SHENANDOAH MEDICAL CENTER

Mental Health Intake Form Children

Please fill out the following information to the best of your ability. It is okay if you do not know the answers to some questions. Skip any you are unsure about and we can discuss them during the session.

Who is completing this:		Relationship to Patient:	
Patient Demographics			
Legal Name:		Appointment Date:	
Preferred Name:	DOB:	Race & Ethnicity:	
Pronouns: ☐ She/Her ☐ He/him ☐ They/them ☐_____		Birth Sex: ☐ Male ☐ Female	
Parent/Guardian Primary Phone:		Parent/Guardian Email:	
Referral Source:			
Primary Care Physician and Phone:			
Please List **ALL** Current Medications, Vitamins, and Supplements:			
Parents are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Cohabitating			
If divorced, what are the custody arrangements?			
If custody is shared, what is the name and contact information for the other parent? Name: Phone: Address:			
Presenting Problem			
Please describe what led you to make this appointment.			
Prior attempts to resolve problem:			
What do you hope to get out of treatment?			

Patient Medical & Mental Health History

Allergies:	Last Physical:

How would you rate the patient's overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Presently seeing a psychiatrist/mental health nurse practitioner? ☐ Yes ☐ No

Presently seeing a psychotherapist? ☐ Yes ☐ No

Medical Problems:

Surgeries/Hospitalizations	**Date**

Inpatient Mental Health Treatment (Most recent if more than 3)	**Date**

Were there any complications during the mother's pregnancy or the patient's birth? ☐ Yes ☐ No
If yes, please describe:

Has the patient ever experienced a head injury, loss of consciousness, or seizure? ☐ Yes ☐ No
If yes, please describe:

If applicable, age of first menses: **Regular** or **Irregular** cycle: Date of last menstrual period:

Diet: How would you rate the patient's diet? ☐ Good ☐ Fair ☐ Poor

Weight: Height: Appetite: ☐ Good ☐ Fair ☐ Poor

How many times does the patient eat in a 24-hour period?

What does a typical meal look like?

Does the Patient: Purge: ☐Y ☐N Restrict: ☐Y ☐N Overeat: ☐Y ☐N Binge: ☐Y ☐N

Exercise: Does the patient exercise regularly? ☐Yes ☐No What kind of exercise?
Duration: Frequency:

Sleep: How many hours, on average does the patient sleep a night?

Suicidal Behaviors: Has the patient attempted to harm/kill themselves? **Yes** **No** If so, please list the occurrences below.

Approximate date of attempt	How did they attempt (method)?

Abuse/neglect history:

Has the patient been abused or assaulted: ☐ Yes ☐ No Is the patient in danger now: ☐ Yes ☐ No

Type of Abuse/Violence	By Whom	Age	Was it Reported?
Sexual			☐ Yes ☐ No
Physical			☐ Yes ☐ No
Emotional			☐ Yes ☐ No
Verbal			☐ Yes ☐ No
Abandoned			☐ Yes ☐ No
Neglect			☐ Yes ☐ No

Pediatric ACEs:

- ☐ Child experienced sexual abuse.
- ☐ Child lived with a parent/caregiver who had mental health issues
- ☐ Child lacked appropriate care by any caregiver
- ☐ Child lived with a parent/caregiver who went to jail/prison
- ☐ Child felt unsupported, unloved, and/or unprotected
- ☐ Child experienced discrimination
- ☐ Child had problems with housing
- ☐ Child lived with a parent/caregiver who died
- ☐ Child saw/heard a parent/caregiver being screamed at, sworn at, insulted, or humiliated by another adult OR saw/heard a parent/caregiver being slapped, kicked, punched, beaten up, or hurt with a weapon
- ☐ Any adult in the household often or very often pushed, grabbed, slapped, or throw something at child OR hit child so hard that the child had marks or was injured OR threatened the child or acted in a way that made the child afraid they might get hurt
- ☐ Child's biological parent or any caregiver had or currently has a problem with alcohol, street drugs, or prescription medication use
- ☐ A parent or caregiver has insulted, humiliated, or put down the child
- ☐ There has been a significant change in the relationship status of the child's caregiver(s)
- ☐ Child has seen, heard, or been a victim of violence in their neighborhood, community, or school.
- ☐ You have worried that the child did not have enough food to eat or that the food for the child would run out before you could buy more.
- ☐ The child has been separated from their parent or caregiver due to foster care or immigration
- ☐ Child lived with a parent/caregiver who had a serious physical illness or disability

