Swanson, Conti & Associates
A Psychological Corporation
818.986.9666
www.SwansonContiAndAssociates.com

Encino Medical Plaza
5400 Balboa Boulevard, Suite 311
Encino, California, 91316

# CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE

Today's Date: _____ Completed by: _____

## Background Information

Child / Patient

Name: _____

Date of Birth: _____ Chronological Age: _____

School: _____ Grade:_____

Mother

Name: _____ Home Phone:_____

Home Address: _____

Occupation: _____ Work Phone: _____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Remarried ☐ Widowed

Current Spouse/Partner: ☐ Father ☐ Other :_____

Father

Name: _____ Home Phone:_____

Home Address: _____

Occupation: _____ Work Phone: _____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Remarried ☐ Widowed

Current Spouse/Partner: ☐ Mother☐ Other :_____

# Dr. Conti's Fee Schedule

## Therapy Sessions, Case Management, Assessment and Report Writing

50 minutes ..... $200

Missed Appointments / Cancellations without 24hr. notification..... $200

## Phone Calls (*including clinical consultation and conversations with clients*)

5 minutes or less ..... $0

6 minutes to 20 minutes ..... $65

21 minutes to 35 minutes ..... $135

36 minutes to 50 minutes ..... $200

## Clinical Observation and On-site Visits (*Billing occurs from the moment Dr. Conti leaves her office or residence to the times he returns. One hour minimum*)

50 minutes ..... $225

75 minutes ..... $335

100 minutes ..... $445

125 minutes ..... $550
(*Billing for longer appointments will be clarified in advance*)

## Billing Matters (*Payment is expected at each session)*

Super Bill for insurance reimbursement

One Super Bill per six visits ..... $0

Additional / More Frequent Super Bills (*per bill*) ..... $25

Billing for accounts outstanding

First billing ..... $35

Additional billing for amounts not paid within 30 days of first bill . $50

# Billing Information

Name: _____

Address _____

_____

## Credit Card Information (Required)

SCA requires a credit card on file to be used for balances outstanding for more that 7 days. If you choose, we can keep your credit card information on file and charge for services after they have been delivered.

Would you like to use your credit card as your primary form of payment for services?

☐ Yes If yes, Initial _____ ☐ No

*If Yes, you will also need to complete a "Permission to Use Credit Card to Bill for Services" form.*

Type of Card: ☐ Visa ☐ Mastercard

☐ American Express ☐ Discover

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ / _____ Security Code: _____

***By signing below, I give Swanson, Conti & Associates ("SCA") permission to bill my credit card for any and all balances outstanding for more than 14 days. I acknowledge that I have been given a Fee for Service Schedule ("FFS") before the beginning of treatment and I understand that any and all charges will be billed in accordance with the FFS. Furthermore, I understand that a fee of $6.00 will be applied for all transactions completed.***

_____ _____

Signature of Card Holder Date

## Insurance Information

Will you be requesting a superbill to submit to your insurance carrier?

☐ Yes ☐ No

If you answered yes, please complete:

Name on Policy: _____

Insurance Carrier: _____

Policy No: _____

Address: _____

Phone: _____

## Referral Information

Referred by: _____

Relationship to Patient: _____

Address: _____

_____

Phone: _____

Permission to contact? ☐ Yes If yes, Initial _____ ☐ No

Describe the reasons for the referral / reasons you are requesting therapy. If possible, list specific questions for which answers are sought.

_____

_____

_____

_____

# Family Information

Language spoken in the home if not English: _____

List all people now living in the household:

| | (1) | (2) | (3) |
|---|---|---|---|
| Name: | _____ | _____ | _____ |
| Relationship: | _____ | _____ | _____ |
| Name to child: | _____ | _____ | _____ |
| Age: | _____ | _____ | _____ |
| With child now? | _____ | _____ | _____ |
| Occupation: | _____ | _____ | _____ |

| | (4) | (5) | (6) |
|---|---|---|---|
| Name: | _____ | _____ | _____ |
| Relationship: | _____ | _____ | _____ |
| Name to child: | _____ | _____ | _____ |
| Age: | _____ | _____ | _____ |
| With child now? | _____ | _____ | _____ |
| Occupation: | _____ | _____ | _____ |

Please indicate if any children in the household were adopted and dates of any previous marriages, divorces or remarriages of parents. Describe custody arrangements. Describe any deaths in the immediate family. Note any unusual family circumstances.

