Clarity Clinic

PEDIATRIC IN-TAKE

In order to serve you properly, please complete ALL of the following information and bring it with you to your first visit. You may need to ask family members about the family history. If assistance was required in filling this form out, please indicate on form with name and relationship.

CONTACT INFORMATION

Patient Name Date

Primary Care Physician (PCP)

Primary Care Physician's Number

Primary Care Address

City State Zip

Current Therapist/Counselor's Name

Current Therapist/Counselor's Number

Email

Referred by (PCP, ZocDoc, Friend, Etc.)

REASON FOR VISIT

Don't know ☐ Evaluation ☐ Therapy for Child ☐ Family Therapy ☐

Medication ☐ Testing ☐

Please Summarize the concerns that led to this referral:

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ABOUT MY CHILD:

Gender _____ Race/Ethnicity_____ Religious Identity_____ Sexual Orientation_____

Interests/Hobbies_____

What do you see as your child's strengths?

SUICIDE RISK ASSESSMENT

Has your child ever expressed or acted in any way that has made you concerned for his/her safety (thoughts of wanting to die, plans to kill self, cutting self, burning self, etc.)?

Yes☐ No☐

If yes, please explain:

REVIEW OF SYMPTOMS			
please check all that apply			
MUSCULOSKELETAL			
Arthralgias	☐	Joint Swelling	☐
Myalgias	☐	NSAID Use	☐
Muscle Weakness	☐	Other	☐
SKIN			
Rash	☐	Nail Changes	☐
Pruritus	☐	Skin Thickening	☐
Sores	☐	Other	☐
NEUROLOGICAL			
Migraines	☐	Tremors	☐
Numbness	☐	Vertigo	☐
Ataxia	☐	Other	☐

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ENDOCRINE			
Excess Thirst	☐	Heat Intolerance	☐
Polyuria	☐	Goiter	☐
Cold Intolerance	☐	Other	☐
PSYCHIATRIC	☐		
Depression	☐	Drug Abuse	☐
Anxiety	☐	Insomnia	☐
Antidepressants	☐	Other	☐
Alcohol Abuse	☐		☐
HEM/LYMPHATIC	☐		
Easy Bruising	☐	Swollen Glands	☐
Bleeding Diathesis	☐	Lymphedema	☐
Blood Clots	☐	Others	☐
ALLERGIC/IMMUNE	☐		
Allergic Rhinitis	☐	Positive PPD	☐
Hay Fever	☐	Hives	☐
Asthma	☐	Other	☐

Please list ALL current prescription medications in reference to your child only

Medication Name	**Total Daily Dosage**	**Estimated Start Date**

PATIENT MEDICAL HISTORY

Height/Weight

Please list all allergies

Current over-the-counter medications or supplements

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Current medical problems

Past medical problems, non-psychiatric hospitalizations or surgeries

---

Have you ever had an EKG Yes No If yes, when was the EKG?

Results: Normal ☐ Abnormal ☐ Unknown ☐

DEVELOPMENTAL HISTORY

Birth History:

Biological Mother's age at time of birth _____ years.

Biological Father's age at time of birth _____years.

Did Biological Mother smoke while pregnant? Yes ☐ No ☐ Drink alcohol Yes ☐ No ☐ Use illicit Drugs Y ☐ N ☐

Did Biological Mother take medications during pregnancy? Yes ☐ No ☐ Please List:_____

Was Biological Mother under a doctor's care during pregnancy? Yes ☐ No ☐ Were there any complications during pregnancy? Yes ☐ No ☐ Please Describe_____

About the delivery: Number of weeks _____ Vaginal ☐ Caesarean ☐ Forceps ☐ Other Complications_____

What were the APGAR Scores? _____

Was the baby in the hospital or NICU for more than 2 days? Yes ☐ No ☐

If YES, please explain _____

DEVELOPMENT As closely as you can remember, please indicate when your child……..

Age of rolling over _____ Age of sitting alone_____ Age of walking_____

Large motor skills developed: Fast ☐ Slow ☐ Average ☐

Fine motor skills developed: Fast ☐ Slow ☐ Average ☐

Did your child seem clumsier than other children? Yes ☐ No ☐

Did your child point to things? Yes ☐ No ☐

Age of first words_____ Age of talking in sentences_____

Is your child: Right-handed ☐ Left-handed ☐ Uses both hands equally ☐

Age when child chose one hand more than the other____

Age when child stayed dry during the day ____

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Age when child stayed dry throughout the night ____

Age when child was bowel trained ____

Temperament As an Infant/Toddler did your child establish the following routines normally….

