North Fulton Pediatrics

Dear Parents,

Because you have expressed a concern regarding your child's focus, behavior or school performance, we are asking your help in gathering information. This packet includes questionnaires for Attention Deficit Hyperactivity Disorder and other mental health issues. Your cooperation in completing this packet will help us do a thorough evaluation.

If you are interested in pursuing an evaluation, you need to:

1. Schedule a Well Child checkup if your child has not had one within the last year
2. Complete all questionnaires
3. Make copies of any previous evaluations, as well as copies of pertinent school records (see parent checklist)

This information needs to be returned to our office before we will schedule your consultation appointment. Your physician/provider will then be able to evaluate and interpret the data prior to this appointment and can let you know if any additional information is needed.

The consultation appointment will last usually at least 45 minutes. We will let you know if your child should attend.

Thank you for your cooperation in this complex process.

Sincerely,

The Physicians and Providers of North Fulton Pediatrics

North Fulton Pediatrics

Evaluation Packet Checklist

Please use this checklist as a reminder to complete all of your forms and to return them to our office at least two (2) weeks prior to your child's / parent appointment.

_____ Patient Information Questionnaire

_____ Parent Vanderbilt Rating Scale (Each parent encouraged to complete separately. You may make a copy)

_____ Teacher Vanderbilt Rating Scale (Has a cover letter to use when you give to the school. You may make additional copies. For middle and high school students, it is best to give to the school counselor to distribute and collect from teachers)

_____ SCARED Scale (For 8 to 11 year olds. You may help your child complete the CHILD version. If your child does not understand, do the PARENT version. There is no need to do both.)

_____ GAD7, PHQ9 (Only for children 12 years and above)

_____ Child and Adolescent Trauma Scale (Only if recommended when completing Patient Information)

_____ ADHD Self Rating (For 12 years and above)

_____ Copies of any previous testing, evaluations

_____ Copies of pertinent school records (recent standardized testing, any prior testing for gifted programs, most recent report card, IEP plans, teacher notes)

_____ Pediatric Cardiovascular Risk Assessment

Please remember to do some independent reading and/or research prior to your visit. These websites are a good start and we look forward to helping you with your child.

www.CHADD.org www.Understood.org www.healthychildren.org

North Fulton Pediatrics

PATIENT INFORMATION
ADHD/BEHAVIOR EVALUATION

PATIENT NAME: _____ DATE: _____
DATE OF BIRTH: _____

BRIEFLY STATE YOUR CONCERNS:

_____
_____
_____

GOALS: What are your goals from this evaluation?

_____
_____
_____

FAMILY/HOME SITUATION: Briefly describe your child's home situation(s). With whom does the child live? If parents are divorced, briefly explain custody and how visitation rights are handled.

_____
_____
_____
_____

FAMILY STRESSORS: Are there any stressors (financial, physical or mental health, emotional, work-related, cultural), new or ongoing, that might help us understand your child and your family better?

_____
_____
_____
_____

ABUSE/TRAUMA HISTORY: Has your child witnessed violence, experienced a traumatic loss of someone important in his or her life, or been in a fire or flood, in a car crash, assaulted, or exposed to other trauma?

_____
_____

If yes, please complete the appropriate Child and Adolescent Trauma Screen (CATS)

FAMILY HISTORY: Is there a family history of (Y/N, Relation to child)

ADHD _____
Learning Disabilities _____
Substance Abuse (alcohol/drugs) _____
Depression _____
Anxiety Disorder _____
Bipolar Disorder _____
Schizophrenia _____
Tic Disorder _____

SCHOOL HISTORY

Current Grade and School: _____

Please summarize the child's progress (e.g. academic, social) within each of these grades

Preschool: _____
_____

Kindergarten: _____
_____

Grades 1-5: _____
_____
_____
_____
_____

Grades 6-8: _____
_____
_____
_____
_____

Grades 9-12: _____
_____
_____
_____
_____

To the best of your knowledge, at what grade level is your child functioning:
Reading/Writing: _____
Math: _____
Describe quality of handwriting: _____
Has your child had any specialized testing done by the school or privately? When? Please describe and explain any diagnosis:

_____
_____
_____

Has your child repeated a grade? If so, when? Why? _____
Has your child received any type of special educational services (EIP/504/IEP/Learning disabilities class/ Resource room/ Behavioral Intervention Plan, Private Tutoring)? If so, please describe, explain why your child received the service, and duration of service: _____
_____
_____
_____

Has your child ever been suspended or expelled from school (Y/N, When)? _____

Does your child have problems with tardiness or missed school days? _____

_____

INTERESTS AND ACCOMPLISHMENTS:

What are your child's main hobbies and interests? What does your child enjoy doing the most?

