Hello,

Below are directions for completing the consultation paperwork for your child.

Please print and complete:

1) Directions to our center (with our **door code** for getting in!).
2) Youth Evaluation Treatment Agreement – initial each section indicted in the form, sign (both parents) and bring to the appointment. (You should also keep a copy for your records.)
3) The SFBACCT Privacy Policy for you to read (for your records).
4) The Privacy Policy Consent (sign and bring to the appointment).
5) The parent questionnaire (bring to the appointment completed).
6) RCADS-P
7) SCARED-Parent
8) CAPS
9) Children's Anxiety Life Interference Scale

Please make sure that you come to the appointment with the following forms completed:

1) The Evaluation_Treatment Agreement
2) The Privacy Policy consent
3) The Parent Questionnaire
4) Additional Questionnaires completed by yourself
5) Any other supporting documents such as testing reports or anything that you think could be relevant.

If there is any confusion or questions related to completing this paperwork, please don't hesitate to email me at djo@sfbacct.com or call me at 510-652-4455 ext.4.

When you arrive in the waiting room, please press button "**3**" on the wall panel to alert me that you have arrived.

I will spend about 5 minutes at the beginning of the session reviewing and scoring some of these questionnaires. I will use the information in the questionnaires to guide the consultation interview, and I will provide you with feedback about what I learn from all these questionnaires.

As a reminder, the consultation appointment is a 90-minute visit. I accept payment in the form of **cash or check** (made out to Daniela Owen) **at the time of the visit** ($375).

I look forward to meeting you at the consultation appointment,
Dr. Daniela Owen

5435 College Avenue
Oakland, CA 94618-1502

Location: The office is about 3 blocks from the Rockridge BART. The office is located behind the Diesel Bookstore.

Entry Enter the office area after walking down an outdoor slate corridor just to the right of Diesel Books (as you face the bookstore). You'll encounter a gate near the beginning of the corridor. This gate is usually unlocked, just push it open. Notice the stairs towards the end of the corridor; our waiting room is to the left of the stairs. The door is labeled "102-108" and lists the practicing doctors. To enter the waiting room, enter **5-4-6-3-5** on the panel (to the left of the door). Once you have entered the waiting room, please press the number "**3**" button on the wall to alert me that you've arrived.

Parking: Generally, 2-hour parking is available on the residential side streets near the office. There is metered parking on College Avenue and you can park at The Levant rug store across the street from the office for $6 in quarters or bills (payable on exiting the lot).

Directions: *From BART*: Take the Concord line and exit at the Rockridge station. Take the stairs down to ground level to College Avenue. Walk South (away from Berkeley and toward Broadway Avenue) on College Avenue about 3 blocks.

From San Francisco: Take Highway 80 across the Bay Bridge East to Oakland. After exiting the Bay Bridge take East Highway 580 and follow the signs to Oakland. Take Highway 24 East to Walnut Creek. Exit at Claremont Avenue. Turn left at the stop sign onto Claremont Avenue. Go about 0.5 mile to College Avenue. Turn right onto College Avenue. Proceed South on College Avenue about 0.5 mile (8-9 blocks) to the intersection of Kales Avenue and College Avenue.

From East Bay: Take Highway 24 West to Oakland through the Caldecott Tunnel. Take the College Avenue exit. Proceed down Miles Avenue to College Avenue. Turn left onto College Avenue. Proceed South on College Avenue about 4-5 blocks to the intersection of Kales and College Avenues.

From South Bay: Take Highway 101 North and follow the *From San Francisco* directions.

From Marin: Take Highway 580 across the Richmond-San Rafael bridge East to Richmond. Follow the *From San Francisco* directions.

san francisco bay area
center for cognitive therapy
5435 college ave | oakland, ca 94618 tel 510.652.4455 | www.sfbacct.com

YOUTH
EVALUATION/TREATMENT AGREEMENT

This document contains important information about the professional services and business policies of Dr. Daniela J. Owen, Ph.D. and the San Francisco Bay Area Center for Cognitive Therapy (SFBACCT). Please read it carefully and discuss any questions you have with Dr. Owen.