Sleep/Wake cycle Yes☐ No☐

Eating Yes☐ No☐

Was your child interested in other people? Yes☐ No☐

Did your child have colic? Yes☐ No☐

Was your child overly sensitive to:

Particular sounds (Sirens, loud noises)? Yes☐ No☐
Particular sensations(tags on clothes, socks, light touch, movement such as swinging? Yes☐ No☐
Particular smells? Yes☐ No☐
Particular tastes? Yes☐ No☐

Was your child:

Slow to warm up? Yes☐ No☐
Underactive? Yes☐ No☐
Aggressive? Yes☐ No☐
Shy? Yes☐ No☐
Overactive? Yes☐ No☐

PAST PSYCHIATRIC HISTORY

Outpatient Treatment Yes☐ No☐

If Yes, please list reasons/date(s), treated by whom

Psychiatric Hospitalizations? Yes☐ No☐

If yes, please list reasons/date(s), treated by whom

Please list if your child has ever taken any of the following medications: Antidepressants, mood stabilizers, antipsychotics, sedatives and hypnotics, ADHD Medications, Anti-Anxiety Medications. If yes, please list:

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FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or treated for:

	Yes	No	Which Family member
Bipolar Disorder	☐	☐	
Schizophrenia	☐	☐	
Depression	☐	☐	
Post-Traumatic Stress	☐	☐	
Anxiety	☐	☐	
Alcohol Abuse	☐	☐	
Other Substance Abuse	☐	☐	
Suicide	☐	☐	
Anger	☐	☐	
Violence	☐	☐	

Has any family member been treated with a Psychiatric Medication Yes☐ No☐
If yes, who was treated, what medications and how effective was treatment:

PAST PSYCHIATRIC HISTORY

Has your child ever been treated for alcohol or drug use or abuse? Yes☐ No☐
If yes, for which substances?

If yes where was he/she treated?

Any history of complicated withdrawal from substances, including seizures or delirium tremens (DTs)? If yes, explain?

Is your child currently using any alcohol, recreational drug, or misusing prescription medications? Yes☐ No☐

Does your child use any tobacco products such as cigarettes, e-cigarettes, cigars, pipes or chewing tobacco? If yes, how much and how often?

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EDUCATIONAL HISTORY

Name of current school_____ Phone Number: _____

Teacher's Name: _____ Grade:_____

Type of school: Public_____ Private_____ Special/Therapeutic_____

Grades repeated:_____ Grades skipped:_____ Suspended/Expelled? Yes☐ No☐ How many times:_____

Does your child have any known learning disabilities? Yes☐ No☐

Does your child have IEP? Yes☐ No☐

Is your child receiving any special education services (speech, reading, etc)? Yes☐ No☐
If yes, please explain:

Describe your child's behavior and academic performance in school over the past month:

Please fill in for current and all previous school years.

Grade	**School Name**	**Academic Performance**			**Behavior**			
Preschool		Good	Fair	Poor	Good	Fair	Poor	
Kindergarten		☐	☐	☐	☐	☐	☐	
1		☐	☐	☐	☐	☐	☐	
2		☐	☐	☐	☐	☐	☐	
3		☐	☐	☐	☐	☐	☐	
4		☐	☐	☐	☐	☐	☐	
5		☐	☐	☐	☐	☐	☐	
6		☐	☐	☐	☐	☐	☐	
7		☐	☐	☐	☐	☐	☐	
8		☐	☐	☐	☐	☐	☐	
9		☐	☐	☐	☐	☐	☐	
10		☐	☐	☐	☐	☐	☐	
11		☐	☐	☐	☐	☐	☐	
12		☐	☐	☐	☐	☐	☐	

ABOUT THE FAMILY

Are the parents/Caregivers of this child:

Married/Partnered Yes☐ No☐ Date:_____
Separated Yes☐ No☐ Date_____
Divorced Yes☐ No☐ Date_____
Remarried/Re-partnered Yes☐ No☐ Date_____

Is your child adopted Yes☐ No☐
Age of Adoption _____
Does your child know adoption status? Yes☐ No☐

Please briefly describe any changes or disruptions within the family background for your child. (Please include marriages/partnerships, separations, divorces, remarriages/re-partnerships.)

What does each Parent/Caregiver do for work?

1st Parent/Caregiver _____ 2nd Parent/Caregiver_____

What is the highest level of education of each Parent/Caregiver?

1st Parent/Caregiver_____ 2nd Parent/Caregiver _____

Other children living in the Home:

Name and Age:_____ Name and Age:_____

Name and Age:_____Name and Age:_____

Name and Age:_____Name and Age:_____

Other Relatives of persons living in the home:

Name and Age:_____Name and Age:_____

Name and Age:_____Name and Age:_____

Siblings/Half-siblings/Step-Siblings NOT Living in the home

Name and Age:_____Name and Age:_____

Name and Age:_____Name and Age:_____

Has your child ever been arrested? Yes☐ No☐
Does he/she have any pending legal problems? Yes☐No☐

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THANK YOU FOR COMPLETING THE FOLLOWING INFORMATION

If there is anything else you would like the provider to know, please indicate below.

SIGNATURE

Signature

Date

Emergency Contact/Relationship

Phone Number

If signed by a patient representative, state relationship to patient

Clarity Clinic

Thank you for choosing Clarity Clinic. In order to serve you properly, we need the following information. Please print. All information will be confidential.

