LIFENET PSYCHIATRY
500 Mariners Plaza Dr., Suite 504
Mandeville, LA 70448
(985) 246-1250
Fax (985) 246-1251
admin@lifenetpsych.com

CONSENT TO EVALUATE AND TREAT

Patient: _____ Age: _____ Date of Birth: _____

Sex: _____ Race: Black____ Hispanic____ White____ Other _____ Marital Status: _____

Address: _____ City: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

SSN: _____ Education Level: _____ Do you smoke? Y N

School/Employer Name: _____ Phone #: _____

Email Address: _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referral Source: _____ Phone #: _____

Pharmacy Name: _____ Location: _____
Any Medication Allergies: _____
Approximate occurrence date: _____ Type of Reaction: _____

Insurance Carrier: _____
Policy or Member ID #: _____ Group#: _____

Policy Holder/Guarantor:
Name: _____ Relationship to Patient: _____
DOB: _____ SS#: _____ Phone #: _____
If Address is different than above:
_____

I authorize LifeNet Psychiatry to evaluate and treat:(please complete here if 18 or older)

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian, having the authority to authorize treatment of minor: (please complete here if patient is under the age of 18)

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

LIFENET PSYCHIATRY
PATIENT RIGHTS/RESPONSIBILITIES

PATIENT RIGHTS:

Privacy and Confidentiality: All records and communications about me will be treated confidentially in compliance with applicable state and federal laws.

Complete and Current information: All information regarding your diagnosis, treatment and prognosis, the nature and purpose of tests, prescribed therapy and/or medications, and potential adverse effects associated with the treatment plan.

Clear Instructions: Clear and precise information concerning the need for follow-up visits, referral to other healthcare professionals, or additional measures necessary to achieve the desired outcome for your diagnosis.

Accept or Refuse Treatment: You as a patient have the right to accept any or all of the treatment plan after receiving a complete explanation.

A Copy of Medical Records: You may receive a copy of your records after a payment of reasonable copying fees and account balances, if any.

Information about your account: You have the right to receive the amount and purpose of charges and policies regarding payment of charges as well as procedures for resolving conflicts in the settlement of the patient's account.

PATIENT RESPONSIBILITIES:

Patient Information: Provide correct and complete information about your health.

Follow the Treatment Plan: Follow instructions by your Psychiatric Practitioner unless you notify him of concerns.

Take Responsibility for Your Actions: If you refuse treatment or do not follow your treatment provider's instructions.

Meet the financial obligations for your care as soon as possible.

Call the office if unable to keep scheduled appointments and arrive on time for scheduled appointment.

INFORMED CONSENT:

By signing below I acknowledge reading, understanding, and agreeing with the above policies and information. I understand that if I do not understand or have any questions about these policies, I may discuss them with my provider.

PATIENT NAME :_____ DOB: _____

SIGNATURE:_____ DATE:_____

IF PATIENT IS A MINOR, PARENT/GUARDIAN: _____

LIFENET PSYCHIATRY
FINANCIAL POLICY AGREEMENT

We believe that everyone benefits when there is a clear and definite understanding of our financial policy prior to treatment.

1. PATIENTS WITHOUT INSURANCE: All patients without insurance are required to pay in full for the service rendered at the time of the appointment.
2. ALL PATIENTS WITH MANAGED CARE PLANS: It is your responsibility to know and understand your managed care plan. Generally, these plans require payment of deductibles and/or copayments. Patients are required to pay for services according to their insurance contract at time of service.
3. ALL PATIENTS WITH INSURANCE: If our office is contracted with your insurance company, we will file your insurance claims if you provide us with the proper information along with a copy of your current insurance card. In the event your insurance overpays, we will refund the overpayments to you promptly upon written request. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and you will be billed accordingly.
4. CANCELLATION POLICY: **There is a charge for failed appointments/late cancellations of appointments when less than a 24-hour notice is given by the patient.** You will be charged the full fee for the service which would have been rendered. We cannot bill insurance companies for these appointments. Reminder calls/text messages/emails to our patients are offered as a courtesy. It is the patients responsibility to keep up with their appointments.
5. DELINQUENT ACCOUNTS: In the event LifeNet Psychiatry is forced to pursue the balance of your account through a collection process, patient will be responsible for any and all costs and fees associated with this process.
6. Payment for services rendered may be made by check, cash or credit card (Master Card, Visa, Discover, or American Express). There is a $35 fee for all NSF checks.

I have read and agree with the terms of this agreement.

