Date:_____

APPS MENTAL HEALTH

NEW CLIENT QUESTIONNAIRE (CHILD) 14-17

Name:_____

DOB:_____ SS#_____-_____-_____ Gender M F Unspecified

Legal Guardian's Name (if applicable):_____

Address:_____

City:_____ State:_____ Zip code:_____

School:_____ Grade:_____

Home Phone:_____ May we leave a message at his number? Y or N

Work Phone:_____ May we leave a message at this number? Y or N

Cell Phone:_____ May we leave a message at this number? Y or N

Email:_____ May we contact you via email? Y or N

Secondary Email:_____ May we send text message reminders? Y or N

Employer:_____ How Long have you been employed there? _____

Highest Level of Education Completed:_____ Degree Obtained:_____

Spouse's Full Name:_____

Primary Care Doctor Name:_____ Phone#_____ Fax#_____

Address:_____ Date of Last Office Visit:_____

Referred By:_____ Phone#_____

Optional-Ethnicity:_____ Race:_____ Religion:_____ Language:_____ Gender:_____

EMERGENCY CONTACT:_____ **Phone:**_____ **Relation:**_____

I give permission to speak with_____ in an emergency, at my provider's discretion.

Therapist Name:_____ Phone:_____ Fax:_____

How often are therapy appoinments?_____

INSURANCE INFORMATION:

Primary Insurance Carrier:_____

ID#:_____ Group#:_____ Insurance Holder name:_____

Relation:_____ Insurance Holer Date of Birth:_____ Active Date:_____

SSN of policy holder:_____-_____-_____ Address of primary insurance holder:_____

Name of Behavioral Health Insurance:_____ Phone:_____

Copay?_____ Deductible?_____ Have you met the deductible? Y N

Do you need a referral for full coverage? Y or N Send Claims to Address:_____

Secondary Insurance Carrier:_____

ID#:_____ Group#:_____ Insurance Holder name:_____

Relation:_____ Insurance Holer Date of Birth:_____ Active Date:_____

SSN of policy holder:_____-_____-_____ Address of primary insurance holder:_____

Name of Behavioral Health Insurance:_____ Phone:_____

Copay?_____ Deductible?_____ Have you met the deductible? Y N

Do you need a referral for full coverage? Y or N Send Claims to Address:_____

_____ _____

Signature Date

_____

Printed Name

Patient Name: _____ Date of Birth:_____

Your signature below indicates that you have **read and understood** the information in this clinician and patient agreement and agree to abide by **all** terms indicated in the document during our professional relationship. As well as CRISP acknowledgment.

_____ _____

Client/Responsible Party Signature Printed Name Date

_____ _____

Client/Responsible Party Signature Printed Name Date

Address for billing and/or office correspondence:
(This authorizes me to send identifying information to this address)

_____

_____

_____

Phone Number (s) for Office Contact

_____

(This authorizes my office to contact you at this/these number(s). The message will indicate a first name of the caller and a number for return contacts from you. Please do not include numbers where you prefer not to be contacted or have messages left for you.)

_____ _____

Email Address Cell Phone Number

Appointment reminders are made in the form of text, email or telephone calls. **Please be advised that NO email or text messaging correspondence is considered confidential and may be recovered by other parties at any time. You may lose your right to confidentially by corresponding with me by email and by receiving correspondence from me by email.**

_____

Your signature above indicates your approval of receiving email and /or cell phone text messaging from me, knowing the limits of confidentiality.

PATIENT NAME ______________________ **DOB:** ______________________ **DATE:** ____________

CURRENT MEDICATIONS:

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

Name of Medication	Dose (mg)	Frequency	Prescribed by	Diagnosis	

PREVIOUS HOSPITALIZATIONS: (NAME OF HOSPITAL-REASON FOR ADMISSION & DMISSION DAYS)

____

____

PAST MENTAL HEALTH MEDICATIONS (APPOX DTES MEDICATION WAS TAKEN AND WHY STOPPED):

____

____

ALLERGIES TO MEDICATIONS (AND REACTION):______________________________

____

____

CONSENT FOR RELEASE OF INFORMATION

CB Benway, CRNP, PMH
Jessica Henderson, CRNP, PMH-BC
Katie Koons, CRNP
13327 Wisdom Way
Hagerstown MD 21742
appsmentalhealth@gmail.com