BILLING INFORMATION		
Patient Name		Date
Date of Birth		Sex
Social Security #		
Address		
City	State	Zip
Preferred Telephone Number (Home/Cell/Work)		
Email		
RESPONSIBLE PARTY		
Name of person responsible for this account		
Address		
City	State	Zip
Telephone Number (Home/Cell/Work)		
Drivers License #		
Date of Birth		
Employer	Employer work Phone	
INSURANCE INFORMATION		
Name of insured	Relationship to patient	Date of Birth
Subscriber ID	Group #	
Insurance Company		
Insurance Company Address		

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (or dependents) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the provider. I understand that unless a 24-hour notice of cancellation is given. I may be charged for the time that the provider has set aside

for the appointment. In addition, that if my (or dependent(s)) account requires the services of a collection agency, I may incur charges to cover court and legal fees.

SIGNATURE

Signature (patient, parent or legal guardian) Date

If signed by a patient representative, state relationship patient

Clarity Clinic

PATIENT EASY PAY CONSENT FORM

(This form is not optional)

I authorize Clarity Clinic to charge my credit/debit card for late fees as outlined in the “Policies and Procedures” Form.

I authorize Clarity Clinic to charge my credit/debit card for all charges and services not paid by my insurance company within 90 days of services rendered including co-pays and no-show fees unless discussed otherwise with the office staff.

BILLING INFORMATION					
Name on Card					
Card Number					
Expiration Date		Type of card			
		VISA ☐	MasterCard ☐	AMEX ☐	Discover ☐
CVV Code					
Billing Address					
City		State	Zip		

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Clarity Clinic.

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	

Clarity Clinic

PATIENT TELEPHONE SESSION RATE

I acknowledge that any phone calls made to my therapist or psychiatrist exceeding 15 minutes will be billed as an out-of-pocket expense. The following rates apply:

Phone Call Duration	Therapist Rate	Psychiatrist Rate
15-30 Minutes	$50	$75
30-45 Minutes	$100	$150
45-60 Minutes	$120	$200

(*These rates DO NOT apply to teletherapy sessions)

AUTHORIZATION AND RELEASE

By signing below I understand and acknowledge these charges are out-of-pocket and will not be billed to my insurance company

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	

Clarity Clinic

CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction(s), they must follow the restriction(s).

Due to the increased frequency and complexity of the medication prior authorization process required by some insurance companies, government, and employers, there will be an administration fee of $10.00 per page to cover time spent by your doctor on the paperwork and a $20.00 fee if time is spent by your doctor on phone calls needed to complete a prior-authorization.

I understand that there will be an additional fee of $30.00 to send or obtain full medical records.
Finally, the administrative charges for additional letters and paperwork may apply to cover the time spent by your doctor on paperwork and phone calls needed to complete the authorization.

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	

Clarity Clinic

POLICIES AND PROCEDURE OVERVIEW

Thank you for choosing Clarity Clinic for your healthcare needs. We are committed to providing high quality, personalized and compassionate, comprehensive patient care. We ask that these policies be reviewed and acknowledged so that we may provide quality service and ensure proper reimbursement. Please sign the policy indicating that you have read the terms and conditions, in agreement to abide by them.

1. Consent for Treatment
    a. I hereby authorize and acknowledge to work with the authorities of Clarity Clinic, and the physician(s)/therapist(s) in charge of my/the case, to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.
2. Pre-Authorization for Benefits
    a. I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered. I understand that a quote of benefits is not a guarantee of payment.
3. Payment Guarantee
    a. Co-payments are due in FULL at the time of each visit.
    b. Full payment is due at the time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement is made with Clarity Clinic Billing Department.
    c. Sessions shortened by the patient will still be charged at the full reserved fee.
    d. Checks written and returned NSF/Account Closed will be charged an additional $35.00.
    e. In the event that a check has been returned NSF/Account Closed, all future payments must be made via Cash, Credit, or Debit Card.
    f. If you do not have insurance, payment is due in full at the time of each visit. Services may be turned away at the discretion of the provider.
    g. Responsibility of an account balance is always the Patient's, NOT the insurance company.
4. Release of Insurance-Related Information
    a. I authorize Clarity Clinic to release any information about me to insurance carriers needed to process claims.
5. Delinquent Accounts
    a. Patients must settle past due balances prior to scheduling future appointments.
    b. All outstanding balances are due in full at the time of service unless payment arrangements have been made with Clarity Clinic Billing Department.
    c. Non-payments of delinquent balances will be grounds for termination of services rendered by Clarity Clinic until the delinquent balance is resolved in its entirety.
    d. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorneys fees, court costs and filing fees will be the responsibility of the patient/guarantor.
6. Late Cancellation/Missed Appointment Charge
    a. We understand that occasionally life can get in the way, causing you to miss an appointment with us. In order for us to effectively care for all of our patients, it is important we are notified in advance when you must miss a scheduled appointment. Giving advance notice when you cannot attend your scheduled appointment permits us an opportunity to care for others.
    b. Fees apply for failure to provide 24-hour advanced notice. When a patient cancels/misses an appointment with less than 24-hour advance notice, the patient will be charged $50.
7. Therapy

