Bright Minds psychiatry

www.brightmindspsychiatry.com
575 Washington St, Unit 1B, Canton, MA 02021
Phone: 508-375-8980
Fax 508-734-5005

Thank you for choosing Bright Minds Psychiatry. Please review the information below and contact us with any questions.

Instructions for completing the New Client Registration Packet

Please print and complete the New Client Registration Packet prior to your first appointment. You'll need to bring the completed packet with you to your first appointment.

Note the following important information:

- Our focus population ranges from ages 6 through 22yrs of age.
- All clients MUST be actively engaged on ongoing individual/behavioral therapy, as we believe that a multidisciplinary treatment approach is the most effective to provide appropriate psychiatric care. Patients without active engagement on therapy will not be accepted.
- Each packet contains three Release of Information forms. One is for the client's current therapist, primary care provider and school. If there are additional providers you would like us to collaborate with, please print an additional copy of the Release of Information form to complete for each additional provider.

Preparing for your first appointment

- Arrive 15 min before your scheduled appointment.
- Bring your printed and completed New Client Registration Packet.
- Bring copies of relevant documents, including a list of your current medications, dose and most importantly, copy of your MOST RECENT Neuropsychiatric evaluation, IEP (psychological/Educational reports), or other formal evaluations.
- If you are transitioning from a different psychiatric provider please bring the INITIAL EVALUATION AND LATEST FOLLOW UP NOTE.
- All children (under 18) must be accompanied by a medical decision-maker (parent/guardian/DCF).
- We will need a copy of your insurance card to keep on file, so please bring your insurance card, along with your ID, to your first visit
- For clients who are paying privately, we will still need a copy of your insurance card for medication/prescribing purposes

Bright Minds Psychiatry shares office space with the Mind and Body Behavioral Health center. Look for signs for their office and have a seat in the waiting room when you arrive.

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CLIENT REGISTRATION

Client Name: ______________________________ **D.O.B:** ____ / ____ / ____

Age: ______ **Sex (please, circle one):** *Female* *Male* **Gender Identity:** ____________________

Preferred Pronouns: ____________________ **Address:** ____________________

City/State/Zip: ____________________ **Home Phone:** ( ) ____________________

Mobile: ( ) ____________________ **Email:** ____________________

Reminder preference (please, underline one): *(call | text | email)* **Occupation:** ____________________

Employer: ____________________ **Work Phone:** ( ) ____________________

SSN: ____________________ **Custody Status (please, circle one):** *Parent/Guardian* *Shared Custody* *D.F.C*

Minor Clients: Parent/Guardian Name: ______________________________

Primary Insurance Carrier: ____________________ **Identification #:** ____________________

Group #: __________ **Subscriber:** __________ **Subscriber Phone: ( )** ____________________

Subscriber Address: ______________________________ **D.O.B:** ____ / ____ / ____

Social Security #: ____________________ **Authorization #:** ____________________

# of Visits: __________ **Dates:** ______ — ______

I authorize the release of information necessary for the completion of any claim for insurance purposes. I further authorize appropriate medical payments to my provider. I acknowledge that I am responsible for such payments if not paid by my insurance carrier (s). Fees that are charged and not paid by the insurance company within 90 days are the responsibility of the client. I am aware that the use of cell phones does not guarantee confidentiality.

SIGNATURE: ______________________________ **DATE:** ____________________

(or signature of parent/guardian if under 18)

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OFFICE POLICIES

The providers at Bright Minds Psychiatry, PLLC, are committed to providing you with evidence based psychiatric care. As a client, you are expected to be involved in your care and actively participate in treatment. This includes attending you scheduled appointments and following through with treatment recommendations.

- If medication is prescribed, it is the client's right to receive information about the medication, including potential adverse effects.
-
- A legal guardian with medical decision-making authority must accompany minors. If there is split custody with joint medical decision-making authority, both guardians must be present to consent to treatment. Client will not be seen if both guardians are not present.

Fees and Payments

Payment is expected at the time services are rendered. Clients can pay by credit card or check.
As a client, you are responsible for:

- Determining if your insurance will reimburse you for care and obtaining a referral, if required by your insurance
- Determining insurance eligibility and tracking reimbursement
- Paying for all charges not reimbursed by your insurance company (Co-payments/Deductibles)

Services fees are collected for any services provided outside of appointment times (e.g. completion of forms, phone calls, collaboration with schools, etc.). Insurance does not typically reimburse for these fees.