Mental and Physical Symptoms:

☐ Anxiety	☐ Feel worthless	☐ Low self-esteem	☐ School/work problems
☐ Avoidance	☐ Flashbacks	☐ Mood swings	☐ Seeing things
☐ Blackouts	☐ Guilt	☐ Muscle Tension	☐ Self-harm
☐ Bullying/harassment	☐ Headaches	☐ Nausea	☐ Shame
☐ Can't concentrate	☐ Hearing Things	☐ Nightmares (recurrent?)	☐ Shortness of Breath
☐ Change in appetite	☐ Homicidal Thoughts	☐ No motivation	☐ Sleep too little
☐ Chest Pains	☐ Hopeless/helpless	☐ Numbness (physically)	☐ Sleep too much
☐ Chills/Hot Flashes	☐ Impulsive	☐ Obsessive	☐ Stomach aches
☐ Depressed	☐ Increased risky behaviors	☐ Panic attacks	☐ Suicidal thoughts
☐ Diarrhea	☐ Irregular Sleep	☐ Paranoid	☐ Suspicious
☐ Dizziness	☐ Irritable/angry	☐ Poor Memory	☐ Sweating
☐ Easily startled	☐ Isolating	☐ Racing Thoughts	☐ Talk too fast
☐ Fainting	☐ Joint/Muscle Pain	☐ Rapid Heartbeat	☐ Trembling/Shaking
☐ Fatigue/no energy	☐ Lack of Interest	☐ Repetitive behaviors	☐ Trouble with Crowds
☐ Fears/phobia	☐ Loneliness	☐ Restless/Can't sit still	☐ Other:
☐ Feel numb (emotionally)	☐ Loss/Bereavement	☐ Sadness	

Family Health History

Issue/Diagnosis	Patient	Father	Mother	Sister	Brother	Aunt/Uncle (which side?)	Grandparent (Which side?)
Depression	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐	☐
Posttraumatic Stress Disorder	☐	☐	☐	☐	☐	☐	☐
Abusive Behavior	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Suicide Attempt/Completion	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Liver Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐	☐	☐
Kidney Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Asthma/Respiratory Problems	☐	☐	☐	☐	☐	☐	☐
Stomach/Intestinal Problems	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Other:							

Has the patient ever been treated for any of the following:

☐ Panic Attacks ☐ Eating Disorder ☐ Self-Harm ☐ Skin picking/hair pulling

Please review the following list of psychiatric medications. Circle any the patient has previously taken.

Abilify (Aripiprazole)	Depakote (Valproic Acid)	Loxapine	Prozac (Fluoxetine)	Thorazine (Chlorpromazine)
Adapin (Doxepin)	Desyrel (Trazodone)	Luvox (Fluvoxamine)	Remeron (Mirtazapine)	Tofranil (Imipramine)
Adderall/Adderall XR (amphetamine/ dextroamphetamine)	Dexedrine (Dextroamphetamine)	Lybalvi	Restoril (Temazepam)	Topamax (Topiramate)
Ambien (Zolpidem)	Effexor/Effexor XR (Venlafaxine)	Metadate (methylphenidate)	Risperdal (Risperidone)	Tranxene (Clorazepate)
Anafranil (Clomipramine)	Elavil (Amitriptyline)	Methadone	Ritalin (Methylphenidate)	Trintellix (vortioxetine)
Antabuse (Disulfiram)	Focalin (Dexmethylphenidate)	Naltrexone	Rozerem (Ramelteon)	Valium (Diazepam)
Ativan (Lorazepam)	Geodon (Ziprasidone)	Nardil (Phenelzine)	Seroquel (Quetiapine)	Viibryd (vilazodone)
Auvelity (dextromethorphan-buproprion)	Halcion (Triazolam)	Norpramin (Desipramine)	Serzone (Nefazodone)	Vistaril (Hydroxyzine)
Buprenorphine	Haldol (Haloperidol)	Pamelor (Nortriptyline)	Sinequan (Doxepin)	Vraylar (cariprazine)
Buspar (Buspirone)	Invega (Paliperidone)	Parnate	Sonata (Zaleplon)	Vyvanse (Lisdexamfetamine)
Campral (Acamprosate)	Jornay	Paxil/ Paxil CR (Paroxetine)	Stelazine (Trifluoperazine)	Wellbutrin XL/SR – (Bupropion)
Caplyta	Klonopin (Clonazepam)	Phentermine	Strattera (Atomoxetine)	Xanax (Alprazolam)
Celexa (Citalopram)	Lamictal (Lamotrigine)	Pristiq (Desvenlafaxine)	Suboxone	Zoloft (Sertraline)
Clozaril (Clozapine)	Lexapro (Escitalopram)	Prolixin (Fluphenazine)	Symbyax (fluoxetine/olanzapine)	Zyprexa (Olanzapine)
Concerta (Methylphenidate)	Librium (Chlordiazepoxide)	Propranolol (Inderal)	Synthroid (Levothyroxine)	
Cymbalta (Duloxetine)	Lithium	Provigil (Modafinil)	Tegretol (Carbamazepine)	