   a. Patients who are under the care of a prescribing psychiatrist are encouraged to keep regular therapy appointments, unless directed otherwise.
8. Prescriptions
   a. Please notify your pharmacy 5 days before you run out of a medication, and have them fax the request to our office during regular business hours. Prescriptions are not refilled when our office is closed. Missing appointments may result in your doctor's inability to refill your prescription.
   b. Refill and prescribing of controlled substances MUST ALWAYS be done at the appointment and will not be able to be called in. No exceptions.
   c. In the event a physician changes, discontinues, or adjusts a patient's medication the patient will be required to make any follow up appointment in the timeframe the physician deems necessary.
9. Follow-up Appointments by Phone
   a. Clarity Clinic clinicians charge for clinical phone consultations with patients. Charges are according to the individual clinician's specific fee schedule. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultations charges are solely the patient's responsibility.
10. Medical Records Change
   a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee of $20 for any released Medical Records.
   b. Medical Record releases take a minimum of 10 business days from the date Clarity Clinic receives a signed release form. Medical Records will be released once the processing fee has been paid in full.
11. Completion of Forms/Letters
   a. The charge for the completion of forms/letters can typically range from $30-$150 ($15 per page). However, please note that depending upon the length of the forms or documentation being requested this charge could be higher.
12. Discharge from Care
   a. You have control over your care, and you have the right to eliminate your care with us at any time. We reserve the right to discharge any patient from this practice at any time for failure to comply with office policies or treatment recommendations. We will provide referral suggestions, if requested, in this event.

Please sign below to authorize treatment indication that you acknowledge these stated policies and your full financial responsibility for services rendered.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date

Clarity Clinic

CONTROLLED SUBSTANCE AGREEMENT

Part 1: I UNDERSTAND

- Part of my treatment may include prescriptions for benzodiazepines, stimulants, and narcotics to improve my ability to function. These medications are only part of my treatment.
- Treatment with these medications may have side effects including nausea, sleepiness, difficulty breathing (if taken in excess), itching, difficulty concentrating, constipation, and difficulty urinating.
    - Additional side effects for men include low testosterone levels.
    - Additional side effects for women include changes in menstrual cycles.
- If I take these medicines for more than a few weeks, I may become used to them and could develop physical dependence and/or addiction. I could experience withdrawal if I stop taking them suddenly, which could lead to death. The risks of dependence, tolerance, and side effects specific to the medication have been explained to me.
- If I do not reach my treatment goals from use of these medications, my provider may gradually discontinue them or may adjust my dose.
- Medication will not be refilled on weekends or holidays.
- Psychiatric symptoms can be improved by good health habits such as exercise, healthy diet, and abstinence from tobacco, alcohol, and illicit drugs.

I WILL

- Tell my provider if I have been diagnosed with, treated, or arrested for drug dependence or abuse prior to starting treatment with the prescribed medications.
- Tell my provider if I have been involved in the sale, illegal possession, or transport of controlled substances prior to starting treatment.
- Take my controlled medication as prescribed, taper the medication if recommended by my provider at any time, and reduce the medication only under the supervision of my provider.
- Tell my other provider(s) and any emergency department I may visit that I am taking controlled medication and have an agreement with Clarity Clinic.
- Tell my provider about ALL of the medications (over-the-counter herbs, vitamins, those ordered by other providers, legal, illegal) that I am taking because this medication can interact with other substances, which could potentially lead to death.
- Only ask for refills during clinic hours (8:00am-5:00pm, Monday-Friday).
- Provide at least three (3) days notice for refills of medications
- Tell my provider if I get the prescribed medications or other controlled substances from any other provider.
- Keep my controlled medications in a safe place, locked away from children and to prevent theft.
- Attend my appointments regularly and call my provider’s offer at least 24 hours in advance if I need to cancel my appointment.
- Submit to random tests of my urine or blood and pill counts within 48 hours of request.
- Actively participate in therapy and other non-medication treatment if I am recommended to do so by the provider as part of my treatment plan.

I WILL NOT

- Share, sell, or trade my medications with anyone.
- Use someone else’s medications.

- Use any illegal drugs (crystal meth, marijuana, cocaine, etc.)
- Change how I take my medications without asking my provider.
- Ask my provider for extra refills if I use up my supply or lose or misplace my medications before my next refill is due. Looking after my medications and complying with my prescription are my responsibility.