ASSESSMENT AND TREATMENT: Dr. Owen will provide an assessment of your family's difficulties and available treatment options. She may recommend that she provide you with cognitive-behavior therapy. Cognitive-behavior therapy has been shown, in controlled outcome studies, to provide effective treatment for a number of problems and disorders. (Dr. Owen will review the outcome data most pertinent to your situation upon request.) However, outcome data may not generalize to any specific case and no promises or guarantees have or can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety, and may result in changes that were not originally intended (such as more conflicts with your child for a period of time). The issue of when and to whom to disclose that you are in treatment with Dr. Owen is a sensitive and complicated issue. Dr. Owen will discuss with you, if you like, the advantages and disadvantages of telling others about your evaluation and treatment. There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your family's situation, Dr. Owen will offer, if you would like, an estimate of the number of sessions of treatment he recommends for your child. For most patients, this ranges between 5 and 50 sessions. Dr. Owen's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to cognitive-behavioral treatment that Dr. Owen can provide are available, including other types of psychotherapy, group, couple, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures can be helpful in some cases and if Dr. Owen recommends this (in your child's case), she will let you know what her recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of your treatment. Dr. Owen will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Dr. Owen is a clinical psychologist licensed (PSY23748) to practice in California. She graduated from the Stony Brook University with a Ph.D. in Clinical Psychology. She has many years of experience conducting cognitive-behavior therapy in the treatment of children, adolescents, and adults with mood disorders, anxiety disorders, OCD, ADHD, social skills deficits, eating disorders, and adjustment to life transitions issues. She has extensive experience working with couples and families as well as individuals.

THE PATIENT'S ROLE: You (and your child) are expected to play an active role in your treatment, including working with Dr. Owen to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If your child is working with another provider, Dr. Owen may ask to speak with that provider to make sure that she can help you support your child's treatment. Your willingness to do this work is an integral part of successful treatment. If at any point you are unhappy about your progress, process, or outcome of the treatment, please discuss this with Dr. Owen in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled "Patient's Bill of Rights," adapted from a publication by the California Department of Consumer Affairs, is attached. Please read it carefully and raise with Dr. Owen any questions you have about it.

HOURS/AVAILABILITY: Dr. Owen is available for therapy sessions from 10 a.m. to 6 p.m. Monday through Thursday and 10 am to 4 pm on Friday. Therapy sessions are usually scheduled as 45-minute sessions once per week, or as your treatment needs dictate and we agree. In the event of an urgent need after business hours, please call (510) 652-4455 x4 and leave a message identifying the call as an emergency. Then, hang up and dial Dr. Owen's cell phone at (631) 764-8644. Please leave Dr. Owen a message on her cell phone *only* if it is truly an emergency. In addition, in a crisis, you can call 911, contact your child's pediatrician or psychiatrist, the local emergency room, or crisis intervention services. When Dr. Owen is out of town, she will let you know, and she will give you the name and telephone number of another therapist who will be available for emergencies.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. In the case of the treatment of families/parents, the parents hold the privilege of deciding when and with whom Dr. Owen may disclose information about your evaluation and treatment. Dr. Owen and the SFBACCT will make every effort to keep the results of your evaluation and treatment strictly confidential, as is required by law. Information about you or your child will be released by Dr. Owen or by the SFBACCT only with your written permission, with the following exceptions:

- When there is suspected child abuse or neglect;
- When, in Dr. Owen's judgment, your child is in danger of harming himself or herself or another person, or if you are unable adequately to care for your child;
- If you or your child communicate to Dr. Owen a serious threat of physical violence against another person, Dr. Owen is required by law to inform both potential victims and legal authorities;
- If Dr. Owen is ordered by a court to release information about your child as part of a legal proceeding; or
- As otherwise required by law.

In the event group therapy services are provided, you and your child are expected to keep material shared in the group confidential. Dr. Owen cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Owen will provide you with a monthly statement you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 45-minute individual psychotherapy session), the date of the session, and the fee. Dr. Owen will include this information on your statement upon your request. In some cases, insurance companies require information about the patient's diagnosis and treatment plan, progress reports, and other records. Please be aware that when information is sent to an insurance company, Dr. Owen has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Owen cannot assure that they will do so. Some share the information they receive with a national medical information data bank for the purposes of deciding eligibility for future life, disability, health, and other insurance. Dr. Owen will provide you with information (including invoices) that you may share with your insurance company regarding your child's treatment. You have a choice about whether to release the information requested by an insurance company, but if you refuse to release the information most insurance programs will not pay for services.