Phone #: 240-970-7300 Fax#: 240-231-9755

INFORMED CONSENT FOR ONLINE THERAPY/MEDICATION MANAGEMENT SERVICES

This form is designed to allow you to give informed consent for the use of video technology for online therapy and medication management. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

I understand that therapy and medication management conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in interruptions. Any problems with internet availability or connectivity are outside the control of the provider and the provider makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing. I agree to call my provider back on 240-970-7300 (office telephone number). Immediately or other arrangements will be made.

I AGREE TO TAKE FULL RESPONIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER OR DEVICE AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my User ID to access these services. I also understand that there will be no recording of any of the online telephone sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

_____	_____	_____
Patient/Client Signature	Printed Name	Date
_____	_____	_____
Parent Guardian/Legal Representative Signature	Printed Name	Date
_____	_____	_____
Provider Signature or Witness Signature	Printed Name	Date

Patient:_____
DOB:_____

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often…**
   Swear at you, insult you, put you down, or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt?
   O YES O NO
2. Did a parent or other adult in the household **often…**
   Push, grab, slap, or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured?
   O YES O NO
3. Did an adult or person at least 5 years older than you ever….
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Try to or actually have oral, anal, or vaginal sex with you?
   O YES O NO
4. Did you **often feel that…..**
   No one in your family loved you or thought that you were important or special?
   Or
   Your family didn't look out for each other, feel close to each other, or support each other?
   O YES O NO
5. Did you **often** feel that….
   You didn't have enough to eat, had to wear dirty clothes and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   O YES O NO
6. Were your parents ever separated or divorced
   O YES O NO
7. Was your mother or step mother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   Or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   O YES O NO
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   O YES O NO
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   O YES O NO
10. Did a household member go to prison?
    O YES O NO

_____ ACE SCORE

Patient: _____

DOB: _____

GAD-7

Over the last 2 weeks how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half Days	Nearly Every Day
1. Feeling nervous, anxious or on edge	0 O	1 O	2 O	3 O
2. Not being able to stop or control worrying	0 O	1 O	2 O	3 O
3. Worrying too much about different things	0 O	1 O	2 O	3 O
4. Trouble relaxing	0 O	1 O	2 O	3 O
5. Being so restless that it is hard to sit still	0 O	1 O	2 O	3 O
6. Becoming easily annoyed or irritable	0 O	1 O	2 O	3 O
7. Feeling afraid as if something awful might happen	0 O	1 O	2 O	3 O

_____+_____+_____

Total Score:_____

Patient:_____

DOB:_____

(MFQ) Mood and Feelings Questionnaire: Short Version

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

For each question, please select 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:
NOTE TRUE=0
SOMETIMES-1
TRUE=2

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

SCORE: _____

Patient:_____

DOB:_____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often Have you been bothered by any of the Following problems?	Not At All	More Several Days	Nearly Than Half the Days	Every Day
1. Little interest or please in doing things	0 O	1 O	2 O	3 O
2. Feeling down, depressed or hopeless	0 O	1 O	2 O	3 O
3. Trouble falling asleep, staying asleep, or sleeping too much	0 O	1 O	2 O	3 O
4. Feeling tired or having little energy	0 O	1 O	2 O	3 O
5. Poor appetite or overeating	0 O	1 O	2 O	3 O
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0 O	1 O	2 O	3 O
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 O	1 O	2 O	3 O
8. Moving or speaking so slowly that other people could have notices. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0 O	1 O	2 O	3 O
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 O	1 O	2 O	3 O

_____+_____+_____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care things at home, or get along with other people?