Our fee schedule for all services, including appointments, is as follows:

- *Initial Evaluation:* $295
- *Follow-Up Appointments:* $145
- *Missed Appointments (any appointment not cancelled 48 hours in advance):* $100
- Additional Services (e.g. phone calls; letters; emails to schools, hospitals, primary care practitioners, and therapists; etc.): $25 per 10 min (10 min minimum)

We cannot currently provide legal documentation (e.g. disability paperwork)

Checks should be made payable to Bright Minds Psychiatry, PLLC. You can also pay with Visa, Mastercard. **Returned checks will be assessed with a $35 fee.**

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ATTENDANCE, CANCELLATIONS AND NO-SHOWS

In order to provide safe and effective care, every client is expected to arrive on time and attend to all scheduled appointments unless arrangements have been previously made. Follow up appointment are 30 min long and initial evaluation is 60 min long. If you arrive more than 10 min late for any appointment, you will not be seen and a No-show fee of $100 will be charged. Additionally, if you need to cancel/reschedule your appointment, you must do so 48hrs in advance. A No-show fee will be charged to those appointments not cancelled within the required time.

If you miss intermittent appointments or you miss two consecutive follow up sessions, your case will be closed.

EMERGENCIES

Please note that Bright Minds Psychiatry is a one-provider practice at this time, we cannot offer 24/7 coverage. This is one of the major limitations of private practice. If you require a higher level of care or comprehensive supports, we are happy to provide you with resources that can better serve you. **In the event of a life-threatening emergency, including threats violence to self or others, overdose, and other medical or psychiatric emergencies, you must call 911 or proceed immediately to your nearest emergency room- if it is safe to do so.**

PRESCRIPTION REFILLS

Prescription refill requests should be made 72 hours in advance by voice message (508) 375-8980. Please include your full name, date of birth, pharmacy, and the medication you are requesting. We do not accept refill requests solicited by pharmacies; requests must be made directly by the client/guardian.

PSYCHIATRY RECORDS

We maintain an electronic health record, which is standard practice in psychiatric care. Though clients are entitled to review these records, due to the sensitivity of the subject material and the possibility for misinterpretation, it may be deemed damaging to release these records to the client. If deemed potentially damaging, we can provide the full record to the mental health provider of your choice. In addition, we will gladly set up an appointment to review your record with you to discuss the contents of your record and/or provide you with a treatment summary.

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CONSENT TO POLICES AND TREATMENT

By signing below, I am acknowledging that I have read this agreement and agree to all terms. I am also consenting to receiving prescription medications as deemed appropriate by my provider, including possible neuroleptic or scheduled medications. I understand that if I violate the terms of this agreement, treatment outcomes could be impacted and may require termination. My signature below acknowledges that I have received a copy of this document if I requested it.

Client's Name / Guardians Signature: ______________________________ **Date:** ____________________

Provider Signature: ______________________________ **Date:** ____________________

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Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purpose of Treatment, Payment, and Health Care Operations

I consent to the use and disclosure of my protected health information (PHI) by Bright Minds Psychiatry, PLLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations at Bright Minds Psychiatry, PLLC.

I understand that diagnosis or treatment of me by Bright Minds Psychiatry, PLLC, might be conditioned upon my consent as evidenced by my signature on this document.
I understand that I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations. Bright Minds Psychiatry, PLLC, is not required to agree to the restrictions I request.

I understand that Bright Minds Psychiatry, PLLC, uses a variety of electronic communication methods, including phone, text messages, and e-mail to communicate with me for the limited purposes of appointments, available services, and other healthcare-related communications. I authorize Bright Minds Psychiatry, PLLC to disclose limited PHI to other persons who may answer my electronic communications (phone, text message, email, and voicemail). This may include information about appointments, available services, or other healthcare-related communications.

I have the right to revoke this consent, in writing, at any time, except to the extent that Bright Minds Psychiatry, PLLC, has taken action in reliance on this consent.