Dr. Owen uses Virtru to attempt to maintain confidentiality of communication through e-mail exchanges. Virtru is a HIPPA compliant program that creates added security to email communication. Although Dr. Owen will make every effort to keep the information she receives via email confidential, she and the San Francisco Bay Area Center for Cognitive Therapy cannot guarantee confidentiality of e-mail communications. Also note that if Dr. Owen obtains information only via e-mail, her clinical judgment in responding is based on limited and imperfect information. If you communicate with Dr. Owen via e-mail, you agree to accept the risk that a breach of confidentiality may occur. ______
(initial)

PRIVACY POLICY CONSENT: Dr. Owen and the SFBACCT are dedicated to maintaining the privacy of your Protected Healthcare Information (PHI). In addition, Dr. Owen is required by law to inform you of how your PHI will be protected, how Dr. Owen and the SFBACCT may use or disclose PHI, and your rights regarding access to your PHI. Copies of the SFBACCT Privacy Policy are available in the waiting room (and one has been included in this packet). Please review this information carefully. You acknowledge receipt of the SFBACCT Privacy Policy. You understand that it is your responsibility to read these documents and present any questions, concerns, or special requests to your therapist. ______
(initial)

RECORD-KEEPING: Dr. Owen maintains a clinical chart for each patient. Information in the chart includes a description of your condition, your diagnosis, treatment goals, treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Owen also keeps records of any consent, release, assessment, insurance, or other forms completed in the course of your treatment. Clinical records are kept in a locked file cabinet and on the computer in Dr. Owen's office. All paper documents are scanned into the electronic chart and subsequently the hard copies may be destroyed. An external hard drive or memory stick that includes the material from your clinical record is stored securely when Dr. Owen is not in the office, and her computer is password protected.

RESEARCH, WRITING, TEACHING, AND CONSULTATION: Dr. Owen and others at the SFBACCT conduct research, training, and supervision, and write for professional and lay audiences. Dr. Owen may also wish to consult with other professionals, especially her colleagues at the San Francisco Bay Area Center for Cognitive Therapy about treatment planning for your case. Your signature below gives Dr. Owen and the SFBACCT permission to use information about your treatment provided they take reasonable efforts to protect your identity.

FOR MEDICARE BENEFICIARIES ONLY: If you are receiving insurance coverage through Medicare, please be aware that Dr. Owen is not a Medicare provider and is excluded from Medicare until 1/2018. Your signature below indicates that you accept full responsibility for payment of Dr. Owen's session fees. Additionally, your signature indicates that you will not submit claims to Medicare for Dr. Owen's fees or ask Dr. Owen to submit claims to Medicare. Please note that Medicare limits do not apply to these fees, Medigap plans will not cover the fees, and other insurance plans may not cover the fees. You have the right to obtain Medicare-covered services from providers who are covered by Medicare. If you see a provider who is covered by Medicare, you do not have to sign a private contract with that provider.

______________________________ *(Client signature)*

______________________________ *(Therapist signature)*

FEES: The fee charged for Dr. Owen's services is $375 per 90-minute consultation session and $210 per 45-minute treatment session. Longer or shorter consultation or treatment sessions are generally prorated from this base fee. You will be charged the standard fee for telephone calls, prorated according to the length of the call. You will be charged for lengthy emails that require extensive responses at a prorated

amount based on my fee. Of course, there will be no charge for brief telephone calls or emails, such as those made to schedule appointments. ______
(initial)

PAYMENT: Please make checks payable to **Daniela Owen, Ph.D**. Payment is due at the time of the session unless another arrangement has been made. Dr. Owen will send you a monthly statement if you request one. All returned checks will be charged the additional bank fee. ______
(initial)

CANCELLATIONS AND MISSED APPOINTMENTS: If you miss or cancel an appointment **with less than 24 hours notice**, you will be charged for the session. Please be aware that insurance companies do not generally reimburse for a missed or cancelled sessions. ______
(initial)

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source. ______
(initial)

ENDING TREATMENT: You may withdraw from treatment at any time. Dr. Owen recommends that you discuss your plan to terminate your child's treatment with her before taking action, so that she has an opportunity to offer her recommendations, and to offer referral options if they are needed.

