MASSACHUSETTS GENERAL HOSPITAL

Patient Name: _____
MGH MRN#: _____
Today's Date: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionaire are strictly confidential
and will become part of you/ your child's medical record

PATIENT:

Name:
Date of birth:
Address:

Home Phone:
Work Phone:

Residence is:

☐ Private Residence - ***(Please circle one)***
Alone With Significant Other
With Family With Friend

☐ Dormitory
☐ Apartment attached to Caregiver/Family residence
☐ Assisted Living
☐ Institution (Date admitted?_____)
☐ Other

Please complete the following questionnaire which seeks information about you/ your child's past medical history, medication use and related issues. This confidential information will assist your clinician in providing the best care possible. Further information will be obtained during your visit, and we will try to address any questions that you have.

REASON(S) FOR VISIT:

☐ Tics/Tourette Syndrome
☐ Obsessions and/or compulsions
☐ Difficulty with attention and concentration
☐ Hyperactivity/restlessness
☐ Anger outbursts
☐ Difficulty with school/learning
☐ Problem with reading or writing
☐ Feeling depressed
☐ Feeling anxious
☐ Other:_____

Please give a brief description:

RELEASE INFORMATION: Please list any other healthcare providers. For example, your primary care physician, neurologist, psychiatrist, therapist or the healthcare provider who referred you to our clinic.

Doctor:
Address:
Phone Number:

Doctor:
Address:
Phone Number:

Are you interested in learning more about participating in clinical research studies? ☐ Yes ☐ No

MASSACHUSETTS GENERAL HOSPITAL

Patient Name: _____
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CURRENT MEDICATIONS: Please list current medications and dose. Bring or attach a list if necessary.

_____ _____

_____ _____

_____ _____

CURRENT OTC MEDICATIONS: Please list current over-the-counter medications (OTC), including vitamins, herbal remedies or supplements, and medications for pain, sleep, etc…

_____ _____

_____ _____

_____ _____

PREVIOUS MEDICATIONS: Please indicate if you felt the medication was helpful.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Does anyone in your family have (or had) any of the following conditions? If so, whom?:

- ☐ Tourette Syndrome
- ☐ Motor or vocal tics
- ☐ Obsessive-compulsive disorder
- ☐ Attention-deficit/hyperactivity disorder
- ☐ Autism Spectrum Disorder
- ☐ Seizures/Epilepsy
- ☐ Adult-onset diabetes
- ☐ High cholesterol
- ☐ Other Neurological/Psychiatric disease; if yes what?

IMMUNIZATIONS: Are all of your/ your child's immunizations up-to-date ☐ Yes ☐ No

Do you experience chronic pain? ☐ Yes ☐ No

Please explain:

Do you have any drug allergies?

- ☐ Yes
- ☐ No

Specify: _____

_____

What happens? _____

_____

Are you concerned that someone at home or in your neighborhood will hurt you?

- ☐ Yes
- ☐ No

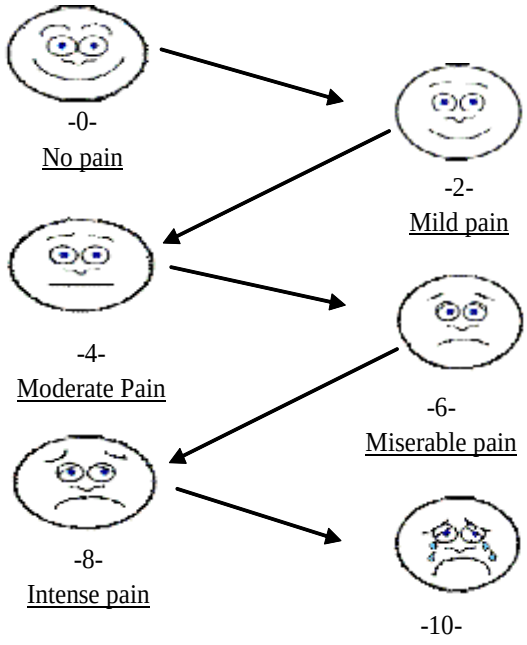
Do you smoke cigarettes? ☐ Yes ☐ No

How much alcohol do you consume in a week? _____

Do you use or have you recently used recreational drugs?

If so, please list: _____

Which best describes any pain that you are having?