O Not difficult at all O Somewhat difficult O Very difficult O Extremely difficult

NICHQ Vanderbilt Assessment Scale PARENT Form

Date:_____ Child's Name:_____ DOB:_____

Parent's Name:_____

Directions: Each rating should be considered in the context of what us appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention or makes careless mistakes with, for example homework	O 0	O 1	O 2	O 3
2. Has difficulty keeping attention to what needs to be done	O 0	O 1	O 2	O 3
3. Does not seem to listen when spoken to directly	O 0	O 1	O 2	O 3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	O 0	O 1	O 2	O 3
5. Has difficulty organizing tasks and activities	O 0	O 1	O 2	O 3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	O 0	O 1	O 2	O 3
7. Loses things necessary for tasks or activities (toys, assignments, pencils or books)	O 0	O 1	O 2	O 3
8. Is easily distracted by noises or other stimuli	O 0	O 1	O 2	O 3
9. Is forgetful in daily activities	O 0	O 1	O 2	O 3
10. Fidgets with hands or feet or squirms in seat	O 0	O 1	O 2	O 3
11. Leaves seat when remaining seated is expected	O 0	O 1	O 2	O 3
12. Runs about or climbs too much when remaining seated is expected	O 0	O 1	O 2	O 3
13. Has difficulty playing or beginning quiet play activities	O 0	O 1	O 2	O 3
14. Is "on the go" or often acts as if "driven by a motor"	O 0	O 1	O 2	O 3
15. Talks too much	O 0	O 1	O 2	O 3
16. Blurts out answers before questions have been completed	O 0	O 1	O 2	O 3
17. Has difficulty waiting his or her turn	O 0	O 1	O 2	O 3
18. Interrupts or intrudes in on others' conversations and/or activities	O 0	O 1	O 2	O 3
19. Argues with adults	O 0	O 1	O 2	O 3
20. Loses temper	O 0	O 1	O 2	O 3
21. Actively defies or refuses to go along with adults' requests or rules	O 0	O 1	O 2	O 3
22. Deliberately annoys people	O 0	O 1	O 2	O 3
23. Blames others for his or her mistakes or misbehaviors	O 0	O 1	O 2	O 3
24. Is touchy or easily annoyed by others	O 0	O 1	O 2	O 3
25. Is angry or resentful	O 0	O 1	O 2	O 3
26. Is spiteful and wants to get even	O 0	O 1	O 2	O 3
27. Bullies, threatens, or intimidates others	O 0	O 1	O 2	O 3
28. Starts physical fights	O 0	O 1	O 2	O 3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	O 0	O 1	O 2	O 3
30. Is truant from school (skips school) without permission	O 0	O 1	O 2	O 3
31. Is physically cruel to people	O 0	O 1	O 2	O 3
32. Has stolen things that have value	O 0	O 1	O 2	O 3
33. Deliberately destroys others property	O 0	O 1	O 2	O 3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	O 0	O 1	O 2	O 3
35. Is physically cruel to animals	O 0	O 1	O 2	O 3
36. Has deliberately set fires to cause damage	O 0	O 1	O 2	O 3
37. Has broken into someone else's home, business or car	O 0	O 1	O 2	O 3
38. Has stayed out all night without permission	O 0	O 1	O 2	O 3
39. Has run away from home overnight	O 0	O 1	O 2	O 3
40. Has forced someone into sexual activity	O 0	O 1	O 2	O 3
41. Is fearful, anxious or worried	O 0	O 1	O 2	O 3
42. Is afraid to try new things for fear of making mistakes	O 0	O 1	O 2	O 3

43. Feels worthless or inferior	O 0	O 1	O 2	O 3
44. Blames self for problems, feels guilty	O 0	O 1	O 2	O 3
45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”	O 0	O 1	O 2	O 3
46. Is sad, unhappy, or depressed	O 0	O 1	O 2	O 3
47. Is self-conscious or easily embarrassed	O 0	O 1	O 2	O 3

Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
48. Overall school performance	O 1	O 2	O 3	O 4	O 5
49. Reading	O 1	O 2	O 3	O 4	O 5
50. Writing	O 1	O 2	O 3	O 4	O 5
51. Mathematics	O 1	O 2	O 3	O 4	O 5
52. Relationship with parents	O 1	O 2	O 3	O 4	O 5
53. Relationship with siblings	O 1	O 2	O 3	O 4	O 5
54. Relationship with peers	O 1	O 2	O 3	O 4	O 5
55. Participation in organized activities (e.g., teams)	O 1	O 2	O 3	O 4	O 5

