Sanand R. Menon, MD, FAAP
Johanna Kelly, MD, FAAP
Jeffrey C. Brendlinger, DO, FAAP, FACOP
Joe K. George, DO, FAAP
Carrie R. Lauer, PA-C
Jamie L. Chmielowski, MD, FAAP

Amanda L. Gosling, MD, FAAP
Jennifer L. Lancaster, CRNP
Lauren M. Zerbe, CRNP
Lilly A. Yi, MD, FAAP
Robin W. Lynn, CRNP
Hanz B. Blatt, MD, FAAP

Maria S. Bell, CRNP
Krystle N. Mills, CRNP
Sophia L. Campbell, PA-C
Alexandra E. Kowker, PA-C

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 an introduction to the providers and the description of the 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

Behavioral Health Team

Douglas Berne, MD, completed his medical education, residency, and Child and Adolescent fellowship at Penn State Medical College in Hershey. He is board certified in both general and child and adolescent psychiatry. He has been in Berks county since 1994. He has worked in a variety of settings in the area since then, including consultations with schools, Caron Foundation, and a variety of outpatient clinics. He was the Section Chief of Child and Adolescent Psychiatry at Reading Hospital for many years before joining KidsPeace Berks Campus as the medical director of the Partial Hospital Program as well as community services. He has been very active in teaching and is a regular lecturer at Drexel University as well as Tower Behavioral Health. Dr. Berne is also involved with the psychiatry residency program at Tower Health. In his free time, he enjoys spending time with his daughters, grandchildren, and his three dogs (including a therapy dog). Dr. Berne will be supervising and consulting at Reading Pediatrics on Tuesdays from 2-4 PM.

Jennifer L Lancaster, CRNP is a Certified Registered Nurse Practitioner who was born in Marietta, Pennsylvania. She graduated from Elizabethtown College with a Bachelor of Arts degree in Psychology. She went on to pursue her nursing degree and earned a Master of Science degree in Pediatric Nurse Practitioner studies at Thomas Jefferson University. Jennifer has practiced in the Reading and Hershey areas and specializes in General Pediatrics and Child Psychology. She is board certified by the Pediatric Nursing Certification Board and is a member of the National Association of Pediatrics Nurse Practitioners. In her spare time, Jennifer enjoys hiking with her husband, Dave, spending time with her 2 children, Connor and Callie, and her dog. She also enjoys reading and taking weekend trips to the beach.

Jen's Office Hours are: Monday, Thursday, and Friday 8 am - 5:00 pm;
Tuesday 8 am - 8:00 pm

Krystle Mills joined the provider team in November 2021. Krystle graduated with a B.S.N. from Kaplan University, ADN from Reading Area Community College and an MSN from DeSales University. She is currently a Board Certified, Psychiatric – Mental Health Nurse Practitioner. Krystle completed clinical education rotations at Devereux Children's Behavioral Health Services in Malvern, St. Luke's Psychiatric Associates in Allentown and inpatient psychiatric care at St. Luke's Hospital in Lehighton. Krystle enjoys spending time with her husband and children. She enjoys traveling with her family and going to the movies. Krystle's office hours are: Monday, Tuesday, and Friday 8 am-5 pm; Wednesday 8 am -8:30 pm

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 (BHCM). 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. Barbara 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 with Scott.

LeeAnn Fouse joined Reading Pediatrics in August of 2020, during the height of COVID. She was instrumental in working on the Well Visit Initiative, doing outreach to patients who were overdue on Well Visits. In September 2021, LeeAnn joined the Behavioral Health Care team and has been instrumental in helping to schedule patients and to help with disseminating packets. LeeAnn was born and raised in Berks County, PA. LeeAnn attended Lock Haven University where she received a BS in Special Education. She worked with Prospectus a local provider for Special Needs Adults, where she served as a Group Home Supervisor, while teaching preschool. Lee Ann then provided in-home daycare while she raised her 3 children: Karlee, Kara and Keegan. Lee Ann enjoys spending her free time with her husband, David, friends, extended family and 2 rescue dogs, Hershel and Oliver.

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 Practioners 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.
This is required to allow for communication with parents.

Patient Name: _____ Date of Birth: ___/___/____

Patient Contact: _____ **(Patient's preferred phone number for direct contact)**

Patient Email: _____ (To receive patient portal access)

Please check one of the boxes below:

☐ I **DO NOT** authorize Reading Pediatrics to release my medical or mental health/ substance abuse information to anyone but myself.

☐ I **DO** authorize Reading Pediatrics to release my medical information including but not limited to: diagnosis, labs, x-ray record, examination rendered to me, claims information, mental health/substance abuse.

This information may be release to:

Name: _____ Relation: _____

Name: _____ Relation: _____

This release of information will remain in effect until termination by me in writing.