If you circled any of the above, was it effective, and what was the reason for discontinuation?

Additional Concerns:	
Personal/Social Adjustment:	**School Adjustment:**
☐ Overly aggressive	☐ Academic problems
☐ Temper tantrums	☐ Difficulty with peers
☐ Withdrawn or shy	☐ Difficulty with authority
☐ Disturbing habits or mannerisms – Describe:	☐ Behavior problems
☐ Strange or bizarre behavior – Describe:	☐ Attendance problems/school reluctance
☐ Problems in peer relationships	☐ Attentional problems
☐ Drug or alcohol problems	☐ Aches and pains related to school
☐ Problems with the law	☐ Learning disabilities
☐ Harms self or others (suicidal or homicidal)	
Family Adjustment:	**Physical/Developmental Factors:**
☐ Parent-child problem	☐ Eating
☐ Marital conflict or co-parenting problems	☐ Sleeping
☐ Sibling conflict	☐ Toileting
☐ Recent family changes	☐ Grooming
☐ Neighborhood difficulties	☐ Perceptual/visual functions
☐ Mother experiencing difficulties	☐ Language or speech
☐ Father experiencing difficulties	☐ Motor coordination problems
☐ Sibling experiencing difficulties	**Other (please describe):**
☐ Drug or alcohol problems in the family	
☐ History of trauma or loss	
☐ Domestic violence	
☐ Abuse	

Background & Current Living Situation

Living Situation: ☐ Apartment ☐ Correctional Facility ☐ Hospice Care ☐ House
☐ Nursing Home ☐ Mobile Home ☐ Residential/Group Home ☐ Extended Care ☐ Condo
☐ Assisted Living ☐ Shelter ☐ Independent Living ☐ Homeless

Significant Exposure ☐ None ☐ Noise ☐ Fumes ☐ Dust ☐ Smoke ☐ Airborne Particles ☐ Solvents

Family/Household Composition

Please fill out the following about **all** parental figures **AND** all adults living in the household.

Relationship to Patient	First Name	In Primary Household?	Highest Education	Occupation	Hours/Week Worked	Quality of Relationship with Patient
		☐				
		☐				
		☐				
		☐				
		☐				
		☐				

Please list other children in the family.

Relationship to Patient	First Name	In Primary Household	Age	Quality of Relationship with Patient
		☐		
		☐		
		☐		
		☐		
		☐		

Where was the patient born?

How many times has the patient moved?

How old was the patient at each move?

School History

Current Grade Level: School: Teacher's Name:

Please summarize the child's progress within each of these grade levels:

Preschool
- Academic:
- Social:

Kindergarten:
- Academic:
- Social:

Grades 1-3:
- Academic:
- Social:

Grades 4-5:
- Academic:
- Social:

Grades 6-8:
- Academic:
- Social:

Grades 9-10:
- Academic:
- Social:

Grades 11-12:
- Academic:
- Social:

Academic Strengths:

Academic Weaknesses:

Has there been a change in the child's school performance? ☐ Yes ☐ No

If yes, please describe:

Does/has the child participated in any of the following?