_____

_____

_____

What are your child's areas of greatest accomplishments?

_____

_____

SOCIAL SKILLS:

How well does each parent get along with the child? _____

_____

_____

Please describe how your child gets along with siblings: _____

_____

_____

How easily does your child make friends? _____

_____

_____

How well does your child keep friendships? _____

_____

_____

How well does your child participate in organized activities outside of school? _____

_____

_____

PROBLEM BEHAVIORS: Please describe any behavior that is impairing for your child, challenging for you or the school, especially any dangerous, aggressive or destructive behaviors. Describe frequency, duration and intensity, suspected causes (what happened before), what happens after, and approaches you have used: _____

_____

_____

_____

_____

_____

_____

_____

DISCIPLINE: Who is the primary disciplinarian in your house? _____

Are there disagreements over discipline style between parents? _____

What types of discipline do you use with your child?

Verbal reprimands _____ Rewards _____

Time out (isolation) _____ Physical punishment _____

Removal of privileges _____ Give in to child _____

Avoidance of child _____ Other _____

PRIOR EVALUATIONS AND TREATMENTS: Please describe any other prior evaluations (therapies, counseling, medical) or treatments (diet, supplements, prior medication) you have tried for your child:

_____
_____
_____
_____
_____

OTHER MENTAL HEALTH CONCERNS: Describe any concerns and age noticed

Anxiety/Fears: _____
_____

Depression: _____
_____

Tics (vocal or motor): _____
_____

Obsessive thoughts or compulsive behaviors: _____
_____
_____

Nervous habits (Picking, hair twisting or pulling, nail biting) _____
_____

Are you aware of your child vaping, smoking, using alcohol or marijuana or other drugs? _____
_____
_____

SLEEPING HABITS: While sleeping, does your child: Circle answers

Snore more than half the time?	Yes	No	Don't Know
Always snore?	Yes	No	Don't Know
Snore loudly?	Yes	No	Don't Know
Have "heavy" or loud breathing?	Yes	No	Don't Know
Have trouble breathing, or struggle to breath?	Yes	No	Don't Know
Have you ever…..			
Seen your child stop breathing during the night?	Yes	No	Don't Know
Does your child….			
Tend to breathe through the mouth during the day?	Yes	No	Don't Know
Have a dry mouth on awakening in the morning?	Yes	No	Don't Know
Occasionally wet the bed?	Yes	No	Don't Know
Does your child….			
Wake up feeling un-refreshed in the morning?	Yes	No	Don't Know
Have a problem with sleepiness during the day?	Yes	No	Don't Know
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Yes	No	Don't Know
Is it hard to wake your child up in the morning?	Yes	No	Don't Know
Does your child wake up with headaches in the morning?	Yes	No	Don't Know
Did your child stop growing at a normal rate at any time since birth?	Yes	No	Don't Know
Is your child overweight?	Yes	No	Don't Know

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

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

Revised - 1102

American Academy of Pediatrics

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National Initiative for Children's Healthcare Quality

McNeil

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	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 (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: _____

American Academy of Pediatrics

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National Initiative for Children's Healthcare Quality

North Fulton Pediatrics

Dear Teacher or School Counselor:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find the NICHQ Vanderbilt Teacher Assessment Scale.

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent make copies for additional rating scales as needed.

Please fill out the forms as completely as possible. If you do not know the answer to the question, please write "don't know", so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant, but we use all of this information to obtain an accurate diagnosis.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. When they are finished, please return all forms via; mail / fax or email form to our office at nurses@northfultonpediatrics.com.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,

The Physicians and Providers of North Fulton Pediatrics

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

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. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous 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 in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3

27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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Screen for Child Anxiety Related Disorders (SCARED)

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

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, check √ the box that corresponds to the response that seems to describe you *for the last 3 months*.

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

Screen for Child Anxiety Related Disorders (SCARED)

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

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

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

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.