Patient Name:_____ **DOB:**_____

Responsible Party Signature:_____ **Date:**_____

ASSIGNMENT OF BENEFITS

I authorize payment of insurance benefits to LifeNet Psychiatry for services rendered.

Responsible Party Signature:_____ **Date:**_____

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Patient Name: _____

DOB: _____

CREDIT CARD CONSENT POLICY FORM

I, the undersigned, authorize LifeNet Psychiatry to keep my signature on file and to charge my credit/debit card account as indicated below:

A charge to the credit/debit card will ONLY be made under the following circumstances:

1. Missed appointments
2. Cancellations made less than 24 hours from time of scheduled appointment and the appointment deemed unexcused
3. Any claim that is denied secondary to insurance not being in effect at the time of service
4. Any claim that is denied secondary to failure on the part of the patient's responsible party to obtain prior authorization or referral and/or complete forms required by insurance company needed to process the claim
5. Any claim that is applied toward a deductible
6. Any claim that becomes more than 120 days past due after proper filing and at least 1 re-filling by this office

Charges are as follows **unless** you are using insurance that is active at each date of service:

1. Medication management initial evaluation $250
2. Medication management follow-ups vary by time spent
3. Psychotherapy evaluation $130.00
4. Psychotherapy follow-ups $110.00 **except** for duel patients

Prior to the first visit, LifeNet Psychiatry will perform an "Authorization Only" transaction in the amount of $1.00 as part of our Credit Card Validation Process. The Cardholder may see this transaction on the account for up to five days.

I the undersigned understand that this form will be valid for the duration of my treatment with this office UNLESS I cancel through written notice to LifeNet Psychiatry, 500 Mariners Plaza Dr., Ste. 504, Mandeville, LA 70448.

Visa_____ MasterCard_____ Discover_____ Amex_____

_____ _____

Patient Name Cardholder Name

_____

Cardholder billing address

_____ CVV_____ Mo_____Yr_____

Credit Card Number Expiration Date

_____ _____

Cardholder Signature Date

LifeNet Psychiatry Service, LLC
500 Mariners Plaza Dr., Suite 504
Mandeville, LA 70448
985-246-1250 Office 985-246-1251 Fax

Patient Name: _____

Date of Birth: _____

Controlled Substance Agreement

Narcotics, amphetamines, and benzodiazepines may be useful in treating some medical conditions. However, because of their high potential for abuse, the above drugs are strictly controlled by state and federal governments and it is a FELONY to violate these guidelines. This is a contract between _____ and LifeNet Psychiatry.
(patient/guardian)

As a patient, I agree that:

1. I will not fill prescriptions for similar controlled substances from more than one provider.
2. I will fill all maintenance medications as well as my controlled medications and understand that if I fill my controlled medications without my maintenance medications I will be in violation of this agreement.
3. Only I will pick these prescriptions up and only I will request refills of these medications. I understand that I can only pick up prescriptions on the day they are due and not prior to that date.
4. I will keep my regularly scheduled appointments.
5. By signing this agreement, I am giving informed consent for the treatment with controlled medications and understand clearly that:
    a. I am responsible for keeping my medications in a secure location so they will not be stolen, lost, etc. These types of drugs may not be replaced. If they are misplaced or stolen a police report needs to be filed immediately and a face to face appointment scheduled.
    b. There is a risk of becoming dependent on controlled substances.
    c. My judgment and actions may be impaired by using controlled substances.
    d. The prescribing practitioner has my permission to share information regarding this contract with the pharmacy, my insurance company, and any doctor I am currently seeing and any doctor I may see in the future.
    e. I agree to random drug screens to determine drug levels as practitioner deems necessary.

If I fail to abide by this contract I may be terminated as a patient from this practice.

_____ _____

Patient's/Guardian's Signature Date

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Patient Name: _____

DOB: _____

I, _____ authorize the following people to have access to my child's mental health record and insurance/billing information.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I will notify LifeNet Psychiatry in writing if people should be added or removed from this list

SIGNATURE: _____ DATE: _____

I, _____ authorize the following people to bring my child to the above facility for treatment. This person is also allowed to have access to my child's mental health information and make medical decisions for my child at his/her visit.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I will notify LifeNet Psychiatry in writing if people should be added or removed from this list.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO CHILD: _____

LifeNet Psychiatry now offers a secure, easy-to-use online patient portal for patients to access their health information. This free self-service health management tool is a convenient way to manage your personal healthcare.

