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Welcome Letter

Greetings,

Welcome to our integrated medical home!

If you are receiving this packet, there may have been new life stressors, behavioral concerns, emotional concerns, or worsening physical health that our mental health team is being asked to support. Prior to your first visit, please review this introduction to the Behavioral Health Team.

In order to make the most of our time together, we ask that you **complete the intake history (pages 15-22) and enclosed screening questionnaires (pages 23-31). Please return them to the office as soon as possible prior to your appointment.** Be advised that one of the Vanderbilt Screenings needs to be filled out by your child's teacher. Please give this to the teacher(s) as soon as possible to give them plenty of time to complete and return.

You may upload your completed documents to the patient portal, fax to 610-621-0127, or drop off to any of our office locations. Faxed or hand delivered documents should be addressed to the attention of the Behavioral Health Care Team.

For patients that are 14 years of age or older, please complete the HIPAA release form (page 7) to let our team know with whom we may share information regarding mental health treatment.

Let our office know if we need to request records from previous providers and specialists and sign the enclosed release of information (page 9). Please bring all medications that are not being prescribed by Reading Pediatrics providers, in their original prescription bottles and any supplements in labeled bottles.

We look forward to working with you!

Behavioral Health Team
Reading Pediatrics

Meet Our Behavioral Health Team



Tarah Bird, Board Certified Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC) joined the Reading Pediatrics team in December 2025. Tarah is originally from Clifton Park, NY. She obtained her Bachelor of Science in Nursing from East Stroudsburg University. She went on to pursue her Master of Science degree in Nursing from Wilkes University. Tarah was a member of Sigma Theta Tau International Honor Society of Nursing. After graduating,

Tarah worked for the St. Luke's University Health Network and then joined a private practice, Complete Mind Care of PA, in the Horsham area. Tarah's responsibilities included managing the behavioral health care of individuals 26 years and younger with a variety of mental health conditions, including Autism, trauma, depression, anxiety, mood and bipolar disorders. Tarah's professional interests are rooted in child and adolescent psychiatry. Through her clinical experience, she recognized a significant gap in access to quality psychiatric care and the urgent need for greater support for children and families.

This inspired her dedication to improving mental health services and advocating for compassionate, evidence-based care. She values a comprehensive approach when providing care, recognizing that each child/ adolescent is a unique individual and tailors treatment plans to meet individual goals/ needs. Tarah recently moved to the Berks County area and felt that the move to Reading Pediatrics supported her professional values. Outside of work, Tara enjoys cooking, baking, taking walks, spending time at the beach, and reading.



Barbara McCaskey is a Licensed Social Worker. Barbara joined the Reading Pediatrics Behavioral Health Care team in June 2018 as the Behavioral Health Care Program Manager/Social Worker. She initially served in this position as a contracted provider and officially joined the staff of Reading Pediatrics beginning July 2019. Barbara attended Albright College, where she graduated with a BA from a Council on Social Work Education accredited Social Work program. She then attended the University of Pennsylvania, where she received a Master of Social Work degree. Barbara returned to Berks County, where she began her career servicing the children and families of Berks County. Barbara's professional experiences include working at Berks County Children and Youth Services, where she was instrumental in developing and implementing the Managed Care Unit. In 2008, Barbara began working directly in the mental health field, where she served as a mental health professional at a partial hospital program. She has also worked as a Family Based therapist, mobile therapist and behavioral specialist consultant, and an out-patient therapist. Barbara enjoys spending time with her husband, Scott; daughters, Kayla and Lauren; and their families. Barbara enjoys traveling and is an avid cruiser!

What to Expect During a Behavioral Health Appointment:

At each office visit, parents will be asked to confirm the child's insurance information and demographics either at the time of check-in or when contacted to confirm the patient's appointment. Although emergencies and delays do occur, Reading Pediatrics strives to maintain a punctual schedule. Therefore, patients more than fifteen minutes late for their appointment will be asked to reschedule their appointment so that the provider can see future patients in a timely manner.

Appointments will occur either in-person or via telehealth. For telehealth appointments, please utilize the link for telehealth appointments found on the Reading Pediatrics website. Please login at least 5 minutes prior to your scheduled appointment. Please be patient with the provider; he/she will connect with you as soon as possible. For in-person appointments, please check in at the front desk. Staff may obtain vital signs including blood pressure, weight and pulse based on medical necessity.

During initial evaluations, the provider will review parent/patient concerns, Vanderbilt, SCARED and PHQ-9 screens and history extensively. The provider will review findings with the patient/family and provide recommendations for services and/or pharmacological interventions. Seeing our provider does not always result in a recommendation for medication. Our team coordinates therapy referrals, educates, and advocates for needs i.e. with schools. Brief therapeutic recommendations can be made but, therapy cannot be provided due to scheduling.

During follow-up appointments, the provider will review the patient's progress since the last appointment, reactions (positive and negative) to any recommended medications and therapeutic interventions.

At the end of the appointment, the provider will advise when a follow-up appointment should occur. If the appointment is not scheduled prior to leaving the office, you should be contacted by RPI staff within 2 weeks. If you do not hear from our staff, please call our Behavioral Health Care Coordinator at x3123.

It is important to remember that psychiatric medications are not typically fast acting medications, taking a minimum of 4-6 weeks before becoming fully effective. Most require time to build up in the patient's system and must be slowly titrated to prevent further medical complications. You will be informed of side-effects that would require immediate attention.

