or IEP)? Specify:
Y	N	9. Is this child **currently receiving any special education services** (like a 504 Plan or IEP)? Specify:
Y	N	10. Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify:
Y	N	11. Does this child need any **special medical assistance**? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **problems reported?** If Yes, please **describe** the teacher or parent concerns in the space provided.

			Academics	**Behavior**
Y	N	1. Preschool		
Y	N	2. Kindergarten and First Grade		
Y	N	3. Second and Third Grade		
Y	N	4. Fourth and Fifth Grade		
Y	N	5. Sixth through Eighth Grade		
Y	N	6. High School		

CURRENT: School Performance Please circle the appropriate number.

	Above Average		Average		Problematic		Above Average		Average		Problematic
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5						

(OFFICE USE ONLY) School Intervention: Y N Academic School Problems: Y N Behavior School Problems: Y N School Performance: Y N

SANDAP

PARENT QUESTIONNAIRE: Child Summary

Child's Name:

HISTORY: Summary

1. Please **summarize your child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings-- home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

(Office Use Only) **Impairment** ≥ 4: Y N

MEDICAL PROVIDER USE ONLY

HR:_____ **BP:**_____/_____ **T:**_____ **WT:**_____ **HT:**_____ **VISION:**_____ **HEARING:**_____

PE:

Children's

CASRC

Child/Adolescent

Mental Health *Integration*

Depression Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to child: ☐ Self ☐ Parent ☐ Other: _____

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

Circle the number on the rating scale that corresponds to how much the described symptoms apply to your child.

	Symptoms	Rating Scale
1	**Depressed mood** May include the following symptoms: sad, tearful, hopeless, isolates from others, feels down	Not at all A little Pretty much Very much Couldn't be worse 0 1 2 3 4 5 6 7 8 9 10
2	**Irritable mood** May include the following symptoms: intense anger, temper tantrums, aggression, inability to deal with frustration, rage episodes	0 1 2 3 4 5 6 7 8 9 10
3	**Loss of pleasure** May include the following symptoms: loss of interest in activities they once found pleasurable, has stopped participating in previous activities (sports, dance, etc.), nothing is fun	0 1 2 3 4 5 6 7 8 9 10
4	**Sleep problems** May include the following symptoms: trouble getting to sleep, wakes frequently, naps during day, gets to sleep late and wakes early, sleeps all the time	0 1 2 3 4 5 6 7 8 9 10
5	**Appetite** May include the following symptoms: loss of appetite, significant weight loss (_____ lbs), increased appetite, significant weight gain (_____lbs)	0 1 2 3 4 5 6 7 8 9 10
6	**Agitation** May include the following symptoms: restless, hyperactive, can't relax	0 1 2 3 4 5 6 7 8 9 10
7	**Loss of energy** May include the following symptoms: tired all the time, doesn't feel up to doing anything, less active than usual, slow speech, seems slowed down	0 1 2 3 4 5 6 7 8 9 10
8	**Feelings of worthlessness** May include the following symptoms: inappropriate guilt, excessive guilt, poor self-esteem, makes negative statements about self	0 1 2 3 4 5 6 7 8 9 10
9	**Poor concentration** May include the following symptoms: can't focus, short attention span, poor listening, easily distracted, can't think, indecisive	0 1 2 3 4 5 6 7 8 9 10
10	**Thoughts of death** May include the following symptoms: suicidal gestures, self-harm, thoughts of suicide, suicide plan, suicide attempt	0 1 2 3 4 5 6 7 8 9 10
11	**Impairment at home caused by the symptoms on this sheet:** symptoms impair child's overall functioning at home	0 1 2 3 4 5 6 7 8 9 10
12	**Impairment at school caused by the symptoms on this sheet:** symptoms impair child's overall functioning at school	0 1 2 3 4 5 6 7 8 9 10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ☐ YES ☐ NO

For office use only: Symptom score (1-10): _____ /100 Impairment score (11-12): _____ /20

MHI011-11/09

MHI Pack 50402

Mental Health *Integration* Child/Adolescent and Adult

Mood Regulation Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ ☐ Self ☐ Parent ☐ Other: _____

Is the patient currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure? ☐ in counseling

Circle the number on the rating scale that corresponds to how much the described symptoms apply to you or your child.