☐ Yes	☐ No	IQ testing (results?)
☐ Yes	☐ No	Resource (for which classes/how many hours?)
☐ Yes	☐ No	Accelerated or Honors programs, explain:
☐ Yes	☐ No	Individual Education Plan (IEP), explain:
☐ Yes	☐ No	Virtual Academy (outside of COVID), explain:
☐ Yes	☐ No	Speech and language therapy
☐ Yes	☐ No	Learning disabilities class
☐ Yes	☐ No	Behavioral/emotional disorders class
☐ Yes	☐ No	Boys and Girls Club
☐ Yes	☐ No	Head Start
☐ Yes	☐ No	Early Intervention Services (ages 0-3)

Has the child had problems with any of the following?

☐ Yes	☐ No	Truancy, explain:
☐ Yes	☐ No	Fights, explain:
☐ Yes	☐ No	Absenteeism, explain:
☐ Yes	☐ No	Detention, explain:
☐ Yes	☐ No	Suspension, explain:
☐ Yes	☐ No	School refusal, explain:
☐ Yes	☐ No	Probation/Juvenile Probation/Detention, explain:

Has the child ever been involved with the following, and if yes, please explain:

☐ Yes	☐ No	Child Protective Services
☐ Yes	☐ No	Children's Mental Health

Are you struggling with your marital relationship or parenting? If yes, please describe:	☐ Yes	☐ No
Has your child had a recent change in friendships?	☐ Yes	☐ No
Do you have any concerns regarding your child's friendships? If yes, please describe:	☐ Yes	☐ No
Are you concerned that your child is using (or has used) drugs (including over-the-counter medicines) or alcohol? If yes, please describe:	☐ Yes	☐ No
Is your child sexually active?	☐ Yes	☐ No
Are you concerned about your child's sexual activities?	☐ Yes	☐ No
Has your child's behavior resulted in police, detention, or court involvement? If yes, please describe:	☐ Yes	☐ No
Does your adolescent have a job?	☐ Yes	☐ No
Is your child involved in any extracurricular or religious activities? If yes, please describe:	☐ Yes	☐ No

Is there anything else you would like us to know about the child?

What are the child's favorite activities?

Screeners

SCARED (COMPLETE IF CHILD IS UNDER 14) Please mark the answer that best describes your child in the **past 3 months**.	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe.	☐	☐	☐	PA/SO
2. My child gets headaches when he/she is at school.	☐	☐	☐	SCH
3. My child doesn't like to be with people he/she doesn't know well.	☐	☐	☐	SOC
4. My child gets scared if he/she sleeps away from home.	☐	☐	☐	SEP
5. My child worries about other people liking him/her.	☐	☐	☐	GA
6. When my child gets frightened, he/she feels like passing out.	☐	☐	☐	PA/SO
7. My child is nervous.	☐	☐	☐	GA
8. My child follows me wherever I go.	☐	☐	☐	SEP
9. People tell me that my child looks nervous.	☐	☐	☐	PA/SO
10. My child feels nervous with people he/she doesn't know well.	☐	☐	☐	SOC
11. My child gets stomachaches at school.	☐	☐	☐	SCH
12. When my child gets frightened, he/she feels like he/she is going crazy.	☐	☐	☐	PA/SO
13. My child worries about sleeping alone.	☐	☐	☐	SEP
14. My child worries about being as good as other kids.	☐	☐	☐	GA
15. When my child gets frightened, he/she feels like things are not real.	☐	☐	☐	PA/SO
16. My child has nightmares about something bad happening to their parents.	☐	☐	☐	SEP
17. My child worries about going to school.	☐	☐	☐	SCH
18. When my child gets frightened, his/her heart beats fast.	☐	☐	☐	PA/SO
19. He/she gets shaky.	☐	☐	☐	PA/SO
20. My child has nightmares about something bad happening to him/her.	☐	☐	☐	SEP
21. My child worries about things working out for him/her.	☐	☐	☐	GA
22. When my child gets frightened, he/she sweats a lot.	☐	☐	☐	PA/SO
23. My child is a worrier.	☐	☐	☐	GA
24. My child gets really frightened for no reason at all.	☐	☐	☐	PA/SO
25. My child is afraid to be alone in the house.	☐	☐	☐	SEP
26. It is hard for my child to talk with people he/she doesn't know well.	☐	☐	☐	SOC
27. When my child gets frightened, he/she feels like he/she is choking.	☐	☐	☐	PA/SO
28. People tell me that my child worries too much.	☐	☐	☐	GA
29. My child doesn't like to be away from his/her family.	☐	☐	☐	SEP
30. My child is afraid of having anxiety (or panic) attacks.	☐	☐	☐	PA/SO
31. My child worries that something bad might happen to their parents.	☐	☐	☐	SEP
32. My child feels shy with people he/she doesn't know well.	☐	☐	☐	SOC
33. My child worries about what is going to happen in the future.	☐	☐	☐	GA
34. When my child gets frightened, he/she feels like throwing up.	☐	☐	☐	PA/SO
35. My child worries about how well he/she does things.	☐	☐	☐	GA
36. My child is scared to go to school.	☐	☐	☐	SCH
37. My child worries about things that have already happened.	☐	☐	☐	GA
38. When my child gets frightened, he/she feels dizzy.	☐	☐	☐	PA/SO
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.	☐	☐	☐	SOC
40. My child feels nervous when they are going to parties, dances, or any place where there will be people that they do not know well.	☐	☐	☐	SOC
41. My child is shy.	☐	☐	☐	SOC