Our Behavioral Health Care Program Manager has been designated to help facilitate communication in between appointments. Please contact her, at x3114, to discuss concerns as she is oftentimes able to provide guidance, answer questions and/or communicate with providers in-between patients on an as needed basis. Our Nurse Practitioners meet with our staff psychiatrist for routine supervision/case consultation.

Our Behavioral Health program is an out-patient program designed to support our patients and their families. We are not a psychiatric emergency facility. If your child is in immediate danger of self-harm, please contact 911, your county crisis center and/or go to the nearest emergency room. (See crisis # list)

The goal of the Behavioral Health Care team, in conjunction with the patient's primary care provider to is stabilize the patient and transition the patient to his/her PCP's care for ongoing monitoring. If the team decides that periodic check-ins with the Behavioral Health Care team would be helpful, a decision will be made regarding the frequency of these appointments.

Missed Appointment Policy

Missed appointments are costly and take away from valuable appointment time from others, therefore, we ask that you be aware of your commitment. Any appointments canceled within 24 hours of the appointment, or any missed appointments/"no show" will incur a cancellation fee of \$100 at the discretion of the practice.

Sharing Confidential/HIPPA Information:

Mental Health regulations in Pennsylvania necessitate obtaining permission from patients, 14 and over, or the parents/guardians of younger children to share protected health information. Therefore, you will find a HIPPA form which should be signed by a patient over the age of 14 which allows RPI staff to communicate with the patient's parent(s)/caretaker(s) regarding behavioral health concerns. A Release of Information form is needed in order for RPI staff to communicate with another provider, community service agency, school, etc. The enclosed Release of Information form must be completed and signed by a patient 14 and over or a parent for younger patients. Please either print additional forms or request additional copies if you have more than 1 provider working with you.

On Site Counseling Collaborators:

Reading Pediatrics has established a partnership with the following agencies who provide therapeutic services in our offices and, if preferred, at their own agencies. We are proud of the partnership which enhances communication and coordination of care between the therapists and our providers.

Betterview Counseling and Trauma Recovery (Temple location)

Address: 845 N. Park Rd., Suite 104, Wyomissing, PA 19610

Phone: 484-709-1381

<http://www.betterviewcounseling.com>

Family Guidance (Wyomissing location)

Address: 1235 Penn Ave, Suite 205, Wyomissing, Pa 19610

Phone: (610) 374-4963

<http://www.familyguidancecenter.com/site/>

Medical Information Release Form

HIPAA release form must be completed by all patients age 14 and older seeking behavioral health services.
This is required to allow for communication with parents.

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Patient E-Mail: _____ (for patient portal access)

Please check the appropriate boxes below:

I DO NOT authorize the release of my medical or mental health/substance use information to anyone but myself.

OR

I DO authorize the release of my medical information, including but not limited to diagnoses, labs, imaging results, examinations rendered, and claims information.

I DO authorize the release of information pertaining to my mental health care or substance abuse history.

This information may be released to:

Name: _____ Relation: _____

Name: _____ Relation: _____

This release of Information will remain in effect until termination by me in **writing**,

Signature: _____ Date: _____

Witness: _____ Date: _____



Reading Pediatrics
40 Berkshire Court Wyomissing, PA 19610
(P) 610-374-7400 (F) 610-374-4252

Authorization for Release of Information

Patient Name: _____

Date of Birth: _____

I hereby authorize Reading Pediatrics to exchange information with:

Name: _____ Phone: _____

Address: _____ Fax: _____

The information to be **RELEASED** for the purpose of coordination of care is:

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Medication List
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Medical History	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Individual Education Plan (IEP)	<input type="checkbox"/> Integrated Clinical Summary	<input type="checkbox"/> Psychological Evaluation
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Substance Abuse Information	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Other: _____		

The information to be **OBTAINED** for the purpose of coordination of care is:

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Medication List
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Medical History	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Individual Education Plan (IEP)	<input type="checkbox"/> Integrated Clinical Summary	<input type="checkbox"/> Psychological Evaluation
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Substance Abuse Information	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Other: _____		

I have been told that, to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited to the person and purposes listed above and will be effective for one year after the date of my signature unless specified below. I also understand that I may revoke this authorization except to the extent that action has already been taken. Refusal to disclose all or some health care information may result in improper diagnosis or treatment. Denial of coverage or a claim, for health benefits/insurance or adverse consequences. Your signature or refusal to sign this consent will not solely be used as a basis for treatment.

This consent shall be in effect from _____ until _____
Date of release _____ (1 year if end date not specified)

Would you like a copy of this release? YES NO

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

Signature of Patient (14 years and older) _____ Date: _____
(Needed for Release of Mental health/Substance Abuse Records)

Witness: _____ Date: _____

Does My Teen Need Help?