	Symptoms	Rating Scale										
		Not at all		A little			Pretty much			Very much		Couldn't be worse
1	**Elevated mood** May include the following symptoms: driven, high energy, never stops, silliness, unusual happiness	0	1	2	3	4	5	6	7	8	9	10
2	**Irritable mood** May include the following symptoms: intense anger, temper tantrums, aggression, inability to deal with frustration, rage episodes	0	1	2	3	4	5	6	7	8	9	10
3	**Self-centered** May include the following symptoms: grandiose, bossy, entitled, unaware of others feelings, believes they are always right, believes nothing can hurt them, believes they are better than others	0	1	2	3	4	5	6	7	8	9	10
4	**Sleep problems** May include the following symptoms: trouble getting to sleep, wakes frequently, naps during the day, gets to sleep late and wakes early	0	1	2	3	4	5	6	7	8	9	10
5	**Talkative** May include the following symptoms: talks constantly, interrupts others, chatterbox	0	1	2	3	4	5	6	7	8	9	10
6	**Racing thoughts** May include the following symptoms: thinks faster than can speak, goes from topic to topic, mind is going 100 miles per hour	0	1	2	3	4	5	6	7	8	9	10
7	**Poor concentration** May include the following symptoms: can't focus, short attention span, poor listening, easily distracted	0	1	2	3	4	5	6	7	8	9	10
8	**Agitation** May include the following symptoms: restless, hyperactive, can't relax	0	1	2	3	4	5	6	7	8	9	10
9	**Increased involvement in high-risk activities** May include the following symptoms: fascination with sex, alcohol/drug use, excessive gambling, reckless driving	0	1	2	3	4	5	6	7	8	9	10
10	**Impulsivity** May include the following symptoms: suicidal gestures, self-harm, running away, poor judgment, sneaky, acting without thinking, not learning from consequences	0	1	2	3	4	5	6	7	8	9	10
11	**Impairment at home caused by the symptoms on this sheet:** symptoms impair overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
12	**Impairment outside the home caused by the symptoms on this sheet:** symptoms impair overall functioning outside the home (school, work, church, with friends, etc.)	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

For office use only: Symptom score (1-10): _____/100 Impairment score (11-12): _____/20

Mental Health *Integration* Child/Adolescent and Adult

Anxiety/Stress Disorder Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to patient: ☐ Self ☐ Parent ☐ Other: _____

Is the patient currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure? ☐ in counseling

Over the last 2 weeks, *how often have the problems below bothered you/your child? Circle a number for each item.*

	General Anxiety Disorder (GAD-7)	How Often			
		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge?	0	1	2	3
	Not being able to stop or control worrying?	0	1	2	3
	Worrying too much about different things?	0	1	2	3
	Trouble relaxing?	0	1	2	3
	Being so restless that it is hard to sit still?	0	1	2	3
	Becoming easily annoyed or irritable?	0	1	2	3
	Feeling afraid as if something awful might happen?	0	1	2	3

Circle the number on the rating scale that corresponds to how much the symptoms below apply to you/your child.

	Other Symptoms	Rating Scale										
		Not at all		A little			Pretty much			Very much		Couldn't be worse
2	**Panic:** This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, getting lightheaded	0	1	2	3	4	5	6	7	8	9	10
3	**Physical symptoms:** This can include stomachache, headache, tight muscles, shaking, muscle twitching, sweats	0	1	2	3	4	5	6	7	8	9	10
4	**Obsessions and/or compulsions:** This can include repeated or persistent thoughts that they can't control (about germs, schoolwork, being perfect, neatness, safety, death); repeated behaviors or extreme routines that they can't control (such as repeated handwashing, checking locks, cleaning, personal hygiene)	0	1	2	3	4	5	6	7	8	9	10
5	**Post-traumatic stress:** This can include repeated, disturbing thoughts or dreams about a traumatic experience from the past, having physical reactions when reminded of the traumatic experience, avoiding situations that are reminders of the experience, feeling distant or emotionally numb, feeling jumpy or easily startled Check if post-traumatic symptoms have lasted **more than 4 weeks:** ☐	0	1	2	3	4	5	6	7	8	9	10
6	**Impairment at home caused by the symptoms listed on this sheet:** Symptoms impair overall functioning at home	0	1	2	3	4	5	6	7	8	9	10
7	**Impairment outside the home caused by the symptoms listed on this sheet:** Symptoms impair overall functioning outside the home (school, work, church, with friends, etc.)	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ☐ YES ☐ NO

For office use only: GAD-7 score (item 1): _____ / 21 Other symptoms (2-5): _____ /40 Impairment score (6-7): _____ /20

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MHI Pack 50402

Mental Health *Integration*

Child/Adolescent

Developmental Disorders Symptom Rating Scale *(page 1 of 1)*

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

Completed by: _____ Relationship to child: ☐ Self ☐ Parent ☐ Other: _____

Is your child currently: ☐ on medication for developmental symptoms ☐ not on medication ☐ not sure? ☐ in counseling

Circle the number on the rating scale that corresponds to how much the described symptoms apply to your child.