MASSACHUSETTS GENERAL HOSPITAL

Patient Name: _____
MGH MRN#: _____
Today's Date: _____

PATIENT MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Have you/your child ever had any of the following, or are you having difficulties with any of the following items? (Please check even if treated or controlled, but please indicate this in the margin)

General
- ☐ Frequent fevers/chills
- ☐ Body aches
- ☐ Fatigue
- ☐ Unexpected weight changes
- ☐ Other

Skin
- ☐ Mole changes/growth
- ☐ Skin rashes
- ☐ Itchy skin
- ☐ Skin dryness
- ☐ Other

Lymphatic
- ☐ Bruising
- ☐ Bleeding
- ☐ Swollen glands
- ☐ Immune problems
- ☐ Anemia/B12 deficiency
- ☐ Other

Lungs/Heart
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Leg cramps
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other

Psychological
- ☐ Frequent crying
- ☐ Being afraid or having fearful thoughts
- ☐ Suicidal thoughts
- ☐ Insomnia
- ☐ Problems oversleeping
- ☐ Treatment for depression
- ☐ Therapy for emotional problems
- ☐ Tension, Stress or Anxiety
- ☐ Anger outbursts
- ☐ Major mental illness
- ☐ Addiction(s)
- ☐ Trouble with the law
- ☐ Difficulty interacting with peers
- ☐ Other

Muscles
- ☐ Painful joints
- ☐ Stiffness
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Other

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Hepatitis
- ☐ Heartburn
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Decreased, blurred or double vision
- ☐ Dizziness/vertigo
- ☐ Ringing in the ears
- ☐ Fainting
- ☐ Unsteadiness while walking
- ☐ Difficulty chewing/swallowing
- ☐ Hoarseness/change in voice
- ☐ Numbness
- ☐ Weakness
- ☐ Drowsiness
- ☐ Head injury or concussion
- ☐ Tremor/ shaking
- ☐ Memory problems
- ☐ Seizures
- ☐ Stroke
- ☐ Falls
- ☐ Other

Endocrine and Genitourinary
- ☐ Diabetes
- ☐ Thyroid trouble
- ☐ Excessive sweating or night sweats
- ☐ Kidney disease
- ☐ Hot flashes or heat intolerance
- ☐ Sexual difficulties
- ☐ Unusual discharge
- ☐ Pain or burning w/ urination
- ☐ Change in urinary frequency
- ☐ Sexually transmitted disease
- ☐ Removal of uterus
- ☐ Removal of ovaries
- ☐ Other

Have you ever had a picture or image taken of your brain? ☐ Yes ☐ No
If available, please bring a copy of this report and copies of actual films, if available.

Previous surgeries or procedures (include dates if known):

_____

_____

PATIENT DETAILS AND DEMOGRAPHICS:

Handedness:
☐ Right
☐ Left
☐ Ambidextrous

Primary Language:
☐ English
☐ Spanish
☐ Other

Did you learn English after a first language?
☐ Yes
☐ No

Birth History:

Duration of pregnancy (in weeks): _____

Birth Weight: _____

Any complications? ☐ Yes ☐ No

Pregnancy (diabetes, pre-eclampsia, drug/alcohol use, injury, emotional problems, stress, other): _____

Labor: _____

Delivery (vaginal, C-section, forceps, etc.): _____

Newborn Period (breathing problems, incubator, infection, jaundice requiring treatment): _____

Did you/your child go home from the hospital with your/his/her parents? ☐ Yes ☐ No

Developmental Milestones:

At what age did you/your child first:

sit unassisted?

crawl?

walk?

speak 1st words?

use 2-3 word sentences?

toilet train?

Social History:

For patients under age 21 (or older if relevant):

Are both parents living in the home? ☐ Yes ☐ No ☐ Separated ☐ Divorced ☐ Deceased

Is patient adopted? In foster care?

Who has custody of the patient?

How often does patient see non-custodial parent?

Please list any people residing at home with the patient (include age and relation):

PATIENT DETAILS AND DEMOGRAPHICS continued:

School History:

For patients under age 21 (or older if relevant):

Current School: Grade:

Type of Program: ☐ Public ☐ Private
☐ Regular Ed ☐ Special Ed (specify type)

If applicable, please check boxes next to special services received (current or past): ☐ Not applicable

☐ Resource Room ☐ Physical Therapy ☐ Counseling
☐ Speech/Language ☐ Occupational Therapy ☐ 1:1 Aide
☐ Other

Have any learning disabilities been identified? If so, what are they and in what grade were they identified?