Part 2: I UNDERSTAND

If I do not do all of the things listed in Part 1, my provider:

- May no longer prescribe the medications for me.
- May stop giving me medical care.
- May send me to drug abuse treatment

PART 3: CLARITY CLINIC CONTROLLED SUBSTANCE POLICIES

- Each patient is allowed up to 1 early refill per year.
- If a patient loses a script, they must come in for an appointment. Prescriptions cannot be left at the front desk or issued without an appointment.
- Newly prescribed patients must come in for an appointment once a month for the 1st year. After the 1st year, prescribed patients must come for at least follow-ups every two months.
- Patients prescribed a dosage that exceeds the FDA approved dosage must come in monthly
    - Vyvanse - 70mg/day
    - Adderall - 60mg/day
    - Concerta/Methylphenidate - 72mg/day
- Patients should receive EKG and blood pressure reading after increasing stimulant dose greater than FDA approved dose and at least once a year.
- Patients on disability and not currently working will not receive Adderall.
- If a prescribed patient is away at college, the patient must come in at least every 3 months. If this is not possible, the patient must find a doctor nearby to manage their medication.
- Patients with blood pressure greater than 160/100 must receive either primary care of cardiology clearance before receiving refills at the next appointment. Failure to do so will result in medication not being refilled.
- Patients with congenital heart, valve issues, Sickle Cell Anemia require cardiology clearance before beginning stimulants.
- Patients with a history of drug addiction on stimulants will be subject to random drug screens. If patient is positive, inferring any potential for drug abuse, the patient will be sent a termination letter.
- Patients on more than 4mg of Xanax, Lorazepam, or Clonazepam must come to clinic at least every 2 weeks until patient is tapered down to 4mg of respective medication. Patients on greater than 2mg and less than 4mg will not receive greater than a 30-day script and will have to come each month to refill medication.

PART 4: SIGN THE FORM

The decision to use controlled substances (benzodiazepines, stimulants, narcotics) has been made between my provider and me because of my specific condition. When I sign this form, I acknowledge that I understand and agree to the above conditions to make my treatment as safe and successful as possible. A copy of this agreement will be maintained in my medical record. I

can cancel this agreement at any time, except to the extent my provider has already acted in reliance on it. If not canceled before, this agreement will end on my last dose of the medications prescribed by my provider. If I cancel this agreement, my provider may take any or all of the actions described above.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date

Clarity Clinic

AUTHORIZATION TO RELEASE OUTPATIENT RECORDS

I, _____, hereby request and authorize Clarity Clinic to release the information which is contained in any outpatient psychiatric, psychotherapy, alcohol and/or substance abuse records, including any & all information gained in interviewing & examining including, but not limited to, any outpatient treatment.

The persons or entities, including oneself, authorized to receive the information and records covered by this consent are: (Please provide relationship, name, address, and telephone number).

Name	Relationship	Phone
Address		
Name	Relationship	Phone
Address		
Name	Relationship	Phone
Address		

- The information and records which may be released are limited to all medical records or other information obtained by **Clarity Clinic,** through interviews or inquiries concerning or obtained from other persons, and will include all outpatient psychiatric, psychotherapy, alcohol and/or substance abuse records which are in the possession of control of **Clarity Clinic.**
- The purpose of such disclosure is for use in connection with Coordination of Care purposes. The information and records released pursuant to this consent will not be used for any other purposes.
- I understand that I may refuse to sign this authorization to release information.
- I understand that I receive a copy of this authorization to release information.
- I understand that this release automatically expires within ninety days unless I authorize it to ask to authorize the expiration to be sooner.

SIGNATURE		
Patient Name (Print)	Patient/Guarantor Signature	Date
Provider Name	Provider Signature	Date

Clarity Clinic

NICHQ VANDERBILT ASSESSMENT SCALE
PARENT

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

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

---

Symptoms	Never	Occasionally	Often	Very Often	
Does not pay attention to details or makes careless mistakes with, for example, homework	☐	☐	☐	☐	
Has difficulty keeping attention to what needs to be done	☐	☐	☐	☐	
Does not seem to listen when spoken to directly	☐	☐	☐	☐	
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	☐	☐	☐	☐	
Has difficulty organizing tasks and activities	☐	☐	☐	☐	
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	☐	☐	☐	☐	
Loses things necessary for tasks or activities (toys, assignments, pencils, or books.)	☐	☐	☐	☐	
Is easily distracted by noises or other stimuli	☐	☐	☐	☐	
Is forgetful in daily activities	☐	☐	☐	☐	
Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐	
Leaves seat when remaining seated is expected	☐	☐	☐	☐	
Runs about or climbs too much when remaining seated is expected	☐	☐	☐	☐	

