Anxiety / Depression Information Packet

Dear Parent:

You have recently called Mesa Pediatrics to set up an appointment for your child to be evaluated due to concerns for depression / anxiety. In order to best evaluate your child, our doctor will need the following information at the time of your visit.

To be completed by the patient if > 12 years of age:
- PHQ-9
- SCARED form

To be completed / reviewed by the parents:
- Intake form
- Confidentiality statement

Please return the documents to Mesa Pediatrics as soon as you can.

Thank you,

Mesa Pediatrics

ANXIETY / DEPRESSION INTAKE FORM

Patient's name: _____

Date of birth: _____ Age: _____ [ ] Male [ ] Female

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship	Age	Sex	Mental Illness

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? [ ] yes [ ] no

If yes, where: _____

Approximate dates of counseling: _____

Has your son or daughter previously seen a psychiatrist? [ ] yes [ ] no

If yes, who and for what diagnosis: _____

Has your son or daughter taken medication for a mental health concern? [ ] yes [ ] no

If yes please list: _____

CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGE				
SLEEP PROBLEMS					LOW ENERGY				
HYPERACTIVITY					POOR CONCENTRATION				
IRRITABILITY					LOW SELF WORTH				
ANXIETY					EXCESSIVE WORRY				
DRUG USE					ALCOHOL USE				
SCHOOL PROBLEMS					PANIC ATTACKS				
MOOD SWINGS					OBSESSIVE THOUGHTS				
HEADACHES					LONELINESS				
PHOBIAS					HALLUCINATIONS				
CUTTING					RACING THOUGHTS				
SUICIDAL THOUGHTS					PAST SUICIDE ATTEMPTS				

PHQ-9 modified for Adolescents (PHQ-A)

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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

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) CHILD Version

TO BE COMPLETED BY CLINICIAN

Name: _____ Date: _____

SCORING:

A total score of ≥ **25 may** indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL=**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 **may** indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PA/SO =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 **may** indicate **Generalized Anxiety Disorder**. **GA=**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 **may** indicate **Separation Anxiety Disorder**. **SEP=**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 **may** indicate **Social Phobic Disorder**. **SOC =**

A score of **3** for items 2, 11, 17, 36 **may** indicate **Significant School Avoidance Symptoms**. **SCH=**

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

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.

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January 19, 2018

Notice of Adolescent Confidentiality for Parents

When speaking with their health care provider, your adolescent has the right to confidentiality.

This means that some of the issues that are discussed with a patient will be private and that we as health care providers will not disclose that information to anyone, including you, unless we have been given permission by the patient to do so. This is in keeping with recognized standards and mandates of practice.

There are limits to this confidentiality. If a health care provider learns that a teen is being abused, or is thinking about hurting him/her self or others, the proper authorities will be contacted.

Please sign this statement and have your child sign to indicate that the policy has been reviewed.

Parent signature _____ **Date** _____

Patient signature _____ **Date** _____