_____

_____

_____

_____

# Current Care Providers

Current Pediatric Care

Pediatrician/Physician: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Permission to talk to pediatrician? ☐ Yes _____ (Please initial if yes) ☐ No

Current Psychiatric Care

Psychiatrist: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Permission to talk to psychiatrist? ☐ Yes _____ (Please initial if yes) ☐ No

Other Current Care Providers:

Other Current Care Provider ☐ None

Name and Type of Provider: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Permission to talk to provider? ☐ Yes _____ (Please initial if yes) ☐ No

Other Current Care Provider ☐ None

Name and Type of Provider: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Permission to talk to provider? ☐ Yes _____ (Please initial if yes) ☐ No

## Pregnancy and Birth History

Describe any complications that occurred during pregnancy:

_____

_____

_____

_____

Describe any complications that occurred during delivery (e.g., prematurity, postmaturity, length of labor, special procedures, etc.).

_____

_____

Birth Length: _____ Birth Weight: _____

How long after birth did you take your baby home? _____

## Early Childhood

Early Temperament

Describe your child's temperament during the first six months (i.e., sleep patterns, colic, eating patterns).

_____

_____

_____

_____

Developmental History

Note the approximate ages of the following:

Toileting:

Sitting unsupported _____

Urine daytime _____

Urine nighttime _____

Bowel daytime _____

Bowel nighttime _____

Walking alone _____

Using single words _____

Using two to three words together _____

Which hand does your child prefer? Right _____ Left _____ Mixed _____

Approximate age established _____

## Medical History

List sicknesses operations and injuries. Note history of frequent ear infections, ruptured eardrums, tubes. Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

_____

_____

_____

_____

_____

_____

_____

_____

Is there anyone in your immediate family or biologically related to your child that currently experiences or has previously experienced the following?

Nervous tics: Yes ____ No ____ Who? _____

Seizures (epilepsy): Yes ____ No ____ Who? _____

Depression: Yes ____ No ____ Who? _____

Bipolar Disorder: Yes ____ No ____ Who? _____

Thyroid problems: Yes ____ No ____ Who? _____

Emotional problems: Yes ____ No ____ Who? _____

ADHD: Yes ____ No ____ Who? _____

Learning problems: Yes ____ No ____ Who? _____

Language problems: Yes ____ No ____ Who? _____

Mental retardation: Yes ____ No ____ Who? _____

Left-handedness: Yes ____ No ____ Who? _____

Similar problems as child: Yes ____ No ____ Who? _____

Does any disease run in the family? Yes ____ No ____

If so, what? _____

## Current Medication

Indicate any medications your child is *currently* taking and prescribing physician. (Include dosage and the reason for taking it.)

| Medication | Dose (mg./ml.) | Time Administered |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Previous Medication

Indicate any medication your child has taken in the past *for more than a month* and the prescribing physician. (Include dosage and the reason for taking it.)

| Medication | Prescribing Physician | Why Stopped |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Vision and Hearing Care

Has your child's vision been examined? _____ Date last examined: _____

If so, by whom? _____

Results: _____

Has your child's hearing been examined? _____ Date last examined: _____

If so, by whom? _____

Results: _____

## Other Relevant Psychological / Medical History

<u>Medical</u>
Other special medical tests (EEG, CAT scan, MRI):

Name of Test: _____ Date tested:_____

Results: _____

Name of Test: _____ Date tested:_____

Results: _____

Psychological

Have there been any previous psychological, psychiatric or neurological evaluations? If so, please list names, addresses and dates of contact.

