



Mental Health Visit Information Packet

To be completed before visit

Dear Parent:

You have recently called Phoenix Children's Pediatrics to set up an appointment for your child to be evaluated due to concerns for depression / anxiety. In order to best evaluate your child, our doctor will need the following information at the time of your visit.

If you are concerned about your child harming him/herself, harming others, or your child has suicidal thoughts, this is an emergency. Please call 911 or call our office.

- To be completed by the patient:
 - SCARED form Child Version (if older than 8 years of age)
- To be completed / reviewed by the parents:
 - Intake form
 - Confidentiality statement
 - SCARED form Parent Version

Please return the documents to Phoenix Children's Pediatrics as soon as you can.

Thank you,

Phoenix Children's Pediatrics

COUNSELING HISTORY

 Has the patient previously seen a counselor? Yes No If yes, where? _____

Approximate dates of counseling: _____

 Has the patient previously seen a psychiatrist? Yes No If yes, who and for what diagnosis? _____

 Has the patient taken medication for a mental health concern? Yes No

If yes, please list: _____

HAVE YOU NOTICED, OR HAS THE PATIENT TOLD YOU ABOUT, ANY OF THE FOLLOWING?

Symptom	None	Mild	Moderate	Severe
Sadness				
Crying				
Sleep problems				
Hyperactivity				
Irritability				
Anxiety				
Alcohol use				
Substance use				
School problems				
Mood swings				
Headaches				
Phobias				
Cutting				
Appetite changes				
Weight change				
Low energy				
Poor concentration				
Low self-worth				
Excessive worry				
Panic attacks				
Obsessive thoughts				
Loneliness				
Hallucinations				
Racing thoughts				
Suicidal thoughts				
Past suicide attempts				



HOME AND FAMILY INFORMATION**Patient lives with:**

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> mother(s) | <input type="checkbox"/> father(s) | <input type="checkbox"/> stepmother | <input type="checkbox"/> stepfather |
| <input type="checkbox"/> siblings: ____ (# of) | <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> foster parent(s) | <input type="checkbox"/> adoptive parent(s) |
| <input type="checkbox"/> aunt | <input type="checkbox"/> uncle | <input type="checkbox"/> cousin | |

Signature of Patient or Legally Authorized Representative_____
Date_____
Printed Name of Patient or Legally Authorized Representative_____
Relationship to Patient_____
Signature of Practitioner_____
Date_____
Time_____
Printed Name of Practitioner



CONFIDENTIAL
PATIENT/PRACTITIONER
RELATIONSHIP CONSENT

Apply Patient Label

Parent/Legally Authorized Representative (LAR)

I, _____, consent to my child, _____,
(Parent or Legally Authorized Representative) (Patient Name)

having a confidential patient-practitioner relationship with _____ so that my child
(Practitioner printed name)

feels more comfortable discussing sensitive issues and questions with his or her healthcare provider. I understand that the practitioner, by law, will be prohibited from disclosing any information shared during private consultations without my child's authorization unless my child discloses certain types of abuse that the practitioner must report by law, or the practitioner believes my child may be a danger to self or others. I understand that some or all of my child's medical record will be withheld from me unless my child authorizes me to have it.

_____ I authorize my child to schedule appointments and receive confidential reports from this office and I agree
(Initial)

to be financially responsible for any bills for visits my child schedules without my knowledge. I understand this consent does not allow my child to consent to his/her own treatment except as expressly allowed by law.

I understand that I may revoke this consent at any time by notifying the practitioner in writing, but the information my child shares while this consent is in effect will remain confidential after I revoke consent.

Parent/Legally Authorized Representative Signature

Date

Parent/Legally Authorized Representative Printed Name

Relationship to patient

Practitioner Signature

Date

Time

Practitioner Printed Name

Patient

I, _____, am entering a confidential patient-practitioner relationship
(Patient Name)

with _____ I will make an effort to communicate with my parent(s) or
(Practitioner Printed Name)

legally authorized representative(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow my practitioner's recommendations.