	Never	Occasionally	Often	Very Often	
Has difficulty playing or beginning quiet play activities	☐	☐	☐	☐	
Is "on the go" or often acts as if "driven by a motor"	☐	☐	☐	☐	
Talks too much	☐	☐	☐	☐	
Blurts out answers before questions have been completed	☐	☐	☐	☐	
Has difficulty waiting his or her turn	☐	☐	☐	☐	
Interrupts or intrudes in others' conversations and activities	☐	☐	☐	☐	
Argues with adults	☐	☐	☐	☐	
Loses temper	☐	☐	☐	☐	
Actively defies or refuses to go along with adult's' requests or rules	☐	☐	☐	☐	
Deliberately annoys people	☐	☐	☐	☐	
Blames others for his or her mistakes or misbehavior	☐	☐	☐	☐	
Is touchy or easily annoyed by others	☐	☐	☐	☐	
Is angry or resentful	☐	☐	☐	☐	
Is spiteful and wants to get even	☐	☐	☐	☐	
Bullies, threatens, or intimidates others	☐	☐	☐	☐	
Starts physical fights	☐	☐	☐	☐	
Lies to get out of trouble or to avoid obligations (i.e. "cons" others)	☐	☐	☐	☐	
Is truant from school (skips school) without permission	☐	☐	☐	☐	
Is physically cruel to people	☐	☐	☐	☐	
Has stolen things that have value	☐	☐	☐	☐	
Deliberately destroys others' property	☐	☐	☐	☐	
Has used a weapon that can cause serious harm (bat, knife, brick, gun)	☐	☐	☐	☐	
Is physically cruel to animals	☐	☐	☐	☐	
Has deliberately set fires to cause damage	☐	☐	☐	☐	

	Never	Occasionally	Often	Very Often	
Has broken into someone else's home, business or car	☐	☐	☐	☐	
Has stayed out at night without permission	☐	☐	☐	☐	
Has run away from home overnight	☐	☐	☐	☐	
Has forced someone into sexual activity	☐	☐	☐	☐	
Is fearful, anxious or worried	☐	☐	☐	☐	
Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐	
Feels worthless or inferior	☐	☐	☐	☐	
Blames self for problems, feels guilty	☐	☐	☐	☐	
Feels lonely, unwanted or unloved, complains that "no one loves him or her"	☐	☐	☐	☐	
Is sad, unhappy or depressed	☐	☐	☐	☐	
Is self-conscious or easily embarrassed	☐	☐	☐	☐	

Performance	**Excellent**	**Above Average**	**Average**	**Somewhat a problem**	**Problematic**
Overall school performance	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Mathematics	☐	☐	☐	☐	☐
Relationship with parents	☐	☐	☐	☐	☐
Relationship with siblings	☐	☐	☐	☐	☐
Relationship with peers	☐	☐	☐	☐	☐
Participation in organized activities (i.e. teams)	☐	☐	☐	☐	☐

Clarity Clinic

COLUMBIA IMPAIRMENT SCALE

Directions: This survey asks questions about how you think your child is doing overall. Please answer the question on a scale from 0 to 4, with "0" being "no problem" and "4" being a "very bad problem." If the question does not apply to your child, please indicate with N/A.

In general, how much of a problem do you think that your child has with:					
	No Problem 0	**1**	**2**	**3**	**Very bad Problem 4**
Getting into trouble	☐	☐	☐	☐	☐
Getting along with his/her mother?	☐	☐	☐	☐	☐
Getting along with his/her father?	☐	☐	☐	☐	☐
Feeling unhappy or sad?	☐	☐	☐	☐	☐
Behavior at school/on the job	☐	☐	☐	☐	☐
Having fun?	☐	☐	☐	☐	☐
Getting along with adults other than his/her parents?	☐	☐	☐	☐	☐
Feeling nervous or worried?	☐	☐	☐	☐	☐
Getting along with brothers/sisters?	☐	☐	☐	☐	☐
Getting along with other kids his/her age?	☐	☐	☐	☐	☐
Getting involved in activities like sports or hobbies?	☐	☐	☐	☐	☐
School/work/job?	☐	☐	☐	☐	☐
Behavior at home?	☐	☐	☐	☐	☐

Clarity Clinic

PEDIATRIC SYMPTOM CHECKLIST
(PARENT FORM)

Subject name: _____ _____
(First name) (Last name)

Today's Date _____/_____/_____

Directions: This instrument asks questions about your child's feelings, complaints or behaviors. All of the items below will be true for every child at sometime in his or her life. Please read each question carefully and fill in the correct tally for the response that you believe is **most true for your child during the past 6 months.**

Does your child:			
	Never	**Sometimes**	**Often**
Fidget, is unable to sit still	☐	☐	☐
Act as if driven by a motor	☐	☐	☐
Daydream too much	☐	☐	☐
Distract easily	☐	☐	☐
Feel sad	☐	☐	☐
Feel hopeless	☐	☐	☐
Have trouble concentrating	☐	☐	☐
Fight with other children	☐	☐	☐
Feel down on him/herself	☐	☐	☐
Worry a lot	☐	☐	☐
Seem to be having less fun	☐	☐	☐
Not listen to rules	☐	☐	☐
Not understand other people's feelings	☐	☐	☐
Tease others	☐	☐	☐
Blame others for his/her troubles	☐	☐	☐
Refuse to share	☐	☐	☐
Take things that do not belong to him/her	☐	☐	☐

Clarity Clinic

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDER (SCARED)

CHILD FORM (8 YEARS AND OLDER*)

*For children ages 8 to 11, it is recommended that the child answer the questionnaire sitting with an adult in case they have any questions

Directions: Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "**Not True or Hardly Ever True"** or "**Somewhat True or Sometimes True"** or **"Very True or Often True"** for you. Then for each statement, indicate which statement corresponds to the response that seems to describe you **now or within the past 6 weeks.** Please respond to all statements as well as you can, even if some do not seem to concern you.