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED)

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

Name: _____ Date: _____

Directions:
Below is a list of 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, check √ the box 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.				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 his/her 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

Screen for Child Anxiety Related Disorders (SCARED)

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

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.				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 his/her 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 (for example: read aloud, speak, play a game, play a sport).				SOC
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.				SOC
41. My child is shy.				SOC

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

GAD-7 Screening Questions

Patient Name: _____ **Date:** _____

	During the last 2 weeks, how often have you been bothered by the following problems?	not at all	several days	more than half the days	nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

Total Score: _____ = Add columns: _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PHQ-9 Modified for Teens

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PHQ-9: Modified for Teens

Name _____

Clinician _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

Office Use Only	Score _____
Q 12. & 13 = Y	or TS=>11

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American Academy of Pediatrics

CLINICIAN TOOLS

ADHD

Child and Adolescent Trauma Screen-Caregiver (CATS-C): 3–6 Years

Caregiver's name _____ Date _____

Child's name _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

Event	YES	NO
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.		
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.		
3. Robbed by threat, force or weapon.		
4. Slapped, punched, or beat up in your family.		
5. Slapped, punched, or beat up by someone not in the family		
6. Seeing someone in the family get slapped, punched or beat up.		
7. Seeing someone in the community get slapped, punched or beat up.		
8. Someone older touching his/her private parts when they shouldn't.		
9. Someone forcing or pressuring sex, or when s/he couldn't say no.		
10. Someone close to the child dying suddenly or violently.		
11. Attacked, stabbed, shot at or hurt badly.		
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed.		
13. Stressful or scary medical procedure.		
14. Being around war.		
15. Other stressful or scary event? Describe:		

Which one is bothering the child the most now? _____

If you marked any stressful or scary events for the child, turn the page and answer the next questions.

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American Academy of Pediatrics

Child and Adolescent Trauma Screen-Caregiver (CATS-C): 3–6 Years

Caregiver's name _____ Date _____

Child's name _____

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks. Answer the best you can:

	0 Never	1 Once in a while	2 Half the time	3 Almost always
1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	☐	☐	☐	☐
2. Having bad dreams related to a stressful event.	☐	☐	☐	☐
3. Acting, playing or feeling as if a stressful event is happening right now.	☐	☐	☐	☐
4. Feeling very emotionally upset when reminded of a stressful event.	☐	☐	☐	☐
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	☐	☐	☐	☐
6. Trying not to remember, think about or have feelings about a stressful event.	☐	☐	☐	☐
7. Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	☐	☐	☐	☐
8. Increase in negative emotional states (afraid, angry, guilty, ashamed, confusion).	☐	☐	☐	☐
9. Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	☐	☐	☐	☐
10. Acting socially withdrawn.	☐	☐	☐	☐
11. Reduction in showing positive feelings (being happy, having loving feelings).	☐	☐	☐	☐
12. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	☐	☐	☐	☐
13. Being overly alert or on guard.	☐	☐	☐	☐
14. Being jumpy or easily startled.	☐	☐	☐	☐
15. Problems with concentration.	☐	☐	☐	☐
16. Trouble falling or staying asleep.	☐	☐	☐	☐

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2s & 3s 0 /16

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others ☐ Yes ☐ No
2. Hobbies/Fun ☐ Yes ☐ No
3. School or daycare ☐ Yes ☐ No
4. Family relationships ☐ Yes ☐ No
5. General happiness ☐ Yes ☐ No

CATS-C 3-6_Version1.2. Berliner & Goldbeck, 2014

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CLINICIAN TOOLS

ADHD

Child and Adolescent Trauma Screen-Caregiver (CATS-C): 7–17 Years

Caregiver's name _____ Date _____

Child's name _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

Event	YES	NO
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.		
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.		
3. Robbed by threat, force or weapon.		
4. Slapped, punched, or beat up in your family.		
5. Slapped, punched, or beat up by someone not in the family.		
6. Seeing someone in the family get slapped, punched or beat up.		
7. Seeing someone in the community get slapped, punched or beat up.		
8. Someone older touching his/her private parts when they shouldn't.		
9. Someone forcing or pressuring sex, or when s/he couldn't say no.		
10. Someone close to the child dying suddenly or violently.		
11. Attacked, stabbed, shot at or hurt badly.		
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed.		
13. Stressful or scary medical procedure.		
14. Being around war.		
15. Other stressful or scary event? Describe:		

Which one is bothering the child the most now? _____

If you marked any stressful or scary events for the child, turn the page and answer the next questions.