_____ Yes, please send me an online invitation to access my health records

_____ No, I decline this invitation

Patient EMAIL ADDRESS: _____

If patient is a minor, please list email address for authorized user

IF YOU ARE A LEGAL GUARDIAN, PLEASE PROVIDE DOCUMENTATION

LifeNet Psychiatry
Child/Adolescent Intake Form

Child's Name:_____ Child's DOB:_____ Today's Date:_____
School/Daycare:_____ Parish:_____ Grade:_____
School Address:_____ Phone:_____
Special Education Placement/Services (if any):_____
Person Completing this Form: (circle) Mother Father Stepmother Stepfather Other_____

Guardianship
Guardian 1
Name:_____ DOB:_____
Address:_____ City:_____
SSN:_____ State:_____ Zip Code:_____
Phone Number:_____ Email:_____
Custody: ☐ LEGAL ☐ PHSYICAL ☐JOINT ☐SOLE
Relationship to Patient: _____
Medical Decision Maker: ☐

Guardian 2
Name:_____ DOB:_____
Address:_____ City:_____
SSN:_____ State:_____ Zip Code:_____
Phone Number:_____ Email:_____
Custody: ☐ LEGAL ☐ PHSYICAL ☐JOINT ☐SOLE
Relationship to Patient: _____
Medical Decision Maker: ☐

PRESENTING PROBLEMS

Briefly describe your child's current difficulties:_____
_____
_____
_____
How long has this problem been a concern to you?_____
When was this problem first noticed?_____
What seems to make this problem worse?_____
Have any other family members had similar problems? Yes No If yes, whom?_____
Previous evaluation or treatment for current problems/similar problems? Yes No
If yes, when and with whom?_____ address:_____
Is your child on any medication at present? Yes No
If yes, please list names of medications:_____

DEVELOPMENTAL HISTORY

PREGNANCY:
Duration of pregnancy (weeks/moths):_____

During pregnancy, did the mother:
_____ suffer from illness or disease
_____ suffer from an accident
_____ undergo surgery
_____ take medication
_____ undergo x-ray studies
_____ smoke tobacco
_____ consume alcohol
_____ use drugs
_____ amniocentesis

Complications of pregnancy included:
_____ excessive vomiting
_____ excessive staining or blood loss
_____ threatened miscarriage
_____ infection(s)
_____ toxemia
_____ diabetes
_____ high blood pressure
_____ poor nutrition
_____ loss of consciousness in mother

LifeNet Psychiatry
Child/Adolescent Intake Form

Patient Name: _____

DOB: _____

DELIVERY:
Duration of Labor:_____ hours Birth Weight?_____ lbs. _____ ozs. Length:_____
Type of Labor: Spontaneous Induced Forceps Used? Yes No
Type of Delivery: Normal Breach Caesarean
Complications: _____ None _____ Delay in breathing
_____ Cord around neck _____ Injury to infant
_____ Hemorrhage _____ Other (specify)_____
_____ Placenta problems

NEWBORN AND POST-DELIVERY PERIOD:
Total days baby was in hospital after delivery:_____ Was baby in NICU? Yes No How long?_____
Medications administered to baby:_____
Complications:

_____ None	_____ Jaundice (yellow skin)	_____ Intraventricular hemorrhage
_____ Addiction	_____ Infection	_____ Meconium staining/aspiration
_____ Anemia	_____ Seizures	_____ Respirator and/or resuscitation
_____ Birth defects		_____ Trouble breathing was required
_____ Vomiting	_____ Diarrhea	_____ Cyanosis (turned blue)

INFANCY-TODDLER PERIOD:
As a baby, the child was:

_____ Active	_____ Difficult	_____ Shy	_____ Hard to please
_____ Cranky	_____ Easy	_____ Sleepy	_____ Lazy or slow moving
_____ Calm	_____ Happy	_____ Social	_____ Persistent

Were any of the following present during the first years of life?

_____ colic	_____ constantly into everything
_____ feeding problems	_____ slow or unable to adapt to changes in routine
_____ sleeping problems	_____ excessively high or low activity level (circle one)
_____ frequent head banging	_____ was not calmed by being held and/or stroked
_____ excessive restlessness	_____ excessive number of accidents compared to other
_____ did not enjoy cuddling children	
_____ withdrawal or other problems adjusting to new people and situations	
_____ variable or irregular body functions (sleep, hunger, bowel movements, etc.)	