	0	1	2
	Not True or Hardly Ever True	**Somewhat True or Sometimes True**	**Very True or Often True**
When I feel frightened, it is hard to breathe	☐	☐	☐
I get headaches when I am at school	☐	☐	☐
I don't like to be with people I don't know well	☐	☐	☐
I get scared if I sleep away from home	☐	☐	☐
I worry about other people liking me	☐	☐	☐
When I get frightened I feel like passing out	☐	☐	☐
I am nervous	☐	☐	☐
I follow my mother or father wherever they go	☐	☐	☐
People tell me that I look nervous	☐	☐	☐
I feel nervous with people I don't know well	☐	☐	☐
I get stomach aches at school	☐	☐	☐
When I get frightened I feel like I am going crazy	☐	☐	☐
I worry about sleeping alone	☐	☐	☐
I worry about being as good as other kids	☐	☐	☐
When I get frightened, I feel like things are not real	☐	☐	☐
I have nightmares about something bad happening to my parents	☐	☐	☐
I worry about going to school	☐	☐	☐

When I get frightened, my heart beats fast	☐	☐	☐
I get shaky	☐	☐	☐
I have nightmares about something bad happening to me	☐	☐	☐
I worry about things working out for me	☐	☐	☐
When I get frightened, I sweat a lot	☐	☐	☐
I am a worrier	☐	☐	☐
I get really frightened for no reason at all	☐	☐	☐
I am afraid to be alone in the house	☐	☐	☐
It is hard for me to talk with people I don't know well	☐	☐	☐
When I get frightened, I feel like I am choking	☐	☐	☐
People tell me that I worry too much	☐	☐	☐
I don't like to be away from my family	☐	☐	☐
I am afraid of having anxiety (or panic) attacks	☐	☐	☐
I worry that something bad might happen to my parents	☐	☐	☐
I feel shy with people I don't know well	☐	☐	☐
I worry about how well I do things	☐	☐	☐
I worry about what is going to happen in the future	☐	☐	☐
When I get frightened, I feel like throwing up	☐	☐	☐
I worry about how well I do things	☐	☐	☐
I am scared to go to school	☐	☐	☐
I worry about things that have already happened	☐	☐	☐
When I get frightened, I feel dizzy	☐	☐	☐
I feel nervous when I am with other children or adults and I have to do something while they watch me (ex: read aloud, speak, play a game, play a sport)	☐	☐	☐
I am shy	☐	☐	☐

Clarity Clinic

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)
(PARENT FORM)

Below is a list of items that describe how people feel. For each item, please darken the circle that best describes your child's feelings **now or in the past 2 weeks.** Please answer all items as well as you can even if some do not seem to concern your child.

	0	1	2
	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
When my child feels frightened, it is hard for him/her to breathe	☐	☐	☐
My child gets headaches when he/she is at school	☐	☐	☐
My child doesn't like to be with people he/she doesn't know well	☐	☐	☐
My child gets scared if he/she sleeps away from home	☐	☐	☐
My child worries about other people liking him/her	☐	☐	☐
When my child gets frightened, he/she feels like passing out	☐	☐	☐
My child is nervous	☐	☐	☐
My child follows me wherever I go (he/she is like my shadow)	☐	☐	☐
People tell my child that he/she looks nervous	☐	☐	☐
My child feels nervous with people he/she doesn't know well	☐	☐	☐
My child gets stomach aches at school	☐	☐	☐
When my child gets frightened, he/she feels like he/she is going crazy	☐	☐	☐
My child worries about sleeping alone	☐	☐	☐
My child worries about being as good as other kids	☐	☐	☐
When my child gets frightened, he/she feels like things are not real	☐	☐	☐
My child has nightmares about something bad happening to his/her parents	☐	☐	☐
My child worries about going to school	☐	☐	☐
When my child gets frightened, his/her heart beats fast	☐	☐	☐