CATS-C-7-17_1.2

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Child and Adolescent Trauma Screen-Caregiver (CATS-C): 7–17 Years

Caregiver's name _____ Date _____

Child's name _____

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks. Answer the best you can:

	0 Never	1 Once in a while	2 Half the time	3 Almost always
1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	☐	☐	☐	☐
2. Having bad dreams related to a stressful event.	☐	☐	☐	☐
3. Acting, playing or feeling as if a stressful event is happening right now.	☐	☐	☐	☐
4. Feeling very emotionally upset when reminded of a stressful event.	☐	☐	☐	☐
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	☐	☐	☐	☐
6. Trying not to remember, think about or have feelings about a stressful event.	☐	☐	☐	☐
7. Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	☐	☐	☐	☐
8. Not being able to remember an important part of a stressful event.	☐	☐	☐	☐
9. Negative changes in how s/he thinks about self, others or the world after a stressful event.	☐	☐	☐	☐
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	☐	☐	☐	☐
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	☐	☐	☐	☐
12. Losing interest in activities s/he enjoyed before a stressful event.	☐	☐	☐	☐
13. Feeling distant or cut off from people around her/him.	☐	☐	☐	☐
14. Not showing positive feelings (being happy, having loving feelings).	☐	☐	☐	☐
15. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	☐	☐	☐	☐
16. Risky behavior or behavior that could harmful.	☐	☐	☐	☐
17. Being overly alert or on guard.	☐	☐	☐	☐
18. Being jumpy or easily startled.	☐	☐	☐	☐
19. Problems with concentration.	☐	☐	☐	☐
20. Trouble falling or staying asleep.	☐	☐	☐	☐

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2s & 3s 0 /20

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others	☐ Yes ☐ No	4. Family relationships	☐ Yes ☐ No
2. Hobbies/Fun	☐ Yes ☐ No	5. General happiness	☐ Yes ☐ No
3. School	☐ Yes ☐ No		

Adapted from Berliner & Goldbeck, 2014

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CURRENT ADHD SYMPTOMS SCALE SELF-REPORT

Patient Name: _____ **Date:** _____

Instructions: Please circle the number next to each item that best describes your behavior **DURING THE PAST 6 MONTHS**.

ITEMS:	**Never or Rarely**	**Sometimes**	**Often**	**Very Often**
Fail to give close attention to details or make careless mistakes in my work	0	1	2	3
Fidget with hands or feet or squirm in seat	0	1	2	3
Difficulty sustaining my attention in tasks or fun activities	0	1	2	3
Leave my seat in classroom or in other situations in which seating is expected	0	1	2	3
Don't listen when spoken to directly	0	1	2	3
Feel Restless	0	1	2	3
Don't follow through on instructions and fail to finish work	0	1	2	3
Have difficulty engaging in leisure activities or doing fun things quietly	0	1	2	3
Having difficulty organizing tasks and activities	0	1	2	3
Feel "on the go" or "driven by a motor"	0	1	2	3
Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort	0	1	2	3
Talk excessively	0	1	2	3
Lose things necessary for tasks or activities	0	1	2	3
Blurt out answers before questions have been completed	0	1	2	3
Easily distracted	0	1	2	3
Have difficulty awaiting turn	0	1	2	3
Forgetful in daily activities	0	1	2	3
Interrupt or intrude on others	0	1	2	3

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Pediatric Cardiac Risk Assessment Form

Children's Healthcare of Atlanta | Sibley Heart Center Cardiology

Please complete this form for all children (athletic participant or not) starting at the age of 6, when the American Academy of Pediatrics recommends starting preparticipation examinations (PPE). It should be completed a minimum of every 3 years, including on entry into middle school and high school. Depending on family and primary care provider concerns, more frequent or earlier screening may be appropriate.

Patient Name: _____ Age: _____

Person Completing Form: _____ Date: _____

Symptom Questions:	**Yes**	**No**	**Unsure**
Have you (patient) ever fainted, passed out, or had an unexplained seizure suddenly and without warning?			
If so, was it during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, or ringing telephones?			
Have you (patient) ever had either of the following during **exercise**: 1. Exercise-related chest pain, particularly pressure-like and not occurring at rest? 2. Unusual or extreme shortness of breath during exercise, not explained by asthma?			
Family History:	**Yes**	**No**	**Unsure**
Are there any immediate family members (include patient's parents or siblings) who have died before age 50 from heart problems or had an unexpected sudden death? *Including drownings, passing away in their sleep, sudden infant death syndrome (SIDS), or unexplained automobile crashes in which the relative was driving.*			

Are there any immediate relatives (patient's parents or siblings) with the following conditions?