Patient Signature

Date

Patient Printed Name

Practitioner Signature

Date

Time

Practitioner Printed Name





**Screen for Child Anxiety
Related Disorders (SCARED)**
Child Version

Apply Patient Label

Screen for Child Anxiety Related Disorders (SCARED)
Child Version—Page 1 of 2 (to be filled out by the CHILD)

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, check the box 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.				PA/SO
2. I get headaches when I am at school.				SCH
3. I don't like to be with people I don't know well.				SOC
4. I get scared if I sleep away from home.				SEP
5. I worry about other people liking me.				GA
6. When I get frightened, I feel like passing out.				PA/SO
7. I am nervous.				GA
8. I follow my mother or father wherever they go.				SEP
9. People tell me that I look nervous.				PA/SO
10. I feel nervous with people I don't know well.				SOC
11. I get stomachaches at school.				SCH
12. When I get frightened, I feel like I am going crazy.				PA/SO
13. I worry about sleeping alone.				SEP
14. I worry about being as good as other kids.				GA
15. When I get frightened, I feel like things are not real.				PA/SO
16. I have nightmares about something bad happening to my parents.				SEP
17. I worry about going to school.				SCH
18. When I get frightened, my heart beats fast.				PA/SO
19. I get shaky.				PA/SO
20. I have nightmares about something bad happening to me.				SEP





**Screen for Child Anxiety
Related Disorders (SCARED)**
Child Version

Apply Patient Label

	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.				GA
22. When I get frightened, I sweat a lot.				PA/SO
23. I am a worrier.				GA
24. I get really frightened for no reason at all.				PA/SO
25. I am afraid to be alone in the house.				SEP
26. It is hard for me to talk with people I don't know well.				SOC
27. When I get frightened, I feel like I am choking.				PA/SO
28. People tell me that I worry too much.				GA
29. I don't like to be away from my family.				SEP
30. I am afraid of having anxiety (or panic) attacks.				PA/SO
31. I worry that something bad might happen to my parents.				SEP
32. I feel shy with people I don't know well.				SOC
33. I worry about what is going to happen in the future.				GA
34. When I get frightened, I feel like throwing up.				PA/SO
35. I worry about how well I do things.				GA
36. I am scared to go to school.				SCH
37. I worry about things that have already happened.				GA
38. When I get frightened, I feel dizzy.				PA/SO
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).				SOC
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.				SOC
41. I am shy.				SOC

Signature of Patient

Printed Name of Patient

Date

Practitioner Signature

Date

Time

Practitioner Printed Name

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.

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.

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments. January 19, 2018



**Screen for Child Anxiety
Related Disorders (SCARED)
Parent Version**

Apply Patient Label

**Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Page 1 of 2 (to be filled out by the PARENT)**

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





**Screen for Child Anxiety
Related Disorders (SCARED)
Parent Version**

Apply Patient Label

	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.				GA
22. When my child gets frightened, he/she sweats a lot.				PA/SO
23. My child is a worrier.				GA
24. My child gets really frightened for no reason at all.				PA/SO
25. My child is afraid to be alone in the house.				SEP
26. It is hard for my child to talk with people he/she doesn't know well.				SOC
27. When my child gets frightened, he/she feels like he/she is choking.				PA/SO
28. People tell me that my child worries too much.				GA
29. My child doesn't like to be away from his/her family.				SEP
30. My child is afraid of having anxiety (or panic) attacks.				PA/SO
31. My child worries that something bad might happen to his/her parents.				SEP
32. My child feels shy with people he/she doesn't know well.				SOC
33. My child worries about what is going to happen in the future.				GA
34. When my child gets frightened, he/she feels like throwing up.				PA/SO
35. My child worries about how well he/she does things.				GA
36. My child is scared to go to school.				SCH
37. My child worries about things that have already happened.				GA
38. When my child gets frightened, he/she feels dizzy.				PA/SO
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).				SOC
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.				SOC
41. My child is shy.				SOC

Signature of Parent/Legally Authorized Representative

Date

Printed Name of Parent/Legally Authorized Representative

Relationship to Patient

Practitioner Signature

Date

Time

Practitioner Printed Name

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.

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**Phoenix
Children's**

Emergency Behavioral Health Resources

National Suicide Prevention Lifeline

<https://988lifeline.org/>

Dial 988

1-800-273-8255

Teen Lifeline (phone or text)

<https://teenlifeline.org/>

602-248-TEEN (8336)

1-800-248- TEEN (8336) outside of Maricopa

Crisis Text Line

<https://www.crisistextline.org/>

Text HOME to 741741

La Frontera EMPACT

<https://lafronteraaz-empact.org/>

480-784-1500

Maricopa County Crisis Line served by Mercy Care

<https://www.maricopa.gov/5043/Mental-Health-Substance-Use>

602-222-9444

1-800-631-1314

211 Arizona

<https://211arizona.org/>

Solari Crisis Response Network

<https://crisis.solari-inc.org/>

General Number (602) 427-4600

Central Arizona Hotline (602) 222-9444

Northern Arizona Hotline (877) 756-4090

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health - Complete Care Plan 1-866-495-6735

Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Steward Health Choice Arizona 1-877-756-4090

Gila River and Ak-Chin Indian Communities 1-800-259-3449

Salt River Pima Maricopa Indian Community 1-855-331-6432