Were there any special problems in the growth and development of your child during the first year?Y/N
If yes, then describe:
_____
_____

DEVELOPMENTAL MILESTONES

The following is a list of infant preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age, but have some idea, write the age followed by a question mark. If you do not remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Walked alone	_____	Stayed dry at night	_____
Spoke first word	_____	Fed Self	_____
Put several words together	_____	Rode tricycle	_____
Became toilet trained	_____		

Compared with other children, the child's early development was: Normal Delayed Advanced

LifeNet Psychiatry
Child/Adolescent Intake Form

Patient Name: _____

DOB: _____

EDUCATIONAL HISTORY

Current Grade: _____ Grade(s) Repeated _____
Describe academic and any other classroom problems: _____
_____
_____
_____
Previous School Interventions: _____
_____
_____
Describe recent school performance (list report card grades): _____
Describe special services received: _____
_____
Current educational problem areas include:

_____ reading	_____ does not respect rights of others	_____ cheats
_____ arithmetic	_____ fights with classmates	_____ inattentive
_____ spelling	_____ detentions and/or suspension	_____ distracted
_____ writing	_____ does not like school	_____ disrupts class
_____ other subjects	_____ does not complete homework	_____ overactive/fidgety
_____ poor study skills	_____ difficulty remembering	_____ worries about school

_____ conflict with teacher(s) _____ does not work well independently
_____ excessive absences (reason: _____
When did school problem begin or first come to your attention: _____
Identify the adults involved in the child's life. Do they reside in the child's home?

IN	OUT	
____	____	biological mother
____	____	biological father
____	____	stepmother
____	____	stepfather
____	____	adoptive mother
____	____	adoptive father
____	____	foster mother
____	____	foster father
____	____	aunt
____	____	uncle
____	____	grandmother
____	____	grandfather
____	____	other relative
____	____	friend
____	____	other_____

Mother's age at first pregnancy_____
Mother's marital status at first pregnancy: _____ Married _____ Unmarried
Marital status at this child's birth: _____Married _____ Single _____ Divorced _____ Separated _____ Widowed
If parents are separated or divorced, how old was child when the separation occurred: _____
What are the current custody/visitation arrangements? _____
Was your child adopted? Yes No Date of Adoption: _____ Age at Adoption: _____
List of all people living in household:

NAME	RELATIONSHIP TO CHILD	AGE

LifeNet Psychiatry
Child/Adolescent Intake Form

Patient Name: _____

DOB: _____

List any brothers or sisters (including stepfamily) who live outside the household: _____
Describe any other important info about home: _____
_____
_____

Are there any transportation issues for patient visits? Yes No If Yes, then please describe: _____
_____

Are there any cultural beliefs that would effect treatment of any mental or behavioral disorder? Yes No
If yes, please describe: _____

CHILD'S MEDICAL HISTORY

Place a check next to any illness/condition that your child has. When you check an item, also note the approximate date for child's age at the time of the illness:

ILLNESS OR CONDITION	AGE/DATES	ILLNESS OR CONDITION	AGE/DATES
____ AIDS or HIV positive	_____	____Fainting Spells	_____
____Allergies	_____	____Fetal Alcohol Syndrome	_____
____Anemia	_____	____Fever(if high or prolonged)	_____
____Aneurysm	_____	____Guillain-Barre Syndrome	_____
____Anoxia	_____	____Head Injury	_____
____Arteriovenous Malformation	_____	____Headaches	_____
____Arthritis	_____	____Heart Disease or Problems	_____
____Asthma	_____	____Lead Poisoning	_____
____Ataxia	_____	____Hepatitis	_____
____Auto Accident	_____	____Herpes	_____
____Back Pains or Problems	_____	____High Blood Pressure	_____
____Bleeding Problems	_____	____Jaundice	_____
____Blood Disorders	_____	____Leukemia	_____
____Bone or Joint Disease	_____	____ Malnutrition	_____
____Broken Bones	_____	____ Meningitis	_____
____Cancer	_____	____Muscular Disease	_____
____Chorea	_____	____Pain Problems	_____
____Coma	_____	____Paralysis	_____
____Cystic Fibrosis	_____	____Pituitary Disorder	_____
____Dazed or Unconscious	_____	____Pneumonia	_____
____Dementia	_____	____Poisoning	_____
____Diabetes	_____	____Poliomyelitis	_____
____Dysarthria	_____	____Rheumatic Fever	_____
____Dysphasia (or Apraxia)	_____	____Scarlet Fever	_____
____Ear Infections (PE tubes)	_____	____Sensory Losses	_____
____Other Ear Problems	_____	____Sexual Molestation	_____
____Eczema or Hives	_____	____Sexually Transmitted Disease	_____
____Electric or Chemical Shock	_____	____Speech/Language Problems	_____
____Encephalitis	_____	____Spells(_____)	_____
____Epilepsy, Seizures, Fits	_____	____Stroke	_____
____Suicide Attempts/Thoughts	_____	____Sunstroke/Heat Exhaustion	_____
____Thyroid Disorder or Problem	_____	____Trauma (_____)	_____
____Tuberculosis	_____	____Tumor	_____
____Visual Problems	_____	____Whooping Cough	_____