Explain/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:_____

DSM-5 Parent/Guardian- Rated Level 1 Cross-Cutting Symptom Measure- Child Age 6-17

Name:_____ DOB:_____ Date:_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past TWO (2) WEEKS, how much (or how often) have you...		**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (Clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	O	O	O	O	O	O
	2.	Said he/she was worried about his/her health or about getting sick?	O	O	O	O	O	O
II.	3.	Had problems sleeping-that is, trouble failing asleep, staying asleep, or waking up too early?	O	O	O	O	O	O
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	O	O	O	O	O	O
IV.	5.	Had less fun doing things than he/she used to?	O	O	O	O	O	O
	6.	Seemed sad or depressed for several hours?	O	O	O	O	O	O
V. & VI	7.	Seemed more irritated or easily annoyed than usual?	O	O	O	O	O	O
	8.	Seemed angry or lost his/her temper?	O	O	O	O	O	O
VII.	9.	Started lots more projects than usual or did more risky things than usual?	O	O	O	O	O	O
	10.	Slept less than usual for him/her, but still had lots of energy?	O	O	O	O	O	O
VIII.	11.	Said he/she felt nervous, anxious, or scared?	O	O	O	O	O	O
	12.	Not been able to stop worrying?	O	O	O	O	O	O
	13.	Said he/she couldn't do thigs he/she wanted to or should have done, because they made him/her feel nervous?	O	O	O	O	O	O
IX.	14.	Said that he/she heard voices- when there was no one there- speaking about him/her or telling him/her what to do or saying bad things to him/her?	O	O	O	O	O	O
	15.	Said that he/she had a vision when he/she was completely awake- this is, saw something or someone that no one else could see?	O	O	O	O	O	O
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	O	O	O	O	O	O
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	O	O	O	O	O	O
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	O	O	O	O	O	O
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	O	O	O	O	O	O
	In the past TWO (2) WEEKS, has your child...							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	O Yes		O No		O Don't Know	
	21.	Smoked a cigarette, a cigar, or a pipe or used snuff or chewing tobacco?	O Yes		O No		O Don't Know	
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, Inhalants or solvents (like glue), or methamphetamine (like speed)?	O Yes		O No		O Don't Know	
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or steroids)?	O Yes		O No		O Don't Know	
XII.	24.	In the last 2 weeks, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	O Yes		O No		O Don't Know	
	25.	Has he/she EVER tried to kill himself/herself?	O Yes		O No		O Don't Know	

DSM-5 Self- Rated Level 1 Cross-Cutting Symptom Measure- Child Age 11-17

Name:_____ DOB:_____ Date:_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past TWO (2) WEEKS, how much (or how often) have you...		**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (Clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	O	O	O	O	O	O
	2.	Worried about your health or about getting sick?	O	O	O	O	O	O
II.	3.	Been bothered by not being able to fall asleep, or but waking up too early?	O	O	O	O	O	O
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	O	O	O	O	O	O
IV.	5.	Had less fun doing things than you used to?	O	O	O	O	O	O
	6.	Felt sad or depressed for several hours?	O	O	O	O	O	O
V. & VI	7.	Felt more irritated or easily annoyed than usual?	O	O	O	O	O	O
	8.	Felt angry or lost your temper?	O	O	O	O	O	O
VII.	9.	Started lots more projects than usual or done more risky things than usual?	O	O	O	O	O	O
	10.	Slept less than usual but still had a lot of energy?	O	O	O	O	O	O
VIII.	11.	Felt nervous, anxious or scared?	O	O	O	O	O	O
	12.	Not been able to stop worrying?	O	O	O	O	O	O
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	O	O	O	O	O	O
IX.	14.	Heard voices- when there was no one there-speaking about you or telling you what to do or saying bad things to you?	O	O	O	O	O	O
	15.	Had visions when you were completely awake- that is, seen something or someone that no one else could see?	O	O	O	O	O	O
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	O	O	O	O	O	O
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	O	O	O	O	O	O
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	O	O	O	O	O	O
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	O	O	O	O	O	O
	In the past TWO (2) WEEKS, have you...							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	O Yes			O No		
	21.	Smoked a cigarette, a cigar, or a pipe or used snuff or chewing tobacco?	O Yes			O No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, Inhalants or solvents (like glue), or methamphetamine (like speed)?	O Yes			O No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or steroids)?	O Yes			O No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	O Yes			O No		
	25.	Have you EVER tried to kill yourself?	O Yes			O No		

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version- Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlene cully, M. Ed., David Brent, M.D., and Sandra McKenzie, PhD., Western Psychiatric Institute and Clinic, University of Pittsburgh (October 1995). Email: biraherb@upmc.edu

See: Birmaher, B., Brent, D.A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M(1999). Psychometric propertied 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.