Please attach any pertinent reports.

| Date(s) | Name of Assessor | Phone | Address |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Diagnoses Given: _____

| Date(s) | Name of Assessor | Phone | Address |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Diagnoses Given: _____

| Date(s) | Name of Assessor | Phone | Address |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Diagnoses Given: _____

## Social/Emotional/Behavioral History

List your child's personality characteristics, both positive and negative:

_____

_____

_____

_____

Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, difficulties paying attention, destructiveness, unusual habits, fears, tenseness, etc.).

_____

_____

_____

Describe your current discipline techniques:

_____

_____

_____

Effective? ☐ Yes ☐ No If 'No,' please explain why _____

_____

Who disciplines? _____

Do parents agree on how to discipline? _____

Please explain any parenting challenges: _____

_____

How does your child respond to discipline? _____

_____

## School History

List previous schools attended with dates or years (include nursery school and preschool):

| School | Grades / Dates Attended |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List current teachers and subjects taught:
(Please bring copies of prior report card to the first meeting)

| Teacher's Name | Subject Taught | Current Grade |
| --- | --- | --- |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Teacher's Name | Subject Taught | Current Grade |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Permission to talk to teachers and other school personnel?

☐ Yes _____ (Please initial if yes) ☐ No

Describe any learning/behavioral/social difficulties at school:

_____

_____

_____

_____

Has your child received any special services in school (resource room, tutors, remedial reading, speech therapy, etc.)? ☐ Yes ☐ No

If so, Date placed: _____ How often? _____

Does your child currently have an IEP or 504 in place? ☐ Yes ☐ No
If so, please provide a copy

Has your child received any special services privately? ☐ Yes ☐ No

| | (1) | (2) |
|---|---|---|
| Name: | _____ | _____ |
| Phone: | _____ | _____ |
| Type of Service: | _____ | _____ |
| Date begun | _____ | _____ |

| | (3) | (4) |
|---|---|---|
| Name: | _____ | _____ |
| Phone: | _____ | _____ |
| Type of Service: | _____ | _____ |
| Date begun | _____ | _____ |

Describe services, how often seen, length of time, effectiveness:

(1) _____

(2) _____

(3) _____

(4) _____

Has your child ever repeated a grade? _____ When? _____

What was the problem? _____

_____

_____

## Addition Comments

I very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments below or on a separate sheet of paper as needed. When you come for your first appointment, please bring copies of any reports or report cards previously received. The more you can bring the better. Please also bring copies of any prior standardized achievement testing the school may have done.

_____

_____

## Symptom Checklists

On the following pages, you will find two copies of a symptoms checklist. Please complete both independently, the mother and father checklist, and bring them to the first meeting.

# Mother's Checklist

Child's name: _____ Date Completed: _____

Answer *Yes* only if the behavior is *considerably more frequent* than that of most people the same age as your child and has persisted for at least six months.

Section A

| Yes | No | |
|---|---|---|
| [ ] | [ ] | 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities |
| [ ] | [ ] | 2. Often has difficulty sustaining attention in tasks or play activities |
| [ ] | [ ] | 3. Often does not seem to listen when spoken to directly |
| [ ] | [ ] | 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) |
| [ ] | [ ] | 5. Often has difficulty organizing tasks and activities |
| [ ] | [ ] | 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) |
| [ ] | [ ] | 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) |
| [ ] | [ ] | 8. Is often easily distracted by extraneous stimuli (sights or sounds or objects unrelated to the task at hand) |
| [ ] | [ ] | 9. Is often forgetful in daily activities |
| [ ] | [ ] | 10. Some of the behaviors listed under Section A have been present before age 7 |
| [ ] | [ ] | 11. The behaviors listed under Section A cause problems at home, school and/or elsewhere |