Signature: _____ Date: ___/___/___

(of **PATIENT** age 14 and up)

Witness: _____ Date: ___/___/___

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

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I hereby authorize Reading Pediatrics to exchange information with :

Agency/Name : _____ Phone : _____

Address : _____ Fax: _____

_____

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

( ) Psychiatric Evaluation	( ) Discharge Summary	( ) Medications	( ) Treatment Plans
( ) Medical History	( ) Lab Reports	( ) Individual Education Plan	( ) Integrated Summary
	( ) Psychological Evaluation	( ) Immunization Records	( ) Substance Abuse Information

The information to be OBTAINED is :

( ) Psychiatric Evaluation	( ) Discharge Summary	( ) Medications	( ) Treatment Plans
( ) Medical History	( ) Lab Reports	( ) Individual Education Plan	( ) Integrated Summary
	( ) Psychological Evaluation	( ) Immunization Records	( ) Substance Abuse Information

I have been told that, in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for 1 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 other 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 _____
(not to exceed 1 year)

DO YOU WANT A COPY OF THE RELEASE? ___ YES ___ NO

Signature of Client (14 years and above) _____ Authority/Relationship to Client _____ Date of Signature

Representative (Parent, Legal Guardian) If Client is under the age of consent. _____ Authority/ Relationship to client _____ Date of Signature

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
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

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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 brie description of each child (birth date, school status, significant characteristics). Please state their relationship to applicant

Nmae	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 prefect
_____ 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 of exposed to it.

_____

_____

_____

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

____Heart disease ____Nausea or vomiting ____Concussions
____Lung disease ____Drug or alcohol abuse ____Nervous disorders
____Liver disease ____Diarrhea (frequently) ____Neurologic testing
____Jaundice ____Diabetes ____High fever
____Seizures ____Tonsillectomy ____Injuries or broken bones
____Fainting ____Orthodontia ____Accident prone
____Asthma ____Skin disease ____Activity limitations
____Dietary problems ____Irregular sleep pattern ____Speech problems
____Hearing problems ____Visual problems ____Other
____Urinary problems ____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	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP

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.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**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 under tools and assessments, or at www.pediatric bipolar.pitt.edu under 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	O	O	O	**PN**
2. My child gets headaches when he/she am at school.	O	O	O	**SH**
3. My child doesn't like to be with people he/she does't know well.	O	O	O	**SC**
4. My child gets scared if he/she sleeps away from home.	O	O	O	**SP**
5. My child worries about other people liking him/her.	O	O	O	**GD**
6. When my child gets frightened, he/she fells like passing out.	O	O	O	**PN**
7. My child is nervous.	O	O	O	**GD**
8. My child follows me wherever I go.	O	O	O	**SP**
9. People tell me that my child looks nervous.	O	O	O	**PN**
10. My child feels nervous with people he/she doesn't know well.	O	O	O	**SC**
11. My child gets stomachaches at school.	O	O	O	**SH**
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	**PN**
13. My child worries about sleeping alone.	O	O	O	**SP**
14. My child worries about being as good as other kids.	O	O	O	**GD**
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	**PN**
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	**SP**
17. My child worries about going to school.	O	O	O	**SH**
18. When my child gets frightened, his/her heart beats fast.	O	O	O	**PN**
19. He/she child gets shaky.	O	O	O	**PN**
20. My child has nightmares about something bad happening to him/her.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

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

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	**GD**
22. When my child gets frightened, he/she sweats a lot.	O	O	O	**PN**
23. My child is a worrier.	O	O	O	**GD**
24. My child gets really frightened for no reason at all.	O	O	O	**PN**
25. My child is afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	**SC**
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	**PN**
28. People tell me that my child worries too much.	O	O	O	**GD**
29. My child doesn't like to be away from his/her family.	O	O	O	**SP**
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. My child worries that something bad might happen to his/her parents.	O	O	O	**SP**
32. My child feels shy with people he/she doesn't know well.	O	O	O	**SC**
33. My child worries about what is going to happen in the future.	O	O	O	**GD**
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	**PN**
35. My child worries about how well he/she does things.	O	O	O	**GD**
36. My child is scared to go to school.	O	O	O	**SH**
37. My child worries about things that have already happened.	O	O	O	**GD**
38. When my child gets frightened, he/she feels dizzy.	O	O	O	**PN**
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	**SC**
41. My child is shy.	O	O	O	**SC**

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 =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

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

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

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

Revised - 1102

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	Excellent	Above Average	Average	Somewhat of a 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: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

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

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

Revised - 0303

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

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 *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	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	Excellent	Above Average	Average	Somewhat of a Problem	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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

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:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(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
1235 Penn Ave., Wyomissing, PA 19610
Additional offices in Kutztown, Hamburg, and Boyertown
610-374-4963, *3482

**Springfield Psychological
https://springpsych.com/
560 Van Reed Rd, Ste 301
Wyomissing, PA 19610
610-544-2110, ext. 163

Alternative Consulting Enterprises #
https://altcsll.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://commwealthclinicalgroup.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

Advanced Counseling and Testing Solutions
https://www.advancedcounselingandtestingsolutions.com/
4 Wellington Blvd, Ste. 101, Wyomissing, PA
484-987-7116

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

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

****Betterview Counseling and Trauma Recovery**
https://betterviewcounseling.com
833 N. Park Road, Suite 207
Wyomissing, PA 19610
484-709-1381