If you/your child is receiving special services, please include copies of any evaluations and your current IEP.

For patients over age 21 (or younger if relevant):

Are you currently: ☐ single ☐ married ☐ separated ☐ divorced

Education:

What was the highest level of education completed?

☐ Elementary School -5yrs
☐ Middle School - 8yrs
☐ High School (Some) - 10yrs
☐ High School Graduate -12yrs
☐ College (Associate's) -14yrs
☐ College (Bachelor's) -16yrs
☐ Graduate or Professional School -18+ yrs

Type of Work: _____
(please give previous if retired)

Current or previous average hours/wk: _____

For all patients:

What non-school (or non-work) activities do you enjoy? _____

_____

Do you belong to any groups, teams or organizations? _____

_____

Please list any talents, special abilities and strengths: _____

_____

Patient Name: _____
MGH MRN#: _____
Today's Date: _____

Race and Ethnicity: (select one or more)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other: _____

Please use this space to explain any checked items from above, any answers marked 'Other', or any concerns you'd like us to know about.

Date:_____Time:_____Patient/Guardian Signature:_____

Date:_____Time:_____Physician Signature:_____Clinical ID#_____

Name:_____ Date:_____

Tic Questionnaire

When completing this questionnaire, please refer to these motor and vocal tic definitions:
Simple motor tics: Any sudden purposeless movements that happen repeatedly such as eye blinking or shoulder shrugging.
Complex motor tics: Any repeated movements that are always done in the same way and involve more than one muscle group like eyes and mouth, or shoulder and arm. These tics may seem like they are being done on purpose or intentionally at times, but usually they are not.
Simple vocal tics: Any sudden sounds that appear meaningless and that happen repeatedly, such as excessive sniffling or throat clearing.
Complex vocal tics: Purposeful in appearance, these tics often mimic brief meaningful utterances such as repeating parts of words, whole words, or phrases when it doesn't make sense to do so or is inappropriate.

Please check the appropriate box.

Never	Ever	Current	I have experienced, or others have noticed, involuntary and apparently purposeless bouts of:	*OFFICE USE: (complexity)*
			Simple eye movements such as: eye blinking, squinting, eyebrow raising , or opening eyes wide (briefly)	0
			Complex eye movements such as: looking surprised or quizzical, eye rolling.	2
			Nose movements such as: nose twitching, broadening or flaring of the nostrils.	1
			Simple mouth movements such as: opening mouth wide, pouting.	1
			Complex mouth movements such as: smiling, sticking out tongue, grimacing or other gestures involving the mouth.	2
			Head movements such as head shaking, head jerks, touching the chin to shoulder, lifting chin up or throwing the head back (as if to get hair out of the eyes).	1
			Simple shoulder movements such as: quickly jerking a shoulder	0
			Complex shoulder movements such as: slowly shrugging shoulders as if to say "I don't know"	1
			Simple hand or arm movements such as: quickly flexing or extending the hands, fingers or arms.	2
			Complex, coordinated hand and arm movements involving multiple muscle groups such as: hand and arm postures and, pinching or, moving fingers in a sequence.	3
			Simple leg/foot movements such as: kicking, flexing, bending or extending the ankles or feet.	1
			Complex leg/foot movements such as: skipping, hopping, jumping, taking one step forward and two steps back, squatting, deep knee bending.	4
			Repeatedly tensing the abdomen or buttocks	1
			Rude/obscene gestures; rude/obscene hand/finger gestures	5
			Complex compulsive motor tics such as: touching, tapping, or evening-up.	3
			Simple vocal tics such as: coughing, throat clearing, sniffing, snorting, humming, or grunting.	0
			Vocal tics such as: whistling (as a tic) or making animal or bird noises.	2
			Vocal tics such as: uttering syllables	2
			Vocal tics such as: uttering (non-obscene) words	3
			Repeatedly uttering rude or obscene words or phrases (as a tic).	5
			Repeating what someone else has said (sounds, single words, or sentences)	4
			Repeating something that you have said over and over again	4

At what age did your tics begin? _____ **years old** ☐ **Not sure/don't remember**

Are your tics still present? ☐ Yes ☐ No

Do you know when they are coming? ☐ Yes ☐ No

Can you control them (even just briefly)? ☐ Yes ☐ No

Have your tics occurred for a period of more than one year, even if they come and go? ☐ Yes ☐ No

Do/did the tics change over time (some tics disappear, while others appear)? ☐ Yes ☐ No