Section B

| Yes | No | | |
|---|---|---|---|
| [ ] | [ ] | 1. | Often fidgets with hands or feet or squirms in seat |
| [ ] | [ ] | 2. | Often leaves seat in classroom or in other situations in which remaining seated is expected |
| [ ] | [ ] | 3. | Often runs about or climbs excessively in situations in which it Is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) |
| [ ] | [ ] | 4. | Often has difficulty playing or engaging in leisure activities quietly |
| [ ] | [ ] | 5. | Is often "on the go" or often acts as if "driven by a motor" |
| [ ] | [ ] | 6. | Often talks excessively |
| [ ] | [ ] | 7. | Often blurts out answers before questions have been completed |
| [ ] | [ ] | 8. | Often has difficulty awaiting turns |
| [ ] | [ ] | 9. | Often interrupts or intrudes on others (e.g., butts into conversations or games) |
| [ ] | [ ] | 10. | Some behaviors listed under Section B have been present before age 7 |
| [ ] | [ ] | 11. | The behaviors listed under Section B cause problems at home, school and/or elsewhere |

Section C

| Yes | No | | |
|---|---|---|---|
| *Aggression towards people and animals* | | | |
| [ ] | [ ] | 1. | Often bullies, threatens, or intimidates others |
| [ ] | [ ] | 2. | Often initiates physical fights |
| [ ] | [ ] | 3. | Has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun) |
| [ ] | [ ] | 4. | Has been physically cruel to people |

[ ] [ ] 5. Has been physically cruel to animals

[ ] [ ] 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)

[ ] [ ] 7. Has forced someone into sexual activity

*Destruction of property*

[ ] [ ] 8. Has deliberately engaged in fire setting with the intention of causing serious damage

[ ] [ ] 9. Has deliberately destroyed others' property (other than by fire setting)

*Deceitfulness or theft*

[ ] [ ] 10. Has broken into someone else's house, building or car

[ ] [ ] 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "con" others)

[ ] [ ] 12. Has stolen items of nontrivial value without confronting a victim (shoplifting, but without breaking and entering; forgery)

*Serious violations of rules*

[ ] [ ] 13. Often stays out at night despite parental prohibitions, beginning before age 13

[ ] [ ] 14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

[ ] [ ] 15. Is often truant from school, beginning before age 13 (for older person, absent from work)

Section D

Yes No

[ ] [ ] 1. Often loses temper

[ ] [ ] 2. Often argues with adults

[ ] [ ] 3. Often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home

[ ] [ ] 4. Often deliberately does things that annoy other people, e.g., grabs other children's hats

[ ] [ ] 5. Often blames others for his or her own mistakes or misbehavior

[ ] [ ] 6. Is often touchy or easily annoyed by others

[ ] [ ] 7. Is often angry and resentful

[ ] [ ] 8. Is often spiteful or vindictive

Section E

Answer "*Yes*" only if the response is clearly not due to a general medical condition.

Yes No

[ ] [ ] 1. Seems to experience a depressed mood most of the day, Nearly every day, as indicated by either subjective report (e.g., "I feel sad or empty") or observation made by others (e.g., appears tearful). Note: In children and adolescents, this can include irritable mood.

[ ] [ ] 2. Appears to have experienced a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account observation made by others).

[ ] [ ] 3. Has experienced a significant weight loss not related to dieting or has experienced a significant weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

[ ] [ ] 4. Has been sleeping too much or too little nearly every day.

[ ] [ ] 5. Has displayed an increase or decrease in motor activity nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

[ ] [ ] 6. Has experienced fatigue or loss of energy nearly every day.

[ ] [ ] 7. Has experienced feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).

[ ] [ ] 8. Has experienced a diminished ability to think or concentrate, or seems more indecisive, nearly every day (either by subjective account or as observed by others).

[ ] [ ] 9. Has experienced recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

[ ] [ ] 10. The symptoms listed in Section E cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.

[ ] [ ] 11. To the best of your knowledge, are the symptoms listed in Section E related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

If so, please explain: _____

_____

_____

[ ] [ ] 12. To the best of your knowledge, are the symptoms listed in section E related to bereavement (i.e., after the loss of a loved one).