If you discontinue your treatment with Dr. Owen for a period of four weeks or more, she will attempt to contact you. If she is unable to reach you, she will assume (unless other arrangements have been made) that you have elected to terminate your treatment with her and she will close your case. Of course, should you wish to resume your treatment with her, she will be happy to discuss that option with you at any time.

Should Dr. Owen become incapacitated or die, one of her colleagues at the San Francisco Bay Area Center for Cognitive Therapy will know how to access his medical records and will contact you to let you know of his incapacitation or death and to help you make arrangements for continuing your care with another provider if needed, and to discuss arrangements for handling your medical record.

*****

I have read and understood this treatment agreement and the "Patient Bill of Rights" (on the following page) and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to my child's participation in evaluation and/or treatment.

Name of Child (please print): ____

Signature of Parent: ____

Signature of Parent: ____

Date: ______________________

Patient Bill of Rights

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical, and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request that the therapist inform you of your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.5.24.01

SFBACCT
PRIVACY POLICY

OUR COMMITMENT TO YOUR PRIVACY

We are dedicated to maintaining the privacy of your* Protected Healthcare Information (PHI). In addition, we are required by law to inform you of how your Protected Healthcare Information (PHI) will be protected, how SFBACCT may use or disclose PHI, and your rights regarding access to your PHI. Please review this information carefully. You will be asked to sign a receipt indicating that you have received and read this document. If you have any questions regarding this notice, please speak with your therapist, who acts as a "Privacy Officer" on your behalf.

We reserve the right to revise or amend this document. Any revision or amendments to this notice will be effective for all records. We will post a copy of the current Privacy Policy in the waiting room and on our website (www.sfbacct.com) for your easy access. You may also request a current copy from your therapist at any time.

**Parents and guardians of under aged patients, the terms "you" and "your" is intended to include your child throughout this document.*

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Every time you visit your therapist, a record of your visit is added to your clinical record. Typically, your clinical record contains a list of your session dates and payments, medications, symptoms, history, test results, diagnoses, treatment, and a plan for future care, as well as any information that you have authorized to have forwarded to your therapist from other healthcare professionals.

HOW WE MAY USE AND DISCLOSE YOUR PHI

Information in your medical record is used primarily for your treatment. It is also used for business activities, called "healthcare operations". These include:

- Accounting and billing activities;
- Collecting data that does not identify you in any way for research, educating mental health professionals, marketing, and public health;
- Collecting data that does not identify you in any way for our assessment so that we may improve our treatment options and techniques as well as improve business and facilities management functions.

We do not share your PHI with any requesting agency (such as insurance companies) or person (such as a physician) unless you sign an authorization form allowing us to do so. This gives you control over the distribution of your Protected Healthcare Information.

You have the right to request restrictions in our use or disclosure of your PHI for treatment, payment, or healthcare operations. For more information on requesting restrictions, please refer to page 4, item #6 under Your Rights Regarding Your PHI.

USE OF YOUR PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI without prior consent; however, we will attempt to contact you in advance when the situation allows:

1. Health and Safety – When there is serious threat to your health and safety or the health and safety of another individual or the public. In this case, your PHI would be shared with any person or organization that might be able to prevent/reduce the threat.
2. Lawsuits and Similar Proceedings – We may be required to use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also be required to disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
3. Law Enforcement – We may be required by law to disclose PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, missing person, complying with a court order, warrant, grand jury subpoena, and other law enforcement purposes.
4. Military – We may be required to disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
5. National Security – We may be required to disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also be required to disclose your PHI to officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.
6. Inmates – We may be required to disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide your health care services, (b) for the safety and security of the institution, and/or (c) to protect their health and safety or the health and safety of other individuals.
7. Workers' Compensation – If your treatment is being paid for through a Workers Compensation claim, then we are likely to be asked to disclose your PHI. We would not give this information without your written consent. However, be aware that if you do not consent to releasing this information, Workers Compensation will likely refuse to pay for the treatment.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights related to your records:

1. **Copies of this Notice** - You have the right to obtain a copy of this notice before or at your first visit. Thereafter, you may request a copy of this notice or any revisions from the waiting room, the website (www.sfbacct.com), or from your therapist.
2. **Authorization to use your PHI** – We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You may revoke at any time, by submitting a request in writing, any authorization you provide to us regarding the use and disclosure of your PHI. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