Have you been diagnosed with Tourette Syndrome by a clinician? Y N

What kind of clinician was it? neurologist psychiatrist psychologist pediatrician other

Name:_____ Date:_____

MOTOR TICS Check one box per line for each question about your current **motor** tics (in the past week)

Number of Current Motor Tics:	0 None ☐	1 **Single** motor tic ☐	2 **2-5** different motor tics ☐	3 **More than 5** different motor tics ☐	4 Multiple different tics plus **at least one pattern** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐	5 Multiple different tics plus **more than 2 patterns** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐
Frequency of Current Motor Tics:	0 No tics ☐	1 **Rarely have motor tics:** tics present during the past week, but not on daily basis ☐	2 **Occasionally have motor tics:** tics present daily but with long tic-free periods during the day ☐	3 **Frequently have motor tics:** tics present daily with tic-free periods as long as 3 hours ☐	4 **Almost Always have motor tics:** tics present every hour of the day ☐	5 **Always have motor tics:** tics present all the time with tic-free periods lasting only 5 to 10 minutes ☐
Intensity of Current Motor Tics:	0 No tics ☐	1 **Minimal Strength:** Motor tics are less strong than regular actions; they are generally not noticed by others ☐	2 **Mild Strength:** Motor tics are the same strength as regular actions ☐	3 **Moderate Strength:** Motor tics are stronger than regular actions and might call attention from others ☐	4 **Marked Strength:** Motor tics are stronger than regular actions and have an exaggerated quality. They frequently call attention from others ☐	5 **Severe Strength:** Motor tics are very strong and exaggerated and may cause physical injury because of their severity ☐
Interference (when motor tics are present):	0 None ☐	1 **Minimal:** tics do not interrupt the flow of activity or actions ☐	2 **Mild:** tics sometimes interrupt the flow of activity or actions ☐	3 **Moderate:** tics often interrupt the flow of activity or actions ☐	4 **Marked:** tics often interrupt the flow of activity or actions and they sometimes completely disrupt actions ☐	5 **Severe:** tics often disrupt actions ☐
FOR OFFICE USE ONLY Complexity of Motor Tics:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Please Turn Page -->

VOCAL TICS Check one box per line for each question about your current **vocal** tics (in the past week)

	0	1	2	3	4	5
Number of Current Vocal Tics:	None ☐	**Single** vocal tic ☐	**2-5** different vocal tics ☐	**More than 5** different vocal tics ☐	Multiple different tics **plus at least one pattern** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐	Multiple different tics plus **more than 2 patterns** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐
Frequency of Current Vocal Tics:	No tics ☐	**Rarely have vocal tics:** present during the past week, but not on daily basis ☐	**Occasionally have vocal tics:** tics present daily but with long tic-free periods during the day ☐	**Frequently have vocal tics:** tics present daily with tic-free periods as long as 3 hours ☐	**Almost Always have vocal tics:** tics present every hour of the day ☐	**Always have vocal tics:** tics present all the time with tic-free periods lasting only 5 to 10 minutes ☐
Intensity of Current Vocal Tics:	No tics ☐	**Minimal Strength:** Vocal tics are less strong than regular actions; they are generally not noticed by others ☐	**Mild Strength:** Vocal tics are the same strength as regular actions ☐	**Moderate Strength:** Vocal tics are stronger than regular actions and might call attention from others ☐	**Marked Strength:** Vocal tics are stronger than regular actions and have an exaggerated quality. They frequently call attention from others ☐	**Severe Strength:** Vocal tics are very strong and exaggerated and may cause physical injury because of their severity ☐
Interference (when vocal tics are present):	None ☐	**Minimal:** tics do not interrupt the flow of speech ☐	**Mild:** tics sometimes interrupt the flow of speech ☐	**Moderate:** tics often interrupt the flow of speech ☐	**Marked:** tics often interrupt the flow of speech, and they sometimes completely disrupt communication ☐	**Severe:** tics often disrupt communication ☐
FOR OFFICE USE ONLY Complexity of Vocal Tics:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Name:_____ Date:_____