Physical Warning Signs:

- ▶ Cuts on arms or legs or other physical signs of self-harm
- ▶ Rapid or major weight loss or weight gain
- ▶ Physical injuries without good explanations
- ▶ Many stomach, head, and/or back aches
- ▶ Worsening of a chronic condition

Behavioral or Emotional Warning Signs:

- ▶ Major change in eating and/or sleeping habits
- ▶ Signs of frustration, stress, or anger
- ▶ Unusual or increasing fear, anxiety, or worry
- ▶ Relationship difficulties with family, friends, classmates, or teachers
- ▶ Skipping school, not participating in class, and/or a drop in grades
- ▶ Changes or problems with energy level or concentration
- ▶ Sudden mood swings
- ▶ Feeling down, hopeless, worthless, or guilty
- ▶ Aggressive or violent behavior
- ▶ Sudden loss of self confidence or sense of security
- ▶ Risky behaviors, breaking laws, stealing, hurting people
- ▶ Signs of alcohol or drug use
- ▶ Losing interest in things that were once enjoyed
- ▶ Constant concern about physical appearance or decrease in personal hygiene
- ▶ Isolation from others and often spends time alone
- ▶ Secretive about activities and whereabouts

If you notice any of the above warning signs, talk with your teen and then call your teen's health care provider. Be ready to discuss how serious the problem is, when the problem started, and any changes in your teen's school or family situation. Don't wait too long before seeking help.

IMPORTANT QUESTIONS TO ASK YOUR TEEN

- When and why did this problem start?
- How much is this problem troubling you?
- Is the problem getting in the way of your school work or relationships with friends or family members?

- Have you been having any thoughts about dying or hurting yourself?
- How can I help you?

Don't be afraid to ask your teen what's going on in his/her life. It will not cause any harm. A teenager in trouble needs support from caring parents.

MENTAL HEALTH EMERGENCIES

- ▶ Losing touch with reality
- ▶ In great danger of harming him/herself
- ▶ In great danger of harming others

If your teen is having an emergency, take her/him to the nearest hospital emergency room or call 911.

DO NOT leave her/him alone or unattended. Remove all dangerous items (guns, knives, pills) from your teen's reach.

Do you have any comments or questions about this handout? Please contact Adolescent Health Working Group by emailing feedback@ahwg.net or calling (415) 554-8429. Thank you.

Sources:

- 1) Goodman RF. Choosing a Mental Health Professional for Your Child. New York University Child Study Center. 2000, <http://www.aboutourkids.org>
- 2) Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. Child and Adolescent Mental Health. 2003, <http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp>

Mental Health Crisis Contacts (effective 06/06/22):

Berks County:

Holcomb Crisis Intervention of Berks County: 610-379-2007 or 1-888-219-3910

Chester County:

Valley Creek Crisis Center: 877-918-2100

Lancaster County:

Lancaster County Crisis Intervention: 717-394-2631

Lebanon County:

Lebanon County Crisis Intervention: 717-274-3363

Montgomery County:

Montgomery County Emergency Services Inc.-Crisis Intervention: 610-279-6100

Schuylkill County:

Schuylkill County- Crisis/Emergency Services: 877-993-4357

Please visit the following website for Crisis Intervention in other PA Counties:

<https://www.cor.pa.gov/Documents/PA%20County%20Crisis%20Contacts.pdf>

ruOKBerks? is a texting option for individuals experiencing suicidal ideations offered via Berks County Suicide Prevention Task Force. Individuals should text 484-816-RUOK (7865).

My Child is in Crisis and is Having Suicidal Thoughts. What Should I do?

You are not alone. This is a difficult time for a family. Children struggle with emotions that they don't know how to handle and parents oftentimes feel helpless when they can't fix the situation for their children. When one child is in crisis, it impacts the entire family.

The following is a general Safety/Crisis Protocol to be implemented to assure your child's safety:

Safety Planning Protocol:

Please be sure to secure:

1. All sharp objects (kitchen/pocketknives, scissors, razors)
2. Medications (over the counter (OTC) or prescription)
 - a. Medications should be dispensed by an adult on a daily/per time basis
 - b. Medications can either be placed into weekly pill organizers if agreed to by provider
3. Any lethal weapons (arrows/guns/rope)

Patient and parent must agree:

1. That patient will share with an adult when experiencing suicidal ideations.
 - a. Communication can be verbal or non-verbal
 - b. Code words designed to communicate that the patient doesn't feel safe or is having negative self-thoughts often work well in these situations
2. Adults can offer to listen if patient wants to talk, but do not force the patient to talk as this often exacerbates the negative feelings.
3. Please be supportive and validate your child's feelings...It must be hard to feel ..., is there anything that I can do to help? We're family, we will get through this together...
4. Be cautious to refrain from telling your child that they have so many things to be thankful for or their feelings don't make sense.
5. Patient will be supervised 1:1 by an adult while these feelings continue
 - a. An adult will be in eyesight of patient at all times
 - b. Patient agrees to leave bathroom door open when in use
 - c. Parent may have to sleep in the same room as patient.
6. Patient will be encouraged to engage in activities including, but not limited to:
 - a. Journaling
 - b. Arts/crafts
 - c. Listening to upbeat music
 - d. Watching humorous television shows/movies
 - e. Go for drive outside the home
 - f. Puzzles

If the patient attends therapy, please contact the therapist to discuss increasing the frequency of sessions.

If the patient receives medication management services, please speak to a provider/representative to discuss whether an adjustment is needed.

If the patient is not prescribed medication, please schedule an appointment with the patient's primary care provider to discuss whether medication may be helpful.

We recognize and respect the level of severity mental health crises present. Please try to be patient. Unfortunately, most mental health medications do take time to become effective.