My child gets shaky	☐	☐	☐
My child has nightmares about something bad happening to him/herself	☐	☐	☐
My child worries about things working out for him/herself	☐	☐	☐
When my child gets frightened, he/she sweats a lot	☐	☐	☐
My child is a worrier	☐	☐	☐
My child gets really frightened for no reason at all	☐	☐	☐
My child is afraid to be alone in the house	☐	☐	☐
It is hard for my child to talk with people he/she doesn't know well	☐	☐	☐
When my child gets frightened, he/she feels like he/she is choking	☐	☐	☐
People tell my child that he/she worries too much	☐	☐	☐
My child doesn't like to be away from his/her family	☐	☐	☐
My child is afraid of having anxiety (or panic) attacks	☐	☐	☐
My child worries that something bad might happen to his/her parents	☐	☐	☐
My child feels shy with people he/she doesn't know well	☐	☐	☐
My child worries about what is going to happen in the future	☐	☐	☐
When my child gets frightened, he/she feels like throwing up	☐	☐	☐
My child worries about how well he/she does things	☐	☐	☐
My child is scared to go to school	☐	☐	☐
My child worries about things that have already happened	☐	☐	☐
When my child gets frightened, he/she feels dizzy	☐	☐	☐
My child feels nervous when he/she is with other children or adults and has to do something while they watch him/her (ex: reading aloud, speak, play a game, play a sport)	☐	☐	☐
My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she does not know well	☐	☐	☐
My child is shy	☐	☐	☐

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MOOD AND FEELINGS QUESTIONNAIRE
(PARENT VERSION)

Please indicate next to the statement that best describes your child in the past two weeks.

	No true	Sometimes	TRUE
S/he felt miserable or unhappy	☐	☐	☐
S/he didn't enjoy anything at all	☐	☐	☐
S/he was less hungry than usual	☐	☐	☐
S/he ate more than usual	☐	☐	☐
S/he felt so tired that s/he just sat around and did nothing	☐	☐	☐
S/he was moving and walking more slowly than usual	☐	☐	☐
S/he was very restless	☐	☐	☐
S/he felt s/he was no good anymore	☐	☐	☐
S/he blamed her/himself for things that weren't his/her fault	☐	☐	☐
It was hard for her/him to make up her/his mind	☐	☐	☐
S/he felt grumpy and cross with you	☐	☐	☐
S/he felt like talking less than usual	☐	☐	☐
S/he was talking more slowly than usual	☐	☐	☐
S/he cried a lot	☐	☐	☐
S/he thought there was nothing good for her/him in the future	☐	☐	☐
S/he thought that life wasn't worth living	☐	☐	☐
S/he thought about death or dying	☐	☐	☐
S/he thought her/his family would be better off without her/him	☐	☐	☐
S/he thought about killing her/himself	☐	☐	☐
She didn't want to see her/his friends	☐	☐	☐
S/he found it hard to think properly or concentrate	☐	☐	☐

S/he thought bad things would happen to her/him	☐	☐	☐
S/he hated him/herself	☐	☐	☐
S/he felt s/he was a bad person	☐	☐	☐
S/he thought s/he looked ugly	☐	☐	☐
S/he worried about aches and pains	☐	☐	☐
S/he felt lonely	☐	☐	☐
S/he thought nobody really loved her/him	☐	☐	☐
S/he didn't have any fun at school	☐	☐	☐
S/he thought s/he could never be as good as other kids	☐	☐	☐
S/he felt s/he did everything wrong	☐	☐	☐
S/he didn't sleep as well as s/he usually sleeps	☐	☐	☐
S/he slept a lot more than usual	☐	☐	☐
S/he wasn't as happy as usual, even when you praised or rewarded her/him	☐	☐	☐

Clarity Clinic

MOOD AND FEELINGS QUESTIONNAIRE

(CHILD VERSION)

Please indicate next to the statement that best describes you in **in the past two weeks.**

	0	1	2
	No true	**Sometimes**	**TRUE**
I feel awful or unhappy	☐	☐	☐
I didn't enjoy anything at all	☐	☐	☐
I was less hungry than usual	☐	☐	☐
I ate more than usual	☐	☐	☐
I felt too tired. I just sat around and did nothing	☐	☐	☐
I was moving and walking more slowly than usual	☐	☐	☐
I was very restless	☐	☐	☐
I felt I was no good anymore	☐	☐	☐
I blamed myself for things that weren't my fault	☐	☐	☐
It was hard for me to make up my mind	☐	☐	☐
I felt grumpy and upset with my parents	☐	☐	☐
I felt like talking less than usual	☐	☐	☐
I was talking more slowly than usual	☐	☐	☐
I cried a lot	☐	☐	☐
I thought there was nothing good for me in the future	☐	☐	☐
I thought that life wasn't worth living	☐	☐	☐
I thought about death and dying	☐	☐	☐
I thought my family would be better off without me	☐	☐	☐
I thought about killing myself	☐	☐	☐
I didn't want to see my friends	☐	☐	☐
I found it hard to pay attention or concentrate	☐	☐	☐
I thought bad things would happen to me	☐	☐	☐
I hated myself	☐	☐	☐

I felt I was a bad person	☐	☐	☐
I thought I looked ugly	☐	☐	☐
I worried about aches and pains	☐	☐	☐
I felt lonely	☐	☐	☐
I thought nobody really loved me	☐	☐	☐
I didn't have any fun at school	☐	☐	☐
I thought I could never be as good as other kids	☐	☐	☐
I felt I did everything wrong	☐	☐	☐
I didn’t sleep as well as I usually sleep	☐	☐	☐
I slept a lot more than usual	☐	☐	☐