3. **Inspection and Copies of your PHI** – You have the right to inspect and copy your PHI, with limited exceptions. To access your PHI, you must submit a written request detailing what information you want access to. You are entitled to view the modalities and frequencies of treatment sessions provided to you, the results of clinical tests and self report forms and symptom monitoring sheets, a written summary from your therapist explaining your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. The only exception to your automatic right to view information in you medical chart is the viewing of psychotherapy session notes written by your therapist. There are specific laws governing psychotherapy session notes, because these notes are intended to assist the psychotherapist only, and have the potential for being misinterpreted by others. If you would still like to view the psychotherapy notes, please include this in your written request to your therapist. Your therapist will review with you the pros and cons of your request in the context of your treatment needs and situation.

   We may deny your request under limited circumstances, and we would only do this if we believe it would be reasonably likely to cause you substantial harm. You have the right to appeal our decision. If we deny your request to access psychotherapy notes, you have the right to request that they be transferred to another mental health professional.

   We may charge a reasonable administrative fee to reimburse us for the time and supplies required to provide you with your PHI.

4. **Amend your PHI** – You have the right to request that we add or correct information in your record at the Center. Your request must be in writing to your therapist and must include a reason that supports your request.

   We may deny your request if the information in your record is, in our opinion, (a) accurate and complete; (b) not part of the PHI kept by or for your therapist at the Center; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by your therapist at the Center.

5. **Confidential Communications** – You have the right to request that we communicate with you in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will make reasonable attempts to accommodate your requests.

6. **Requesting Restrictions** - You have the right to request restrictions in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Please know that we are not required to comply with your request; however, if we do comply, we are bound by a restrictions agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat. In order to request a restriction in our use and disclosure of your PHI, you must make your request in writing to your therapist. Your request must describe in a clear and concise fashion: the information you wish restricted; whether you are requesting to limit our use, disclosure or both; and to whom you want the limits to apply.

7. **Accounting of Disclosures** – You have the right to request "an accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures your therapist has made of your PHI. Non-routine disclosures include disclosures made for purposes other than treatment, payment collection, or healthcare operations. In order to obtain an account of disclosures, you must submit your request in writing to your therapist. All requests must specify a time period (start and end dates). We may charge a reasonable administrative fee to reimburse us for time and supplies require to provide the accounting of disclosures.

8. **Right to File a Complaint** – You have the right to file a complaint with your therapist and/or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be submitted in writing. You will not be penalized by your therapist for filing a complaint. If you are not satisfied with the manner in which your therapist handles your complaint, you may submit a formal complaint to:

Department of Health and Human Services
Offices of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

9. **Other Rights** – You may have other rights granted to you by the laws of the State of California and these may be the same or different than the federal rights described above. For further information on California State Law protecting patient rights, please visit www.chcf.org (the California Healthcare Foundation website). If you have additional questions about this issue, please speak with your therapist.

   For further information on HIPAA (Health Insurance Portability and Accountability Act, 1996) regulations or your right to privacy regarding healthcare information, please visit www.hhs.gov/ocr/hipaa (the US Department of Health and Human Services website).

   For further information about your rights as a psychotherapy patient, please visit www.apa.org/publicinfo/rights (the American Psychological Association's website).

san francisco bay area
center for cognitive therapy
5435 college ave | oakland, ca 94618 tel 510.652.4455 | www.sfbacct.com

Privacy Policy Consent

Dr. Owen and the San Francisco Bay Area Center for Cognitive Therapy (SFBACCT) are dedicated to maintaining the privacy of your child's Protected Healthcare Information (PHI). In addition, Dr. Owen is required by law to inform you of how your child's PHI will be protected, how she and the SFBACCT may use or disclose PHI, and your rights regarding access to your child's PHI. The SFBACCT Privacy Policy is available at www.sfbacct.com. Additional copies of the SFBACCT Privacy Policy are available in the waiting room.

I acknowledge receipt of the SFBACCT's Privacy Policy. I understand that it is my responsibility to read these documents and present any questions, concerns, or special requests to my therapist.