If your child's feelings continue for a 24 hour period of time or he/she expresses suicidal ideations with an active plan and/or intent please:

1. Call your county's crisis center (see list below)
2. Go to the nearest emergency room
3. Call 911

I agree to follow the above stated safety protocol:

Patient	Date
Parent/Guardian	Date

Crisis Contacts:

Berks County:

Holcomb Crisis Intervention of Berks County: 610-379-2007 or 1-888-219-3910

Chester County:

Valley Creek Crisis Center: 877-918-2100

Lancaster County:

Lancaster County Crisis Intervention: 717-394-2631

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Montgomery County:

Montgomery County Emergency Services Inc.-Crisis Intervention: 610-279-6100

Schuylkill County:

Schuylkill County- Crisis/Emergency Services: 877-993-4357

Please visit the following website for Crisis Intervention in other PA Counties:

<https://www.cor.pa.gov/Documents/PA%20County%20Crisis%20Contacts.pdf>

ruOKBerks? is a texting option for individuals experiencing suicidal ideations offered via Berks County Suicide Prevention Task Force. Individuals should text 484-816-RUOK (7865)

Patient: _____ Appt date/time: _____ Provider: _____

CHILD AND ADOLESCENT PATIENT QUESTIONNAIRE

Who referred your child? _____

What was their concern? _____

What is your primary concern? _____

What is the school's primary concern? _____

When did you first become aware of concerns? _____

Name of Child: _____
First _____ Middle _____ Last _____

Date of Birth: _____ Place of Birth: _____

Who has legal custody or guardianship of child? _____

FAMILY DATA

Father:

Name: _____ DOB: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Place of Employment: _____ Title: _____

Highest Level of Education: _____ Religious Affiliation: _____

Mother:

Name: _____ DOB: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Place of Employment: _____ Title: _____

Highest Level of Education: _____ Religious Affiliation: _____

Stepmother:

Name: _____ DOB: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Place of Employment: _____ Title: _____

Highest Level of Education: _____ Religious Affiliation: _____

Stepfather:

Name: _____ DOB: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Place of Employment: _____ Title: _____

Highest Level of Education: _____ Religious Affiliation: _____

Please identify marital status including dates of all marriages, divorces and remarriages, for both natural and stepparents:

List on this page in chronological order the names of all children including the applicant, Stepbrothers and sisters, half brothers and sisters. Also give a brief description of each child (birth date, school status, significant characteristics). Please state their relationship to applicant

Name	Relationship to your child	Gender	Age	Education and/or occupation

List other children or adults who have lived or are now living in the home and their relationship to the applicant.

List dates or moves and for what reason:

DEVELOPMENTAL INFORMATION

Length of Pregnancy: _____ Birth Weight: _____

Planned or unplanned Pregnancy: _____

Was the pregnancy complicated or involved with drugs or alcohol? _____

Nature of delivery: _____ Natural _____ Caesarian _____ Breech

Condition of child at time of birth: _____

If child is adopted, from where? _____

At what age was child adopted? _____

Age of parents at time of birth or adoption: Father: _____ Mother: _____

Please give age your child: Crawled: _____ Walked: _____ Talked: _____ Toilet Trained: _____

What have the significant stressors or traumas been to the family or child?

EDUCATIONAL HISTORY

Where is child attending school now? _____

What grade? _____

If it is an ungraded class, state approximate grade achieved: _____

If child is not enrolled, name last school attended, grade achieved, date withdrawn.

List in order of attendance, all school enrollments child has had; also name of tutors, if any, give name and address. Indicate if it was a public or private school and the grade attended:

School	Address	Public/Private	Average Grade Made

Have any grades been repeated? _____

Has your child been identified for special education, learning support or emotional support? Please state year identification and provisions made.

Please check those items that pertain to your child:

- Often fails to finish things he or she starts
- Easily distracted
- has difficulty concentrating
- Shifts excessively from one activity to another
- Frequently is disruptive in class
- Has difficulty awaiting his/her turn (i.e. games)
- Has difficulty sitting still
- Impulsive or acts without thinking
- Abusive to animals
- Physically violent towards property (i.e. vandalism, destructive)
- Physically abusive to self (scratches self, suicidal attempts)
- Fire setting
- Stealing, Shoplifting, Breaking and Entering
- Runaway
- Lying
- Chronic violation of parental limits
- Drug Abuse (what kind?) _____
- Alcohol abuse (what kind?) _____
- Any involvement with juvenile court
- Unrealistic fears (explain) _____
- Acts too young for his/her age
- Clings to adults or too dependent
- Feels no one loves him/her
- Gets teased a lot
- Complains of loneliness
- Demands a lot of attention
- Easily made jealous
- Refusal to attend school
- Avoidance of being left alone
- Excessive need for reassurance
- Very self-conscious or easily embarrassed.