- ☐ Hypertrophic cardiomyopathy or hypertrophic obstructive cardiomyopathy (HCM/HOCM)
- ☐ Long QT syndrome (LQTS) or short QT syndrome
- ☐ Marfan syndrome or Loeys-Dietz syndrome
- ☐ Arrhythmogenic right ventricular cardiomyopathy (ACM)
- ☐ Catecholaminergic polymorphic ventricular tachycardia (CPVT)
- ☐ Brugada syndrome (BrS)
- ☐ Anyone younger than 50 years old with a pacemaker or implantable defibrillator?
- ☐ ***I have no known immediate family members with the above conditions.***

Please explain more about any "yes" answers here:

PSYCHOLOGISTS
Testing for ADD / ADHD / Learning Differences, etc.
Check with your individual Insurance Plan for In-Network providers
(If Recommended By Your Provider)

Remember to verify that the psychologist you choose is contracted on your insurance and that they cover Psychological testing under your mental health benefits. Calling your Insurance Company for a list of In-Network providers may be a good option as well. You can also check on the website: www.psychologytoday.com. Often, insurance companies do not cover testing.

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Stephanie H. Perleberg, Ph.D
North Point Psychology
3534 Old Milton Pkwy
Alpharetta, GA 30005
Ph: (678) 624-0310 / (678) 971-2386 ext. 115

Peachtree Psychology LLC
555 Sun Valley Dr.
Roswell, GA
Ph: (678) 381-1687
Neil Martin Psyd (cash rate for testing)

Judy Wohlman, Ph.D
6000 Lake Forrest Drive, Suite 575
Sandy Springs, GA 30328
Ph: (404) 255-1032

Mary Danielak, Psy.D
314 Maxwell Rd., Ste 400
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Ph: (770) 442-9447 ext. 121

Marcia Rogers, Psy.D
1115 Upper Hembree Rd., Ste B
Roswell, GA 30076
Ph: (770) 685-6412 ext. 4

Sue Miller, Ph.D
Specializes Autism eval age 4 and up
6740 Jamestown Dr.
Alpharetta, GA 30005
Ph: (678) 339-1221

Jackie O'Connell, Ph.D
Milton Grisham, Ph.D
8910 Main Street
Woodstock, GA 30188
Ph: (678) 339-1221 / (770) 809-6136 ext 308
www.cherokeecounseling.com
(9 other therapists)

Brooke Jones, Psd.D / Fresh Start
310 Paper Trail Way, Ste 106
Canton, GA 30115
Ph: (404) 808-1161 / (678) 880-4645
www.cantoncounseling.com

Laura Greve, PsyD
1115 Upper Hembree Road, Suite B
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Ph: 678-215-1814

Mel Eldridge, Ph.D
North Creek Office Park
3715 Northside Parkway
Bldg. 200, Suite 605
Atlanta, GA 30327

North Fulton Pediatrics

FOLLOW-UP OF ATTENTION DEFICIT DISORDER

Dear Parent,

REFILLS:
We are excited to tell you that North Fulton Pediatrics, P.C. has transitioned to electronic medical records. As part of this transition, we are able to electronically prescribe (send electronically) your child's refills to participating pharmacies. We still require 72 hours-notice for all refills. We cannot refill on the same day basis as the providers need to review your child's records and your provider may be off that day to do the actual refill.

WE REQUEST THAT YOU:

1. Go to our website, www.northfultonpediatrics.com and register your child(ren) on our patient portal. Here you can request medication refills among other things. This also saves you time with having to call in for a refill request. (We must have the same email address on file you will be registering with on our portal)
2. Make sure your pharmacy will accept prescriptions for controlled substances electronically.
3. We will need your pharmacy name and address with each refill. Please include this information with all refill requests.

FOLLOW-UP: All newly diagnosed patients will be required to follow-up in our office

1. Within 30 days of starting medication
2. At least 2 other times within the first 9 months. One can be a check-up if it should occur during this time.

FOLLOW-UP: ALL patients with a diagnosis of ADD/ADHD will require follow-up in our office. When appropriate, some of these visits may be done via telehealth.

1. At a yearly check-up
2. One month after any dose change
3. At other times when problems warrant face to face communication with you and your child.

Note: Recommended follow-up is every 3 to 6 months when your child is stable on a medication and dose.

CHARGES:
At check-ups, we routinely assess your child's progress on medication, make adjustments, etc. The extra time it will take to do this may generate an additional charge(s) associated with a co-pay even for a patient who does not usually owe a co-pay at a check-up. As a small business, we must now collect these co-pays at the time of the visit.

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