Client's Name / Guardians Signature: ______________________________ **Date:** ____________________

Provider Signature: _________________________________ **Date:** ____________________

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REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: ______________________________________ **D.O.B:** ____ / ____ / ____

I hereby authorize: (Name and address of outside provider)

____

____

To ☐ send / ☐ receive the following information from the record of the above named client:

☐ Psychiatric evaluation
☐ Progress Notes; Psychotherapy Notes
☐ Medical Exam/Lab Results
☐ Psychological Testing Results
☐ Case History
☐ Hospital Admission and Discharge Summaries
☐ Other: ____
☐ All health information, excluding: _________________________________

This information is needed for the purpose of coordination of care.

I understand that my record may contain information about infectious diseases including HIV/AIDS status, alcohol or drug abuse, STDs, information relative to the diagnosis and treatment of my mental or emotional conditions. I consent to this information being disclosed. I understand that the provider abides by Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191which protects the confidentiality of the record and that information in my record cannot be disclosed without consent unless otherwise provided for in the regulation.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon termination of care or from date: ____________________

I herewith release and hold harmless Bright Minds Psychiatry, PLLC and any contractors, agents, employees, directors or volunteers from any liability for the release of information provided in accordance with this directive.

If information is requested, please send to:
Bright Minds Psychiatry - Phone: 508-375-8980 - Fax 508-734-5005 - 575 Washington St, Unit 1B, Canton, MA 02021.
Signed under the pains and penalties of perjury:

Client's Name / Guardians Signature: _________________________ **Date:** _________________

*** REVOCATION** OF REQUEST FOR INFORMATION - To be signed when revoking this release.*
Client's Name / Guardians Signature: _________________________ **Date:** _________________

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: _______________________________________ Date of Birth: ______________

Parent's Name: _______________________________________ Parent's Phone Number: __________________________

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

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

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

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

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

Revised - 1102

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NICHQ

National Initiative for Children's Healthcare Quality

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: ____

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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

Revised - 0303

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National Initiative for Children's Healthcare Quality

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Consumer & Specialty Pharmaceuticals

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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Consumer & Specialty Pharmaceuticals

11-20/rev0303

MOOD AND FEELINGS QUESTIONNAIRE: Short Version

This form is about how your child might have been feeling or acting **recently**.

For each question, please check (✓) how s/he has been feeling or acting ***in the past two weeks***.

If a sentence was not true about your child, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about your child most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. S/he felt miserable or unhappy.			
2. S/he didn't enjoy anything at all.			
3. S/he felt so tired that s/he just sat around and did nothing.			
4. S/he was very restless.			
5. S/he felt s/he was no good anymore.			
6. S/he cried a lot.			
7. S/he found it hard to think properly or concentrate.			
8. S/he hated him/herself.			
9. S/he felt s/he was a bad person.			
10. S/he felt lonely.			
11. S/he thought nobody really loved him/her.			
12. S/he thought s/he could never be as good as other kids.			
13. S/he felt s/he did everything wrong.			

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MOOD AND FEELINGS QUESTIONNAIRE: Short Version

This form is about how you might have been feeling or acting **recently**.

For each question, please check (✓) how you have been feeling or acting ***in the past two weeks***.

If a sentence was not true about you, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about you most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	**NOT TRUE**	**SOME TIMES**	**TRUE**
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I felt so tired I just sat around and did nothing.			
4. I was very restless.			
5. I felt I was no good anymore.			
6. I cried a lot.			
7. I found it hard to think properly or concentrate.			
8. I hated myself.			
9. I was a bad person.			
10. I felt lonely.			
11. I thought nobody really loved me.			
12. I thought I could never be as good as other kids.			
13. I did everything wrong.			

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Screen for Child Anxiety Related Disorders (Scared)

Child Version - Page 1 of 2 (to be filled 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 for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my par-ents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

Screen for Child Anxiety Related Disorders (Scared)

Child Version - Page 2 of 2 (to be filled 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	o	o	o
22.	When I get frightened, I sweat a lot	o	o	o
23.	I am a worrier	o	o	o
24.	I get really frightened for no reason at all	o	o	o
25.	I am afraid to be alone in the house	o	o	o
26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
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)	o	o	o
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	o	o	o
41.	I am shy	o	o	o

**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.*

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Screen for Child Anxiety Related Disorders (Scared)

Parent Version - Page 1 of 2 (to be filled 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	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (Scared)

Parent Version - Page 2 of 2 (to be filled 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	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
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)	o	o	o
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	o	o	o
41.	My child is shy	o	o	o

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