- _____ Often appears tense and unable to relax
- _____ Frequent physical complaints (i.e. headaches, stomachaches, nausea)
- _____ Overly concerned with future events
- _____ Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
- _____ Feelings of inadequacy
- _____ Panic – feelings of intense fear/discomfort with palpitations, shortness of breath, choking feeling, etc.
- _____ Obsessions – unwanted ideas, images, or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with other symmetry or exactness.)
- _____ Can't get his/her mind off certain thoughts
- _____ Fears he/she may do something bad
- _____ Fears she/he has to be perfect
- _____ Strange thoughts or ideas (Explain) _____
- _____ Hallucinations – visual or auditory (Describe) _____
- _____ Inappropriate expression of feelings (i.e. laughing at something sad)
- _____ Concern that people are out to get him/her
- _____ Severe mood changes (i.e. very sad to very happy)
- _____ Often appears sad
- _____ confused or seems to be in a fog
- _____ Day dreams or gets lost in his/her thoughts
- _____ Doesn't seem to have much energy
- _____ Social withdrawal
- _____ Overtired
- _____ Pessimistic outlook toward the future
- _____ Excessive tearfulness or crying
- _____ Recurrent thoughts about death or preoccupation with death
- _____ Suicidal thoughts or verbalized intentions
- _____ Concerns about sexual identity
- _____ Sexual promiscuous
- _____ Inappropriate sexual behavior (Explain) _____
- _____ Poor relationship with parents
- _____ Sibling rivalry
- _____ Negative peer associates – hangs with others that get in trouble
- _____ Argues a lot, bragging, boasting
- _____ Mean to others
- _____ Has difficulty making or keeping friends
- _____ Does not associate with people his or her own age
- _____ Avoids unfamiliar social situations
- _____ Is easily led by others
- _____ Has difficulty participating in organized activities (sports)
- _____ Avoids competitive situations
- _____ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
- _____ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fears of trying new foods, tremendous concern about weight)
- _____ Poor personal hygiene (does not keep self clean or take any interest in appearance)
- _____ Enuretic (urinates during the day or night on self)
- _____ Encopretic (soils self)
- _____ Deliberately harms self
- _____ Tics (sudden rapid, recurrent motor movements or vocalizations)
- _____ Behaves like the opposite sex

PSYCHIATRIC /PSYCHOLOGICAL/ MEDICAL

List all doctors and mental health professionals who have examined and/or treated your child.
Please give name, address, and phone number of each.

Name of doctor	Address	Phone

Family physician: _____

Medications your child has been on in the past for mood or behavior: _____

What medication(s) is your child taking now?: _____

List any allergic reactions to medications: _____

If your child has ever been **hospitalized** please explain when and for what reason:

Name of hospital	Date	Diagnosis

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object of the abuse or exposed to it.

Please check if any of the following pertain to your child and explain (see back of page if necessary)

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Concussions
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Drug or alcohol abuse	<input type="checkbox"/> Nervous disorders
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Diarrhea (frequently)	<input type="checkbox"/> Neurologic testing
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High fever
<input type="checkbox"/> Seizures	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Injuries or broken bones
<input type="checkbox"/> Fainting	<input type="checkbox"/> Orthodontia	<input type="checkbox"/> Accident prone
<input type="checkbox"/> Asthma	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Activity limitations
<input type="checkbox"/> Dietary problems	<input type="checkbox"/> Irregular sleep pattern	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Visual problems	<input type="checkbox"/> Other
<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Bowel elimination problems	

Gynecology

Menstrual problems Birth control: (if so, what type) _____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant mental/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother	Child's Sister	Child's Grandp(s)	Other
Childhood opposition/defiant						
Problems with aggression						
Attentional problems						
Learning disability						
Failed high school						
Mental retardation						
Psychosis/schizophrenia						
Depression (greater than 2 weeks)						
Anxiety or adjustment disorder						
Panic disorder						
Other mental disorders (describe below)						
Tic disorder or Tourettes						
Alcohol abuse						
Substance abuse						
Antisocial behavior (assault/thefts)						
Arrests/incarcerations						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						

Name of person completing this form: _____

Relationship to applicant: _____

I do certify that all the foregoing information is true and complete.

NAME _____ DATE _____

PARENT/LEGAL GUARDIANS, PLEASE COMPLETE IF THERE IS A CUSTODY AGREEMENT.

Patient name: _____ DOB: _____

In order to provide psychiatric services to your minor child, we require consent from any parent or legal guardian not attending the appointment when there is a legal custody agreement in place:

1 I have sole legal custody – I have attached a letter from my attorney or a copy of the legal custody agreement verifying that I am the sole legal custodian who has the right to make mental health decisions for the minor named above.

2a I have joint or shared legal custody – I am the other parent or legal guardian and I give permission for the minor named above to receive psychiatric treatment at Reading Pediatrics, 40 Berkshire Court, Wyomissing, Pa 19610

Relationship: _____ Phone: _____

Printed name: _____

Signature: _____ Date: _____

OR

2b I am the caregiver for this minor child and other parent is currently unreachable and cannot provide or sign any documentation given consent for treatment due to _____. I am aware that the absent parent can choose to limit treatment interactions or to terminate treatment at this office because I do not have sole legal custody. I also am aware that if custody issues interfere with the doctor/patient relationship, this could result in the termination of treatment at this office.

Relationship: _____ Phone: _____

Printed name: _____

Signature: _____ Date: _____

Acknowledgement by Provider: _____ Date: _____

To be filled out by patient (Ages 8-18). Allow older children privacy when answering these questions. (2 pages)

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

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10), 1230–6.