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 "Very True or Often True" for you. Then, for each sentence, select the 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.	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP
21. I worry about things working out for me.	O	O	O	GD
22. When I get frightened, I sweat a lot.	O	O	O	PN
23. I am a worrier.	O	O	O	GD
24. I get really frightened for no reason at all.	O	O	O	PN
25. I am afraid to be alone in the house.	O	O	O	SP
26. It is hard for me to talk with people I don't know well.	O	O	O	SC
27. When I get frightened, I feel like I am chocking.	O	O	O	PN
28. People tell me that I worry too much.	O	O	O	GD
29. I don't like to be away from my family.	O	O	O	SP
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. I worry that something bad might happen to my parents.	O	O	O	SP
32. I feel shy with people I don't know well.	O	O	O	SC
33. I worry about what is going to happen to my parents.	O	O	O	GD
34. When I ger frightened, I feel like throwing up.	O	O	O	PN
35. I worry about how well I do things.	O	O	O	GD
36. I am scared to go to school.	O	O	O	SH
37. I worry about things that have already happened.	O	O	O	GD
38. When I get frightened, I feel dizzy.	O	O	O	PN
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	SC
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	SC
41. I feel shy.	O	O	O	SC

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version- Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlene cully, M. Ed., David Brent, M.D., and Sandra McKenzie, PhD., Western Psychiatric Institute and Clinic, University of Pittsburgh (October 1995). Email: biraherb@upmc.edu

See: Birmaher, B., Brent, D.A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M(1999). Psychometric propertied 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.

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 "Very True or Often True" for you. Then, for each sentence, select the 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 my child feels frightened, it is hard for him/her to breathe.	O	O	O	PN
2. My child gets headaches when he/she is at school.	O	O	O	SH
3. My child doesn't like to be with people he/she doesn't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she feels like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomach aches at school.	O	O	O	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	PN
13. My child worries about sleeping alone.	O	O	O	SP
14. My child worries about being as good as other kids.	O	O	O	GD
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	PN
16. My child has nightmares about something bad happening to his/her parents	O	O	O	SP
17. My child worries about going to school	O	O	O	SH
18. When my child gets frightened, his/her heart beats fast.	O	O	O	PN
19. My Child gets shaky.	O	O	O	PN
20. My child has nightmares about something bad happening to him/her.	O	O	O	SP
21. My child worries about things working out for him/her.	O	O	O	GD
22. When my child gets frightened he/she sweats a lot.	O	O	O	PN
23. My child is a worrier.	O	O	O	GD
24. My child gets really frightened for no reason at all.	O	O	O	PN
25. My child is afraid to be alone in the house.	O	O	O	SP
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	SC
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	PN
28. People tell me that my child worries too much.	O	O	O	GD
29. My child doesn't like to be away from his/her family.	O	O	O	SP
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. My child worries that something bad might happen to his/her parents.	O	O	O	SP
32. My child feels shy when people he/she doesn't know well.	O	O	O	SC
33. My child worries about what is going to happen in the future.	O	O	O	GD
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	PN
35. My child worries about how ell he/she does things.	O	O	O	GD
36. My child is scared to go to school.	O	O	O	SH
37. My child worries about things that have already happened.	O	O	O	GD
38. When my child gets frightened, he/she feels dizzy.	O	O	O	PN
39. My child feels nervous when he/she is with other children or adults and he/she have to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
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	SC
41. My child is shy.	O	O	O	SC

Patient:_____ DOB:_____ DATE:_____

GARS-3

Section 5: Ratings

Directions: On a scale of 0 to 3, rate the following items in terms of how adequately the item describes the individual's behavior. Circle the number that best describes your observations of the person's typical behavior under ordinary circumstances (i.e., in most places, with people he or she is familiar with, and usual daily activities). Remember to rate every item. If you are uncertain about how to rate an item, delay the rating and observe the person for a 6-hour period to determine your rating.