[ ] [ ] 13. Have the symptoms listed in Section E persisted for longer than 2 months.

[ ] [ ] 14. Does your child possess a preoccupation with suicidal ideation.

Section F

Yes No

[ ] [ ] 1. Experienced excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

[ ] [ ] 2. Has difficulty controlling the worry.

[ ] [ ] 3. Feels restlessness or feeling keyed up or on edge.

[ ] [ ] 4. Is easily fatigued.

[ ] [ ] 5. Experiences difficulty concentrating or mind going blank.

[ ] [ ] 6. Is often irritable.

[ ] [ ] 7. Reports muscle tension.

[ ] [ ] 8. Has experienced a disturbance in sleep (difficulty falling or staying asleep, or restless unsatisfying sleep).

[ ] [ ] 9. Experiences panic attacks.

[ ] [ ] 10. Has unusual obsessive rituals, interests or thoughts.

[ ] [ ] 11. Has multiple physical complaints.

[ ] [ ] 12. Has intense fears

If yes, please explain:

_____

_____

_____

[ ] [ ] 13.Avoids public places

[ ] [ ] 14.Is afraid to separate from parents or primary care givers

[ ] [ ] 15.Has experiences a major or traumatic life event

If yes, please explain:_____

_____

_____

[ ] [ ] 16. The symptoms listed in Section F cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.

[ ] [ ] 17. To the best of your knowledge, are the symptoms listed in Section F related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

# Father's Checklist

Child's name: _____ Date Completed: _____

Answer *Yes* only if the behavior is *considerably more frequent* than that of most people the same age as your child and has persisted for at least six months.

Section A

| Yes | No | | |
|---|---|---|---|
| [ ] | [ ] | 1. | Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities |
| [ ] | [ ] | 2. | Often has difficulty sustaining attention in tasks or play activities |
| [ ] | [ ] | 3. | Often does not seem to listen when spoken to directly |
| [ ] | [ ] | 4. | Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) |
| [ ] | [ ] | 5. | Often has difficulty organizing tasks and activities |
| [ ] | [ ] | 6. | Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) |
| [ ] | [ ] | 7. | Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) |
| [ ] | [ ] | 8. | Is often easily distracted by extraneous stimuli (sights or sounds or objects unrelated to the task at hand) |
| [ ] | [ ] | 9. | Is often forgetful in daily activities |
| [ ] | [ ] | 10. | Some of the behaviors listed under Section A have been |

present before age 7

[ ] [ ] 11. The behaviors listed under Section A cause problems at home, school and/or elsewhere

Section B

Yes No

[ ] [ ] 1. Often fidgets with hands or feet or squirms in seat

[ ] [ ] 2. Often leaves seat in classroom or in other situations in which remaining seated is expected

[ ] [ ] 3. Often runs about or climbs excessively in situations in which it Is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

[ ] [ ] 4. Often has difficulty playing or engaging in leisure activities quietly

[ ] [ ] 5. Is often "on the go" or often acts as if "driven by a motor"

[ ] [ ] 6. Often talks excessively

[ ] [ ] 7. Often blurts out answers before questions have been completed

[ ] [ ] 8. Often has difficulty awaiting turns

[ ] [ ] 9. Often interrupts or intrudes on others (e.g., butts into conversations or games)

[ ] [ ] 10. Some behaviors listed under Section B have been present before age 7

[ ] [ ] 11. The behaviors listed under Section B cause problems at home, school and/or elsewhere

Section C

Yes No

*Aggression towards people and animals*

[ ] [ ] 1. Often bullies, threatens, or intimidates others

[ ] [ ] 2. Often initiates physical fights

[ ] [ ] 3. Has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun)

[ ] [ ] 4. Has been physically cruel to people

[ ] [ ] 5. Has been physically cruel to animals

[ ] [ ] 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)

[ ] [ ] 7. Has forced someone into sexual activity

*Destruction of property*

[ ] [ ] 8. Has deliberately engaged in fire setting with the intention of causing serious damage