Name: _____ Date: _____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then, for each sentence, 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
2. I get headaches when I am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
3. I don't like to be with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
4. I get scared if I sleep away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. I worry about other people liking me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When I get frightened, I feel like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. I am nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. I follow my mother or father wherever they go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that I look nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. I feel nervous with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. I get stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When I get frightened, I feel like I am going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. I worry about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. I worry about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When I get frightened, I feel like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. I have nightmares about something bad happening to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. I worry about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When I get frightened, my heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. I get shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. I have nightmares about something bad happening to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP

Screen for Child Anxiety Related Disorders (SCARED)

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

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
22. When I get frightened, I sweat a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
23. I am a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
24. I get really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
25. I am afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
26. It is hard for me to talk with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
27. When I get frightened, I feel like I am choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
28. People tell me that I worry too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
29. I don't like to be away from my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
30. I am afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
31. I worry that something bad might happen to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
32. I feel shy with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
33. I worry about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
34. When I get frightened, I feel like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
35. I worry about how well I do things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
36. I am scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
37. I worry about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
38. When I get frightened, I feel dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
41. I am shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC

SCORING:

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

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

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

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

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

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

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.

The SCARED is available at no cost at www.wpic.pitt.edu/research/tools_and_assessments, or at www.pediatric_bipolar.pitt.edu/instruments.

"

To be filled out by one or both parents/guardians. You may print multiple copies if multiple households. (2 pages)

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

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10), 1230–6.

Name: _____ Date: _____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
2. My child gets headaches when he/she am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
3. My child doesn't like to be with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
4. My child gets scared if he/she sleeps away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. My child worries about other people liking him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When my child gets frightened, he/she feels like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. My child is nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. My child follows me wherever I go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that my child looks nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. My child feels nervous with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. My child gets stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. My child worries about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. My child worries about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When my child gets frightened, he/she feels like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. My child has nightmares about something bad happening to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. My child worries about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When my child gets frightened, his/her heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. He/she child gets shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. My child has nightmares about something bad happening to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the RCTGP V)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. O { "ej kf "y qttkgu about things working out for j ko lj gt.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
22. When o { "ej kf getu frightened, j gluj g sweatu a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
23. O { "ej kf "ku a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
24. O { "ej kf "getu really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
25. O { "ej kf "ku afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
26. It is hard for m{ "ej kf to talk with people j gluj g dogun't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
27. When o { "ej kf getu frightened, j gluj g feelu like j gluj g"ku choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
28. People tell me that o { "ej kf worrkgu too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
29. O { "ej kf "f qgupvlike to be away from j kulj gt family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
30. O { "ej kf "ku afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
31. O { "ej kf worrkgu that something bad might happen to j kulj gt parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
32. O { "ej kf feelu shy with people j gluj g dogun't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
33. O { "ej kf "worrkgu about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
34. When o { "ej kf getu frightened, j gluj g feelu like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
35. O { "ej kf worrkgu about how well j gluj g dogu things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
36. O { "ej kf ku scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
37. O { "ej kf "y qttkgu about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
38. When o { "ej kf getu frightened, j gluj g feelu dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
39. O { "ej kf feelu nervous when j gluj g"ku with other children or adults cpf "j gluj g"j cu"q "f q"something while they watch j ko lj gt (for example: tgcf "cnqwf . "ur gcm"r n { "c "game, play a sport).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
40. O { "ej kf feelu nervous when j gluj g"ku"going to parties, dances, or any r n reg"y j gtg"y j gtg"y j knidg"people that j gluj g dogun't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
41. O { "ej kf "ku shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC

SCORING:

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

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

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

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

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

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

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

**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 not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other 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 too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	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 in on others' conversations and/or activities	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 go along with adults' requests or rules	0	1	2	3
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 wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "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 things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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
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	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

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: _____

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To be filled out by patient's teacher. You may print multiple copies if multiple teachers. (2 pages)

D4

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	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 instructions 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 in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which 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 excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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HE0351

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance	Somewhat of a Problem				
	Academic Performance	Excellent	Above Average	Average	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problematic	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

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 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

Please fax responses to:
Reading Pediatrics
Fax: 610-621-0127
Attn: Behavioral Health Team

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To be filled out by patient. (AGES 11 AND UP)
Please allow your child to answer these questions in private.

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

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

Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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

Yes No

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

Yes No

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

Office use only:

Severity score: _____

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

Limited List of Local Behavioral Health Providers

@Family Guidance Center #

<https://familyguidancecenter.com/site>

1105 Berkshire Blvd., Suite 110
Wyomissing, PA 19610
Additional offices in Kutztown, Hamburg, and
Boyertown
610-374-4963

****@Betterview Counseling and Trauma**

Recovery #

<https://betterviewcounseling.com>

845 N. Park Road, Suite 101
Wyomissing, PA 19610
484-709-1381
Fax: 833-490-1352

@Alternative Consulting Enterprises #

<https://altesll.org>

527 East Lancaster Ave., Shillington, PA 19607
610-796-8110

@Concern Counseling #

<https://concern4kids.org>

22-24 North Franklin St., Fleetwood, PA 19522
610-944-0445
1120-C Hobart Ave., Wyomissing, PA 19610
610-371-8035