OTHER MEDICAL PROBLEMS: _____
MEDICATION ALLERGIES: _____

LifeNet Psychiatry
Child/Adolescent Intake Form

Patient Name: _____

DOB: _____

Indicate if the child has undergone any of these Medical tests (place check and give age):

____Electroencephalogram (EEG)_____
____Skull X-rays _____
____CT Scan _____
____MRI Scan _____
____BEAM Study _____
____Evoked Potential _____
____Ophthalmologic (Vision) _____
____Audiological Evaluation _____

Pediatrician's name and address:_____

If the child has ever been treated with medication other than for colds and minor infections, please list medications below:

MEDICATION	AGE	REASON PRESCRIBED
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Has your child ever suffered a head injury which caused confusion/loss of consciousness? Yes No

FAMILY MEDICAL HISTORY

Place a check next to any illness/condition, or problem experienced by any blood relatives. When you check an item, please note the member's relationship to the child. If any problems run in the family, please write them down at the end of the list:

CONDITION	RELATIONSHIP TO CHILD
____ Alcoholism	_____
____ Antisocial (criminal) behavior	_____
____ Blood Disease	_____
____ Cancer	_____
____ Cerebral vascular accident (stroke)	_____
____ Dementia	_____
____ Drug addiction or drug problems	_____
____ Headaches (e.g., migraine)	_____
____ Heart disease or attack	_____
____ Hyperactivity	_____
____ Hypertension (high blood pressure)	_____
____ Learning Problems	_____
____ Lung Disease (e.g., asthma, emphysema)	_____
____ Manic-Depressive disorder	_____
____ Mental Retardation	_____
____ Movement disorders	_____
____ Nervous or mental problems	_____
____ Pain problems (e.g., back pain)	_____
____ Schizophrenia	_____
____ Seizures, epilepsy or convulsions	_____
____ Sexual/physical abuse	_____
____ Suicide or suicide attempt	_____

I certify that all statements made and all questions answered are true and accurate to the best of my knowledge

SIGNATURE_____DATE_____

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Patient Name: _____

DOB: _____

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	___	___	___	___
2. I did not feel like eating, I wasn't very hungry.	___	___	___	___
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	___	___	___	___
4. I felt like I was just as good as other kids.	___	___	___	___
5. I felt like I couldn't pay attention to what I was doing.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	___	___	___	___
7. I felt like I was too tired to do things.	___	___	___	___
8. I felt like something good was going to happen.	___	___	___	___
9. I felt like things I did before didn't work out right.	___	___	___	___
10. I felt scared.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	___	___	___	___
12. I was happy.	___	___	___	___
13. I was more quiet than usual.	___	___	___	___
14. I felt lonely, like I didn't have any friends.	___	___	___	___
15. I felt like kids I know were not friendly or that they didn't want to be with me.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	___	___	___	___
17. I felt like crying.	___	___	___	___
18. I felt sad.	___	___	___	___
19. I felt people didn't like me.	___	___	___	___
20. It was hard to get started doing things.	___	___	___	___

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____ DOB: _____

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.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

Patient Name: _____ DOB: _____	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.	○	○	○

SCORING:

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

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**.

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

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

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

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

**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.*

Developed by Boris Birmaher, M.D., Suneela Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1. Does not pay attention to details or makes careless mistakes, such as in homework	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 instruction 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations when 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 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 on others (butts into conversations or games)	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 comply with adults' requests or rules	0	1	2	3

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Each rating should be considered in the context of what is appropriate for the age of your child.

Patient Name: _____

DOB: _____

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

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 vindictive	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Initiates physical fights	0	1	2	3
29. Lies to obtain goods for favors or to avoid obligations ("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 items of nontrivial value	0	1	2	3
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

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Each rating should be considered in the context of what is appropriate for the age of your child.

Patient Name: _____

DOB: _____

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

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

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavior					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5