C-FOCI

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

	In the past month?	Ever?
1. Concerns with contamination (dirt, germs, chemicals, radiation) or getting a serious illness such as AIDS?	☐Yes ☐ No	☐Yes ☐ No
2. Overconcern with keeping objects (clothing, toys, books) in perfect order or arranged exactly?	☐Yes ☐ No	☐Yes ☐ No
3. Images of death or other horrible events?	☐Yes ☐ No	☐Yes ☐ No
Have you worried a lot about terrible things happening, such as:		
4. Fire, burglary or flooding of the house?	☐Yes ☐ No	☐Yes ☐ No
5. Accidentally hitting a pedestrian with your car or letting it roll down a hill?	☐Yes ☐ No	☐Yes ☐ No
6. Spreading an illness (giving someone AIDS)?	☐Yes ☐ No	☐Yes ☐ No
7. Losing something valuable?	☐Yes ☐ No	☐Yes ☐ No
8. Harm coming to a loved one because you weren't careful enough?	☐Yes ☐ No	☐Yes ☐ No
Have you felt driven to perform certain acts over and over again, such as		
9. Excessive or ritualized washing, cleaning or grooming?	☐Yes ☐ No	☐Yes ☐ No
10. Checking light switches, water faucets, the stove, or door locks?	☐Yes ☐ No	☐Yes ☐ No
11. Counting, arranging; evening-up behaviors (making sure socks are at same height)?	☐Yes ☐ No	☐Yes ☐ No
12. Repeating routine actions (in/out of chair, going through doorway) a certain number of times or until it feels *just right*?	☐Yes ☐ No	☐Yes ☐ No
13. Needing to touch objects or people?	☐Yes ☐ No	☐Yes ☐ No
14. Unnecessary rereading or rewriting?	☐Yes ☐ No	☐Yes ☐ No
15. Examining your body for signs of illness?	☐Yes ☐ No	☐Yes ☐ No
16. Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (those that start with "D" signify death) that are associated with scary events or thoughts?	☐Yes ☐ No	☐Yes ☐ No
17. Needing to "confess" or repeatedly ask for reassurance that you said or did something correctly?	☐Yes ☐ No	☐Yes ☐ No
18. Excessive morning or bedtime rituals?	☐Yes ☐ No	☐Yes ☐ No

If you answered YES to three or more of these questions, please continue below.

Please Turn Page →

The following questions refer to the repeated thoughts, images, urges or behaviors identified above.
Check the box for the most appropriate number from 0 to 4 for how they have been in the last 30 days and also for how they were when they were their worst ever.

On average, how much time is occupied by these thoughts or behaviors each day?	0 none	1 mild (less than 1 hour)	2 moderate (1-3 hours)	3 severe (3-8 hours)	4 extreme (more than 8 hours)
In last 30 days	☐	☐	☐	☐	☐
Worst ever time	☐	☐	☐	☐	☐
How much do they bother you?	0 none	1 mild	2 moderate	3 severe	4 extreme
In last 30 days	☐	☐	☐	☐	☐
Worst ever time	☐	☐	☐	☐	☐
How hard is it for you to control them?	0 complete control	1 much control	2 moderate control	3 little control	4 no control
In last 30 days	☐	☐	☐	☐	☐
Worst ever time	☐	☐	☐	☐	☐
How much do they cause you to avoid doing things, going places, or being with people?	0 no avoidance	1 occasional avoidance	2 moderate avoidance	3 frequent and extensive avoidance	4 extreme avoidance (housebound)
In last 30 days					
Worst ever time	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
How much do they interfere with school, your social or family life, or your job?	0 none	1 slight interference	2 definitely interferes with functioning	3 much interference	4 extreme interference (disabling)
In last 30 days	☐	☐	☐	☐	☐
Worst ever time	☐	☐	☐	☐	☐
Office Use: Total score last 30 days (max=20)	_____				
Office Use: Total score worst ever time (max=20)_____	_____				

At what age did the symptoms begin? _____
At what age were they their worst? _____

Name:_____ Date:_____

The SNAP-IV Rating Scale

James M. Swanson, Ph.D.