@PA Counseling

<https://pacounseling.com/reading-wyomissing/>

1733 Penn Ave.,
West Lawn, PA 19609
610-670-7270

@Berkshire Psychiatry and Behavioral Health Services #

<https://berkshirepsychiatric.com/>

716 North Park Rd., Wyomissing, PA 19610
610 375-0544
640 Walnut St. Suite 303, Reading PA 19601
610-208-8860

@Empowerment Behavioral Health

<https://empowermentbh.com>

833 North Park Rd, Suite 101, Wyomissing, PA
19610
610-396-5094

@Child and Family Support Services

<https://cfss-pa.com>

1418 Clarion St., Reading, PA 19601
610-376-8558

@Berks Counseling Center #

<https://berkscounselingcenter.org>

645 Penn St., 2nd floor, Reading, PA 19602
610-373-4281

Berks Counseling Associates

<https://www.berkscounselingassociates.com>

1150 Berkshire Blvd., Ste 250, Wyomissing, PA
19610
610-373-7005

@Commonwealth Clinical Group

<https://commonwealthclinicalgroup.com>

450 South 5th St., Reading, PA 19602
844-331-3551; 610-372-5645

@DGR Behavioral Health

<https://dgrbehavioralhealth.com>

2201 Ridgewood Rd., Ste. 400, Wyomissing,
PA 19610
610-378-9601

@Reading Counseling Services

<https://readingcounselingservices.com/>

122 W. Lancaster Ave., Shillington, PA 19607
(888) 768-4372

Mind Matters

<https://www.mymindmatterscounseling.com/>

Van Reed Office Plaza
2209 Quarry Drive, A-10
Reading, Pennsylvania 19609
(844) 696-4631

These providers see patients in the Reading Pediatrics offices. Please speak with your provider for specific referral to these providers. @- has psychiatric services within practice **Bold-provider accepts Medical Assistance/CCBH #- Provider accepts CHIP

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Limited List of Local Behavioral Health Providers

@Creative Health Services

<https://creativehs.org/>

321 N. Furnace St., Ste. 40, Birdsboro, PA 19508
610-404-8825
5th and Montgomery Ave. Boyertown, PA 19512
610-369-7271
11 Robinson St., Pottstown, PA 19464
484-941-0500

Fairview Counseling

<https://fairviewcounseling.org>

1255 Perkiomen Ave., Reading, PA 19602
610-396-9091

@Holcomb Behavioral Health Systems

<https://chimes.org/about/chimes-family/holcomb-behavioral-health-systems>

1011 Reed Ave, Ste. 900, Wyomissing, PA 19610
610-939-9999

Paragon Behavioral Health Services

<https://paragonbhs.com>

510 N. Park Rd., Ste. 2, Wyomissing, PA 19610
484-516-2330

@Malvern Community Health Services

<https://malvernchs.com/clients/reading>

144 N. 6th St., Reading, PA 19601
610-375-74754
1610 Medical Dr., Ste. 310
Pottstown, PA 19464
610-970-5000

Shoudt and Reilly Psychological Services

<https://shoudtreillypsychologicalservices.com>
6720 E. Perkiomen Ave., Birdsboro, PA 19508
610-544-2110

River of Hope Therapeutic Ministries

(Christian Counselors):

<https://riverofhope.org>

100 Forney Rd., Lebanon, PA 17042
717-274-3950

@Furnace Creek Counseling

<https://www.furnacecreekcounseling.com/>

140 Penn Ave., Ste. 2, Robesonia, PA 19551
610-750-9135

@Center for Mental Health (Tower Health)

<https://towerhealth.org>

Sixth and Spruce Sts.
Building K
Reading, PA 19611
484-628-8070

Everlasting Wellness

<https://everlastingwellnesscounseling.com/>

2913 Windmill Rd.
Wyomissing, PA 19608
610-379-2041

Emotional Wellness

<http://emwell.org/services/>

The Spine and Wellness Center
3933 Perkiomen Avenue, Suite 102
Reading, PA 19606
610-779-7272

Jeff Laubach

2209 Quarry Dr., Suite C-36
West Lawn, PA 19609
610-685-8621

Empowering Minds

3803 Kutztown Road
Laureldale, PA 19605
(610) 859-4242

These providers see patients in the Reading Pediatrics offices. Please speak with your provider for specific referral to these providers. @- has psychiatric services within practice **Bold-provider accepts Medical Assistance/CCBH #- Provider accepts CHIP

Rev. 01/02/2026

ATTENTION

PARENTS OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS

Chronic Conditions: Physical, Developmental, Behavioral, or Emotional

Are you aware your child may be eligible for medical assistance?

Medical Assistance Benefits are **not** dependent on parent's income

Your child may be eligible even if you have other insurance

Medical Assistance can pay for services **not** covered by other insurance

For More Information:
CALL: 1-800-986-KIDS
OR

www.compass.state.pa.us

NOTE -Mark application "MA only child with disability"



Why You Should Have Medical Assistance (MA) for Your Child And the Steps to follow to obtain MA

Regardless of whether the child is covered under private insurance, a child with special healthcare needs should have medical assistance. Why? Because medical assistance covers many things that are not covered by private insurance.

Medical assistance (hereinafter “MA”) has the broadest coverage of medical and mental health services for individuals under 18 of any insurance plan. Services provided under MA that private insurance often does not cover include behavioral health services, in-home nursing services, in-home personal care services, diapers, nutritional supplements, prescriptions and transportation to medical appointments. Behavioral health services are often referred to as “wraparound” services and included a Therapeutic Support Staff (TSS), a Mobile Therapist (MT) and a Behavior Specialist Consultant (BSC) who all work together to provide behavior support to children at home and at school. MA also covers various types of therapy such as occupational, physical, and speech and language. Often private insurance companies place a cap on these services whereas MA does not. MA can be a child’s only insurance or it can be secondary. Where it is secondary, MA will cover services not covered by insurance, including co-pays, and can cover the therapies in addition to those covered by insurance.