	Symptoms	Rating Scale
1	**Language** May include the following symptoms: speech overly precise or formal, talks like a walking dictionary, monotone voice, talks like he has a foreign accent, forgets to take turns in a conversation, interprets things literally, has trouble understanding figures of speech Did your child have normal language development by age 3? ☐ yes ☐ no ☐ don't know	Not at all / A little / Pretty much / Very much / Couldn't be worse 0 1 2 3 4 5 6 7 8 9 10
2	**Emotional sensitivity** May include the following symptoms: lacks empathy, over- or under-reacts to stress, difficulty understanding feelings of others, trouble managing emotions, intense emotional reactions, emotionally unresponsive, displays little emotion, not in tune with others' emotions	0 1 2 3 4 5 6 7 8 9 10
3	**Social awareness** May include the following symptoms: not aware of peer pressure, not aware of social norms, expects others to know his or her thoughts, not interested in group activities, poor team member, avoids social contact, not interested in your side of the conversation	0 1 2 3 4 5 6 7 8 9 10
4	**Sensory integration** May include the following symptoms: overly sensitive or not sensitive enough to sound, touch, light, pain, touch	0 1 2 3 4 5 6 7 8 9 10
5	**Impairment at home caused by the symptoms on this sheet:** Symptoms interfere with child's overall functioning at home	0 1 2 3 4 5 6 7 8 9 10
6	**Impairment at school caused by the symptoms on this sheet:** Symptoms interfere with child's overall functioning at school	0 1 2 3 4 5 6 7 8 9 10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ over 2 years

For office use only: Symptom score (1-4): _____ /40 Impairment score (5-6): _____ /20

Mental Health *Integration*

Child /Adolescent

Home Impairment Scale *(page 1 of 1)*

Today's Date: _____ Child's Name: _____ Parent's Name: _____

Directions: For each of the **Domains of Functioning** listed in the left column, please circle the number (1-7) that best describes your child's degree of impairment. Remember — the higher the number, the greater the impairment.

Domain of Functioning	Your child has symptoms that are appropriate to age/gender. Your child shows **no** signs of impairment at home.	Your child has symptoms **a little more** frequently or intensely than expected of children of similar age/gender. Symptoms only **rarely** interfere with normal functioning at home.	Your child has symptoms **somewhat more** frequently or intensely than expected of children of similar age/gender. Symptoms **sometimes** interfere with normal functioning at home.	Your child has symptoms **a lot more** frequently or intensely than expected of children of similar age/gender. Symptoms **usually** interfere with normal functioning at home.	Your child displays symptoms **a great deal more** frequently or intensely than expected of children of similar age/gender. **Most of the time,** symptoms interfere with normal functioning at home.	Your child has symptoms **so much more** frequently or intensely than expected of children of similar age/gender that symptoms **almost always** interfere with normal functioning at home.	Your child's symptoms are **so frequent or intense** that they completely impair normal functioning. The symptoms **may create a crisis** that needs action right away to prevent serious danger or harm.
	No impairment	**Slight impairment**	**Mild impairment**	**Moderate impairment**	**Severe impairment**	**Very severe impairment**	**Profound impairment**
Behavior How much do your child's symptoms interfere with (impair) the ability to follow home rules, parents' commands, or general behavioral expectations?	1	2	3	4	5	6	7
Interpersonal Relationships How much do your child's symptoms interfere with (impair) the ability to form and maintain positive peer relationships?	1	2	3	4	5	6	7
Emotions How much do your child's symptoms interfere with (impair) the ability to express or control emotions?	1	2	3	4	5	6	7
Responsibilities How much do your child's symptoms interfere with (impair) the ability to perform daily home responsibilities and tasks?	1	2	3	4	5	6	7

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