0 Not al all like the individual
1 Not much like the individual
2 Somewhat like the individual
3 Very much like the individual

PLEASE RATE EVERY ITEM

Restricted/repetitive Behaviors

1.	If left alone, the majority of the individual's time will be spent in repetitive pr stereotyped behaviors.	0	1	2	3
2.	Is preoccupied with specific stimuli that are abnormal in intensity.	0	1	2	3
3.	Stares at the hands, objects, or items in the environment for at least 5 seconds.	0	1	2	3
4.	Flicks fingers rapidly in front of eyes for periods of 5 seconds or more.	0	1	2	3
5.	Makes rapid lunging, darting movements when moving from place to place.	0	1	2	3
6.	Flaps hands and fingers in front of face or at sides.	0	1	2	3
7.	Makes high-pitched sounds (e.g., spins cars, takes action toys apart).	0	1	2	3
8.	Uses toys or objects inappropriately (e.g., spins cars, takes action toys apart).	0	1	2	3
9.	Does certain things respectively, ritualistically.	0	1	2	3
10.	Engages in stereotyped behaviors when playing with toys or objects.	0	1	2	3
11.	Repeats unintelligible sounds (babbles) over and over.	0	1	2	3
12.	Shows unusual interest in sensory aspects of play materials, body parts or objects.	0	1	2	3
13.	Displays ritualistic or compulsive behaviors.	0	1	2	3

Subtotal: _____ + _____ +_____

Restricted/Repetitive Behaviors Raw Score_____

Social Interaction

14.	Does not initiate conversation with peers or others.	0	1	2	3
15.	Pays little or no attention to what peers are doing.	0	1	2	3
16.	Dails to initiate other people in games or learning activities.	0	1	2	3
17.	Doesn't follow other's gestures (cues) to look at something (e.g. when other person nods head, points, or uses Other body language cues).	0	1	2	3
18.	Seems indifferent to other person's attention (doesn't try to get, maintain, or direct the other person's attention).	0	1	2	3
19.	Shows minimal expressed pleasure when interacting with others.	0	1	2	3
20.	Displays little or no excitement in showing toys or objects to others.	0	1	2	3
21.	Seems uninterested in pointing out things in the environment to others.				
22.	Seems unwilling or reluctant to get others to interact with him or her.	0	1	2	3
23.	Shows minimal or no response when others attempt to interact with him or her.	0	1	2	3
24.	Displays little or no reciprocal social communication (e.g. doesn't voluntarily say "bye-bye" in response to Another person saying "bye-bye" to him or her).	0	1	2	3
25.	Doesn't try to make friends with other people.	0	1	2	3
26.	Fails to engage in creative, imaginative play.	0	1	2	3
27.	Shows little or no interest in other people	0	1	2	3

Subtotal: _____ + _____+_____

Sical Interaction Raw Score _____

Social Communication

28.	Responds inappropriately to humorous stimuli (e.g., doesn't laugh at jokes, cartoons, funny stories).	0	1	2	3
29.	Has difficulty understanding jokes.	0	1	2	3
30.	Has difficulty understanding slang expressions.				
31.	Has difficulty understanding when someone is teasing.	0	1	2	3
32.	Has difficulty understanding when he or she is being ridiculed.	0	1	2	3
33.	Has difficulty understanding what causes people to dislike him or her	0	1	2	3
34.	Fails to predict probable consequences in social events.	0	1	2	3
35.	Doesn't seem to understand that people have thoughts and feelings different from his or hers.	0	1	2	3
36.	Doesn't seem to understand that the other person doesn't know something.	0	1	2	3

Subtotal: _____+_____+_____

Social Communications Raw Score:_____

Emotional Responses

37.	Needs excessive amount of reassurance if things are changed or go wrong.	0	1	2	3
38.	Becomes frustrated quickly when he or she cannot do something.	0	1	2	3
39.	Temper tantrums when frustrated.	0	1	2	3
40.	Becomes upset when routines are changed.	0	1	2	3
41.	Responds negatively when given commands, requests or directions.	0	1	2	3
42.	Has extreme reactions (e.g. cries, screams, tantrums) in response to loud, unexpected noise.	0	1	2	3
43.	Temper tantrums when doesn't get his or her way.	0	1	2	3
44.	Temper tantrums when told to stop doing something he or she enjoys doing.	0	1	2	3

Subtotal: _____+_____+_____

Emotional Response Raw Score:_____

Is the individual mute? ___Yes _____No If your answer is yes, do not complete the next two subscales.