A common misconception about MA is that income of the parents is considered; however, income of the parents is irrelevant to eligibility. Why? Because of Category PH 95, which is considered a “loophole” and allows qualified individuals to obtain MA without consideration of the parents’ income. Generally speaking, in order to qualify under the loophole, the child must have a disability or condition that limits his or her ability to perform basic functions including physical, neurological, sensory, cognitive, and psychological functioning.

Thus, the majority of children who have an Individualized Education Plan (IEP) will be eligible for MA. In order to establish that your child meets these standards you will need to provide any medical reports, therapy reports, guidance counseling reports and Evaluation Reports (ERs) prepared by your school district, intermediate unit or early intervention program.

To apply, you can call 1-800-986-5437 and request to begin the application over the phone. You can also apply online at <https://www.compass.state.pa.us>

In addition, documentation of your child’s disability (diagnosis), you will need to provide the child’s social security card, birth certificate, proof of address and documentation of income in the child’s name (interest or dividends and earnings of a child’s income are considered)

You will also need to obtain a Supplemental Security Income (SSI) determination. SSI provides a monthly check and MA to qualified persons who meet Social Security’s disability criteria and have low income and assets. Even if you are not seeking SSI, your local county office may advise that you need an SSI eligibility determination to obtain MA. To receive an SSI eligibility determination, you simply call 1-800-772-1213 and follow the prompts to speak to a representative to set up a phone or in-person interview. Keep in mind that parental income matters for SSI so many families will be denied.

Thus, be prepared to have documentation of income available for the interview. If you do not meet SSI requirements for income reasons, you will receive a denial letter which you then need to provide to your county case worker.

You will receive a DAP (Disability Advocacy Program) referral packet and the county caseworker typically will highlight the areas within the packet that require your signature or initials. Once you receive the packet, sign the required forms and mail back immediately. Your signature will allow the county case worker to follow the progress of the SSI application.

Having medical coverage for your child is essential, especially when you have a child with special needs. Medical assistance provides extensive coverage that private insurance may not.

Income of the parent is not relevant to qualification for MA. Thus, parents who have a child with a disability should take the necessary steps to ensure they have MA for their child.

MA Application Tips for Applying due to Patient's Behavioral Health needs:

1. Plan to spend 1.5-2 hours completing the application.
2. Use the big blue box on the left side of the page. Box states "Apply Now"
3. Take a picture of or write down your efile # once provided in the event that you are booted out of the program while completing the application process.
4. Gather pertinent information before starting for all household members.
 - a. Name
 - b. date of birth
 - c. driver's license numbers
 - d. social security numbers
5. For adult members, questions are asked regarding:
 - a. name and location of employers
 - b. income prior to taxes
 - c. amount earned per hour/salary
 - d. how often is pay received
 - e. when was the last payment
 - f. how many miles do you drive to work
 - g. do you own a car, do you pay \$ for transportation to someone else
6. Does anyone have a serious medical condition? Yes.
 - a. This will eventually generate a drop-down box where you add patient's diagnoses (all medical and behavioral health) and a statement that patient has been recommended for intensive in-home services.
 - b. Needs to be brief as box is not long
7. Does anyone have any paid or unpaid medical bills in the past 90 days? Answer yes if patient has been to any provider in the past 3 months.
8. At the end of the application, there is a box for comments. Please note "I/we believe that patient qualifies for MA under PH95."
9. You may be told that you must file for SSI or SSD benefits. You will have to complete the process if you want approval for MA, but may not qualify based on family income.

Suggestions for Working through the Wraparound Service Process

Obtaining services for your disabled child is a *process*. It takes time, but if you follow the steps carefully your child will ultimately get the services he/she needs to succeed. The process can take *months*, so patience is required.

First, access the following website to apply for medical assistance online (www.compass.state.pa.us).

Be sure to identify your special needs child when asked during the online application process.

Medical assistance can not be denied to a family with a disabled child based on that family's income, however, you must complete the income information section of the application and provide documentation concerning your income. The application will not be processed without this information.

Be sure you have proof of your child's disability or diagnosis in the form of a medical report from a doctor, a developmental evaluation report from a doctor, an evaluation report (ER) prepared by your school district, intermediate unit or early intervention program, or a letter from a psychologist/psychiatrist who is working with and/or evaluating your child.

Once you have a Medical Assistance (MA) Card, you should call one of the wraparound providers which can be found on Community Care Behavioral Health's website (www.ccbh.com) and request an evaluation for wraparound services. The agency will complete an evaluation and determine how they can best help your child.

The following questions may be helpful to families as they begin the process of evaluating and ultimately choosing a wraparound provider:

- How long has your agency been providing wraparound services?
- Does your agency work with pre-school, school age, adult individuals?
- Do you currently have a waiting list? How long is the waiting list?
- What are the educational requirements of the TSS (Therapeutic Support Staff) workers/behavioral health specialists?
- Do any of your TSS workers/behavioral specialists specialize in or have experience with other individuals with my child's disability?
- What is involved in your evaluation process? How long does it take?
- How often will my child's case be reviewed?
- What will occur if my child's TSS services are temporarily discontinued due to lack of staffing?
- Is your agency willing to work with the staff in my child's educational program?
- Is your agency willing to provide services at different times and in different locations (home, school, or community)?