For each item, check the column which best describes you when you were a child:	Not At All	Just A Little	Quite A Bit	Very Much
1. Often failed to give close attention to details or made careless mistakes in schoolwork or tasks				
2. Often had difficulty sustaining attention in tasks or play activities				
3. Often did not seem to listen when spoken to directly				
4. Often did not follow through on instructions and failed to finish schoolwork, chores, or duties				
5. Often had difficulty organizing tasks and activities				
6. Often avoided, disliked, or reluctantly engaged in tasks requiring sustained mental effort				
7. Often lost things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often was distracted by extraneous stimuli				
9. Often was forgetful in daily activities				
10. Often had difficulty maintaining alertness, orienting to requests, or executing directions				
11. Often fidgeted with hands or feet or squirmed in seat				
12. Often left seat in classroom or in other situations in which remaining seated was expected				
13. Often ran about or climbed excessively in situations in which it was inappropriate				
14. Often had difficulty playing or engaging in leisure activities quietly				
15. Often was "on the go" or often acted as if "driven by a motor"				
16. Often talked excessively				
17. Often blurted out answers before questions had been completed				
18. Often had difficulty awaiting turn				
19. Often interrupted or intruded on others (e.g., butted into conversations/games)				
20. Often had difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home				
21. Often loses temper				
22. Often argues with adults				
23. Often actively defies or refuses adult requests or rules				
24. Often deliberately does things that annoy other people				
25. Often blames others for his or her mistakes or misbehavior				
26. Often touchy or easily annoyed by others				
27 Often is angry and resentful				
28. Often is spiteful or vindictive				
29. Often is quarrelsome				
30. Often is negative, defiant, disobedient, or hostile toward authority figures				
31. Often makes noises (e.g., humming or odd sounds)				
32. Often is excitable, impulsive				
33. Often cries easily				
34. Often is uncooperative				
35. Often acts "smart"				
36. Often is restless or overactive				
37. Often disturbs other children				
38. Often changes mood quickly and drastically				
39. Often easily frustrated if demand are not met immediately				
40. Often teases other children and interferes with their activities				
41. Often is aggressive to other children (e.g., picks fights or bullies)				
42. Often is destructive with property of others (e.g., vandalism)				
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or "cons" others)				
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)				
45. Has persistent pattern of violating the basic rights of others or major societal norms				

Did any of these symptoms begin before age 7? Y N

If you answered "quite a bit" or "very much" to any of items 1-10, at what age did they begin? _____

If you answered "quite a bit" or "very much" to any of items 11-20, at what age did they begin? _____

Did these symptoms cause you difficulties at home? Y N

Did these symptoms cause you difficulties at school? Y N

Did these symptoms cause you difficulties in other public settings (church, synagogue, the grocery store, etc)? Y N

Did these problems interfere with your family life? Y N

Did these problems interfere with your social relations? Y N

Did these problems interfere with your daily life at school? Y N

Do you still have trouble with these symptoms? Y N

Have you ever been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? Y N

If yes, by whom? neurologist psychiatrist psychologist pediatrician other

How old were you when you were diagnosed? _____

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

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

Please Turn Page -->

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 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.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 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, fill in one circle 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.	○	○	○
2. I get headaches when I am at school.	○	○	○
3. I don't like to be with people I don't know well.	○	○	○
4. I get scared if I sleep away from home.	○	○	○
5. I worry about other people liking me.	○	○	○
6. When I get frightened, I feel like passing out.	○	○	○
7. I am nervous.	○	○	○
8. I follow my mother or father wherever they go.	○	○	○
9. People tell me that I look nervous.	○	○	○
10. I feel nervous with people I don't know well.	○	○	○
11. I get stomachaches at school.	○	○	○
12. When I get frightened, I feel like I am going crazy.	○	○	○
13. I worry about sleeping alone.	○	○	○
14. I worry about being as good as other kids.	○	○	○
15. When I get frightened, I feel like things are not real.	○	○	○
16. I have nightmares about something bad happening to my parents.	○	○	○
17. I worry about going to school.	○	○	○
18. When I get frightened, my heart beats fast.	○	○	○
19. I get shaky.	○	○	○
20. I have nightmares about something bad happening to me.	○	○	○

Please Turn Page -->

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 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.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
23. I am a worrier.	○	○	○
24. I get really frightened for no reason at all.	○	○	○
25. I am afraid to be alone in the house.	○	○	○
26. It is hard for me to talk with people I don't know well.	○	○	○
27. When I get frightened, I feel like I am choking.	○	○	○
28. People tell me that I worry too much.	○	○	○
29. I don't like to be away from my family.	○	○	○
30. I am afraid of having anxiety (or panic) attacks.	○	○	○
31. I worry that something bad might happen to my parents.	○	○	○
32. I feel shy with people I don't know well.	○	○	○
33. I worry about what is going to happen in the future.	○	○	○
34. When I get frightened, I feel like throwing up.	○	○	○
35. I worry about how well I do things.	○	○	○
36. I am scared to go to school.	○	○	○
37. I worry about things that have already happened.	○	○	○
38. When I get frightened, I feel dizzy.	○	○	○
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	○	○	○
41. I am shy.	○	○	○

Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
   - 0 I never take longer than 30 minutes to fall asleep.
   - 1 I take at least 30 minutes to fall asleep, less than half the time.
   - 2 I take at least 30 minutes to fall asleep, more than half the time.
   - 3 I take more than 60 minutes to fall asleep, more than half the time.
2. Sleep during the night:
   - 0 I do not wake up at night.
   - 1 I have a restless, light sleep with a few brief awakenings each night.
   - 2 I wake up at least once a night, but I go back to sleep easily.
   - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.
3. Waking up too early:
   - 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   - 1 More than half the time, I awaken more than 30 minutes before I need to get up.
   - 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   - 3 I awaken at least one hour before I need to, and can't go back to sleep.
4. Sleeping too much:
   - 0 I sleep no longer than 7–8 hours/night, without napping during the day.
   - 1 I sleep no longer than 10 hours in a 24-hour period including naps.
   - 2 I sleep no longer than 12 hours in a 24-hour period including naps.
   - 3 I sleep longer than 12 hours in a 24-hour period including naps.
5. Feeling sad:
   - 0 I do not feel sad.
   - 1 I feel sad less than half the time.
   - 2 I feel sad more than half the time.
   - 3 I feel sad nearly all of the time.
6. Decreased appetite:
   - 0 There is no change in my usual appetite.
   - 1 I eat somewhat less often or lesser amounts of food than usual.
   - 2 I eat much less than usual and only with personal effort.
   - 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

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Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

7. Increased appetite:
   - 0 There is no change from my usual appetite.
   - 1 I feel a need to eat more frequently than usual.
   - 2 I regularly eat more often and/or greater amounts of food than usual.
   - 3 I feel driven to overeat both at mealtime and between meals.
8. Decreased weight (within the last two weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight loss.
   - 2 I have lost 2 pounds or more.
   - 3 I have lost 5 pounds or more.
9. Increased weight (within the last two weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight gain.
   - 2 I have gained 2 pounds or more.
   - 3 I have gained 5 pounds or more.
10. Concentration/Decision making:
   - 0 There is no change in my usual capacity to concentrate or make decisions.
   - 1 I occasionally feel indecisive or find that my attention wanders.
   - 2 Most of the time, I struggle to focus my attention or to make decisions.
   - 3 I cannot concentrate well enough to read or cannot make even minor decisions.
11. View of myself:
   - 0 I see myself as equally worthwhile and deserving as other people.
   - 1 I am more self-blaming than usual.
   - 2 I largely believe that I cause problems for others.
   - 3 I think almost constantly about major and minor defects in myself.
12. Thoughts of death or suicide:
   - 0 I do not think of suicide or death.
   - 1 I feel that life is empty or wonder if it's worth living.
   - 2 I think of suicide or death several times a week for several minutes.
   - 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

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Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

13. General interest:

0 There is no change from usual in how interested I am in other people or activities.

1 I notice that I am less interested in people or activities.

2 I find I have interest in only one or two of my formerly pursued activities.

3 I have virtually no interest in formerly pursued activities.

14. Energy level:

0 There is no change in my usual level of energy.

1 I get tired more easily than usual.

2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).

3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

0 I think, speak, and move at my usual rate of speed.

1 I find that my thinking is slowed down or my voice sounds dull or flat.

2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.

3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

0 I do not feel restless.

1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.

2 I have impulses to move about and am quite restless.

3 At times, I am unable to stay seated and need to pace around.

Name:_____ Date:_____

Body-Related Behaviors and Concerns

For each applicable question below, please mark an X in the YES or NO column.

Chronic Hair Pulling	**YES**	**NO**
1) Have you ever been unable to stop pulling out your hair? (or eyebrows? or eyelashes?) If yes, describe:		
2) Did you end up with a bald spot or noticeable hair loss from your hair pulling?		
If **YES**, please continue below; If **NO**, please go to Nail Biting (item # 9)		
3) What effect has hair pulling had on your life?		
4) Has hair pulling caused you a lot of distress?		
5) Has your hair pulling had any effects on family, friends, or coworkers? If yes, describe:		
6) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
7) Do you feel a sense of pleasure, relief, or gratification upon completing the behavior?		
8) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		

Nail Biting	**YES**	**NO**
9) Have you ever been unable to stop biting your nails?		
If **YES**, please continue below; If **NO**, please go to Skin Picking (item #16)		
10) What effect has nail biting had on your life?		
11) Has nail-biting caused you a lot of distress?		
12) Has your nail biting had any effects on family, friends, or coworkers? If yes, describe:		
13) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
14) Do you feel a sense of pleasure, relief, or gratification upon completing the behavior?		