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

Pediatric Symptom Checklist (COMPLETE IF CHILD IS UNDER 13) Please mark the answer that best fits your child.	Never	Sometimes	Often
1. Complains of aches/pains	☐	☐	☐
2. Spends more time alone	☐	☐	☐
3. Tires easily, has little energy	☐	☐	☐
4. Fidgety, unable to sit still	☐	☐	☐
5. Has trouble with a teacher	☐	☐	☐
6. Less interested in school	☐	☐	☐
7. Acts as if driven by a motor	☐	☐	☐
8. Daydreams too much	☐	☐	☐
9. Distracted easily	☐	☐	☐
10. Is afraid of new situations	☐	☐	☐
11. Feels sad, unhappy	☐	☐	☐
12. Is irritable, angry	☐	☐	☐
13. Feels hopeless	☐	☐	☐
14. Has trouble concentrating	☐	☐	☐
15. Less interest in friends	☐	☐	☐
16. Fights with others	☐	☐	☐
17. Absent from school	☐	☐	☐
18. School grades dropping	☐	☐	☐
19. Is down on him or herself	☐	☐	☐
20. Visits doctor with doctor finding nothing wrong	☐	☐	☐
21. Has trouble sleeping	☐	☐	☐
22. Worries a lot	☐	☐	☐
23. Wants to be with you more than before	☐	☐	☐
24. Feels he or she is bad	☐	☐	☐
25. Takes unnecessary risks	☐	☐	☐
26. Gets hurt frequently	☐	☐	☐
27. Seems to be having less fun	☐	☐	☐
28. Acts younger than children his or her age	☐	☐	☐
29. Does not listen to rules	☐	☐	☐
30. Does not show feelings	☐	☐	☐
31. Does not understand other people's feelings	☐	☐	☐
32. Teases others	☐	☐	☐
33. Blames others for his/her troubles	☐	☐	☐
34. Takes things that do not belong to him/her	☐	☐	☐
35. Refuses to share	☐	☐	☐
Does your child have any emotional or behavioral problems for which he/she needs help?		☐ Yes	☐ No
Are there any services that you would like your child to receive for these problems? If Yes, what services?		☐ Yes	☐ No

Vanderbilt **(Complete for all ages)** - Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, think about your child's behavior in the **past 6 months.**

Is this evaluation based on a time when the child was on medication? ☐ Yes ☐ No ☐ Unsure

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 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 (i.e., "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
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (e.g., teams)	1	2	3	4	5

Comments:

For Office Use Only

Total positive in 1-9		Total symptom score 1-18		Total positive in 27-40		Total positive in 48-55	
Total positive in 10-18		Total positive in 19-26		Total positive in 41-47		Avg. performance score	

American Academy of Pediatrics and National Initiative for Children's Healthcare Quality-Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.