Cognitive Style

45.	Uses exceptionally precise speech.	0	1	2	3
46.	Attaches very concrete meanings to words.	0	1	2	3
47.	Talks about a single subject excessively.	0	1	2	3
48.	Displays superior knowledge or skill in specific subjects.	0	1	2	3
49.	Displays excellent memory.	0	1	2	3
50.	Shows an intense, obsessive interest in specific intellectual subjects.	0	1	2	3
51.	Makes naïve remarks (unaware of reaction produced in others).	0	1	2	3

Subtotal:_____+_____+_____

Cognitive Raw Score:_____

Maladaptive Speech

52.	Repeats (echoes) words or phases verbally or with signs.	0	1	2	3
53.	Repeats words out of context (repeats words or phases heard at an earlier time).	0	1	2	3
54.	Speaks (or signs) with flat tone affect.	0	1	2	3
55.	Uses "yes" and "no "inappropriately. Says "yes" when asked if he or she wants an aversive stimulus or says "no" when asked if he or she wants a favorite toy or treat.	0	1	2	3
56.	Uses "he" or "she" instead of "I" when referring to self.	0	1	2	3
57.	Speech is abnormal in tone, volume or rate.	0	1	2	3
58.	Utters idiosyncratic words or phrases that have no meaning to others.	0	1	2	3

Subtotals: _____+_____+_____

Maladaptive Speech Raw Score:_____

CONSENT FOR RELEASE OF INFORMATION
ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC

CB Benway CRNP, PMH, Owner
Jessica Henderson, CRNP, PMH-BC
Katie Koons, CRNP
13327 Wisdom Way
Hagerstown, Maryland 21742
appsmentalhealth@gmail.com
Telephone: 240-970-7300 Fax: 240-231-9755

Patient Name: _____ DOB:_____

I hereby authorize the exchange of information between:

_____
(Full name of person or provider you wish us to contact or exchange information with or get information from).

and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC.

This may include: All records, evaluations, results, and verbal conversations and any other pertinent data for continuity of care, continuation of care, collaboration of care and/or transfer of care.

I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC. It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation. I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

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_____ _____
Clients Signature Parent or Legal Guardian

_____ _____
Witness Date

Advanced Practice Psychiatric Solutions, LLC

13327 Wisdom Way
Hagerstown, MD 21742
Office: (240) 970-7300
Fax: (240) 231-9755
appsmentalhealth@gmail.com

Delegation of Authority Consent for Treatment

I_____, certify that I am the parent or legal guardian of

_____ Date of Birth_____.
(Name of Child)

I Hereby delegate to the following individual ("Designee") the authority to consent for any and all medical/mental health treatment provided by Advanced Practice Psychiatric Solutions, LLC for the above-named child.

NAME OF DESIGNEE_____

ADDRESS OF DESIGNEE_____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

EMAIL ADDRESS: _____

This authority includes, but is not limited to, the following methods of treatment:

Physical Health Assessment
Prescription of specific medications
Physical health assessment
Psychotherapy-individual group or/and family
Art Therapy
Speech and Language Therapy

I further authorize Advanced Practice Psychiatric Solutions, LLC, to release medical record information about the above-named child to my Designee.

I understand that this delegation of authority shall remain in effect until it I revoked by me or my Designee in writing, AND a copy of such revocation is received by Advanced Practice Psychiatric Solutions, LLC.

I release Advanced Practice Psychiatric Solutions, LLC and their directions, officers, employees and agents from any claim or liability arising solely out of reliance upon this delegation of authority.

_____ _____
(SIGNATURE OF PARENT/GUARDIAN) (DATE)