[ ] [ ] 9. Has deliberately destroyed others' property (other than by fire setting)

*Deceitfulness or theft*

[ ] [ ] 10. Has broken into someone else's house, building or car

[ ] [ ] 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "con" others)

[ ] [ ] 12. Has stolen items of nontrivial value without confronting a victim (shoplifting, but without breaking and entering; forgery)

*Serious violations of rules*

[ ] [ ] 13. Often stays out at night despite parental prohibitions, beginning before age 13

[ ] [ ] 14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

[ ] [ ] 15. Is often truant from school, beginning before age 13 (for older person, absent from work)

Section D

Yes No

[ ] [ ] 1. Often loses temper

[ ] [ ] 2. Often argues with adults

[ ] [ ] 3. Often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home

[ ] [ ] 4. Often deliberately does things that annoy other people, e.g., grabs other children's hats

[ ] [ ] 5. Often blames others for his or her own mistakes or misbehavior

[ ] [ ] 6. Is often touchy or easily annoyed by others

[ ] [ ] 7. Is often angry and resentful

[ ] [ ] 8. Is often spiteful or vindictive

Section E

Answer "*Yes*" only if the response is clearly not due to a general medical condition.

Yes No

[ ] [ ] 1. Seems to experience a depressed mood most of the day, Nearly every day, as indicated by either subjective report (e.g., "I feel sad or empty") or observation made by others (e.g., appears tearful). Note: In children and adolescents, this can include irritable mood.

[ ] [ ] 2. Appears to have experienced a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account observation made by others).

[ ] [ ] 3. Has experienced a significant weight loss not related to dieting or has experienced a significant weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

[ ] [ ] 4. Has been sleeping too much or too little nearly every day.

[ ] [ ] 5. Has displayed an increase or decrease in motor activity nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

[ ] [ ] 6. Has experienced fatigue or loss of energy nearly every day.

[ ] [ ] 7. Has experienced feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).

[ ] [ ] 8. Has experienced a diminished ability to think or concentrate, or seems more indecisive, nearly every day (either by subjective account or as observed by others).

[ ] [ ] 9. Has experienced recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

[ ] [ ] 10. The symptoms listed in Section E cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.

[ ] [ ] 11. To the best of your knowledge, are the symptoms listed in Section E related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

If so, please explain: _____

_____

_____

[ ] [ ] 12. To the best of your knowledge, are the symptoms listed in section E related to bereavement (i.e., after the loss of a loved one).

[ ] [ ] 13. Have the symptoms listed in Section E persisted for longer than 2 months.

[ ] [ ] 14. Does your child possess a preoccupation with suicidal ideation.

Section F

Yes No

[ ] [ ] 1. Experienced excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

[ ] [ ] 2. Has difficulty controlling the worry.

[ ] [ ] 3. Feels restlessness or feeling keyed up or on edge.

[ ] [ ] 4. Is easily fatigued.

[ ] [ ] 5. Experiences difficulty concentrating or mind going blank.

[ ] [ ] 6. Is often irritable.

[ ] [ ] 7. Reports muscle tension.

[ ] [ ] 8. Has experienced a disturbance in sleep (difficulty falling or staying asleep, or restless unsatisfying sleep).

[ ] [ ] 9. Experiences panic attacks.

[ ] [ ] 10. Has unusual obsessive rituals, interests or thoughts.

[ ] [ ] 11. Has multiple physical complaints.

[ ] [ ] 12. Has intense fears

If yes, please explain:

_____

_____

_____

[ ] [ ] 13.Avoids public places

[ ] [ ] 14.Is afraid to separate from parents or primary care givers

[ ] [ ] 15.Has experiences a major or traumatic life event

If yes, please explain:_____

_____

_____

[ ] [ ] 16. The symptoms listed in Section F cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.

[ ] [ ] 17. To the best of your knowledge, are the symptoms listed in Section F related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).