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15) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		
Skin Picking	**YES**	**NO**
16) Did you ever pick at your skin excessively?		
17) Did you ever pick at a scab or scar excessively?		
18) Were you unable to stop, even though you tried to?		
If **YES**, continue below; If **NO**, go to Body Dissatisfaction (item #25)		
19) What effect has skin picking had on your life?		
20) Has skin picking caused you a lot of distress?		
21) Has your skin picking had any effects on family, friends, or coworkers? If yes, describe:		
22) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
23) Does you feel a sense of pleasure, relief, or gratification upon completing the behavior?		
24) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		

Body Dissatisfaction	**YES**	**NO**
25) Have you ever been excessively bothered by something in your appearance?		
26) If yes, how often have you thought about it? In a typical day, approximately how much time would you spend thinking about this aspect of your appearance? For example, at least an hour a day? Describe:		
27) How much has this bothered you? What effect has this had on your life? Has it made it difficult for you to go to work or be with friends? Describe:		
28) How old were you when your concerns with your appearance started? Age of Onset = _____		
Office Use Only: Is preoccupation better accounted for by another disorder?		
Office Use Only: Is preoccupation markedly excessive or unrealistic?		

CAST

Child's Name: ..... Date:.....

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

1. Does s/he join in playing games with other children easily?	Yes	No
2. Does s/he come up to you spontaneously for a chat?	Yes	No
3. Was s/he speaking by 2 years old?	Yes	No
4. Does s/he enjoy sports?	Yes	No
5. Is it important to him/her to fit in with the peer group?	Yes	No
6. Does s/he appear to notice unusual details that others miss?	Yes	No
7. Does s/he tend to take things literally?	Yes	No
8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)?	Yes	No
9. Does s/he like to do things over and over again, in the same way all the time?	Yes	No
10. Does s/he find it easy to interact with other children?	Yes	No
11. Can s/he keep a two-way conversation going?	Yes	No
12. Can s/he read appropriately for his/her age?	Yes	No
13. Does s/he mostly have the same interests as his/her peers?	Yes	No
14. Does s/he have an interest which takes up so much time that s/he does little else?	Yes	No
15. Does s/he have friends, rather than just acquaintances?	Yes	No
16. Does s/he often bring you things s/he is interested in to show you?	Yes	No
17. Does s/he enjoy joking around?	Yes	No

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18. Does s/he have difficulty understanding the rules for polite behaviour?	Yes	No
19. Does s/he appear to have an unusual memory for details?	Yes	No
20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)?	Yes	No
21. Are people important to him/her?	Yes	No
22. Can s/he dress him/herself?	Yes	No
23. Is s/he good at turn-taking in conversation?	Yes	No
24. Does s/he play imaginatively with other children, and engage in role-play?	Yes	No
25. Does s/he often do or say things that are tactless or socially inappropriate?	Yes	No
26. Can s/he count to 50 without leaving out any numbers?	Yes	No
27. Does s/he make normal eye-contact?	Yes	No
28. Does s/he have any unusual and repetitive movements?	Yes	No
29. Is his/her social behaviour very one-sided and always on his/her own terms?	Yes	No
30. Does s/he sometimes say "you" or "s/he" when s/he means "I"?	Yes	No
31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts?	Yes	No
32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about?	Yes	No
33. Can s/he ride a bicycle (even if with stabilisers)?	Yes	No
34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems?	Yes	No
35. Does s/he care how s/he is perceived by the rest of the group?	Yes	No

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36. Does s/he often turn conversations to his/her favourite subject rather than following what the other person wants to talk about? Yes No

37. Does s/he have odd or unusual phrases? Yes No

SPECIAL NEEDS SECTION

Please complete as appropriate

38. Have teachers/health visitors ever expressed any concerns about his/her development? Yes No

If Yes, please specify.....

39. Has s/he ever been diagnosed with any of the following?:

Language delay Yes No

Hyperactivity/Attention Deficit Disorder (ADHD) Yes No

Hearing or visual difficulties Yes No

Autism Spectrum Condition, incl. Asperger's Syndrome Yes No

A physical disability Yes No

Other (please specify) Yes No