____

Patient's Name (please print)

____

Parent's Name

____

Parent's Signature

____

Date

san francisco bay area
center for cognitive therapy
5435 college ave | oakland, ca 94618 | tel 510.652.4455 | www.sfbacct.com

5435 College Avenue, 103 • Oakland, CA 94618 • 510.652.4455 x 4 (tel) • 510.380.2988 (fax) • djo@sfbacct.com (email)

Parent Questionnaire

Date of First Visit: ______________ Referred by: ______________________________

Child's Name: ______________________ ______________________ ______
Last First MI

Street Address: ____

City: ______________ State: ______________ Zip: ______________

Home Telephone: ______________ Mobile Telephone: ______________

Grade/Education Level: ______________ Age: ______ Date of Birth: ______________

School: ____

Child's Pediatrician: ______________________ Telephone: ______________

Name of Person Filling Out This Form: ______________________ Email: ______________

Relation to Child: ______________________ Date: ______________

RESPONSIBLE PARTY

Relationship to patient: ______________________ Age: ______ Date of Birth: ______________

Name: ______________________ ______________________ ______
Last First MI

Social Security Number ______________________ Email: ______________

Other parent/guardian's name: ____

RESPONSIBLE PARTY'S HOME ADDRESS

Home Telephone: ______________ Mobile Telephone: ______________

Address: ____

City: ______________________________ Zip: ______________

RESPONSIBLE PARTY'S EMPLOYER Office Telephone: ______________

Name of Employer: ____

Employer Address: ____

City: ______________________________ Zip: ______________

REIMBURSEMENT You are responsible for collecting reimbursement from your insurance company or other source. If you would like to receive a monthly statement for this purpose, please indicate below:

Please mail the monthly statement to the following address (circle one): Home Business Other

____ ______________

IN CASE OF EMERGENCY CONTACT

Name Address Telephone Relationship to

____

PROBLEMS

A. What are your main concerns about your child and questions you would like answered by this evaluation?

B. What have you tried to do in the past to deal with the problem(s) (e.g., tutoring, counseling, behavioral management, medications)?

C. Is your child currently receiving any treatments or interventions (e.g., counseling, psychotherapy, medications, tutoring, occupational therapy)? If yes, what type of treatment or intervention and with whom (Please provide contact information below.)?

D. Has this child already had testing/evaluations/IEP? If yes, what were the conclusions? (Please include copies of test reports)

E. What do you consider to be your child's greatest:

1. Strengths:

2. Limitations:

SOCIAL HISTORY

Please list who lives at home with this child:

Please list who cares for this child throughout the day (parent, step-parent, family member, sibling, program, etc.):

Please complete the following information for the biologic or non-biologic parents of this child:

	Number of Years in School	Occupation	Marital Status
Biologic Mother			
Non-Biologic Mother			
Biologic Father			
Non-Biologic Father			

Please complete the following information for each of the biologic (B) or non-biologic (NB) siblings of this child:

Name of Sibling	B/NB	Age	School Grade	Any School Problems

What additional information do you think is important to know about your child?

PRENATAL HISTORY

How was this child's mother's health during the pregnancy? __________

How much weight did this child's mother gain during the pregnancy? __________

How active was the baby? __________

Check which of the following conditions occurred during the pregnancy and briefly describe:

- ❑ Edema (swelling of feet): __________
- ❑ High blood pressure: __________
- ❑ Fever/Infections: __________

5435 College Avenue, 103, Oakland, CA 94618 • 510.652.4455 x 4 (tel) • 510.380.2988 (fax) • djo@sfbacct.com (email)

- ❑ Vaginal bleeding: ______
- ❑ Hospitalizations: ______
- ❑ X-rays/Medical procedures: ______
- ❑ Emotional distress: ______
- ❑ Trauma/Accidents: ______
- ❑ Other (e.g., anemia, poor health): ______

List any medications (prescribed or over-the-counter) or injections this child's mother received during pregnancy:

Medication	Reason	Amount	Month(s) Taken

Check any that apply and explain:

☐ Smoking ☐ Alcohol Use ☐ Illicit Drug Use (e.g., amphetamines, cocaine, heroin, etc.) ☐ Prescription Drug Use

Please explain: ______

BIRTH HISTORY

Birth weight: ______ lb. ______ oz. Length: ______ Apgar scores: ______/______

Place of birth: ______ Number of days baby in hospital: ______

Type of birth: ☐ Vaginal ☐ C-section Presentation: ☐ Head ☐ Breech

Type of anesthesia: ☐ Gas ☐ Spinal ☐ Caudal block

Was the baby: ☐ On time ☐ Early ☐ Late

By how many days/weeks late or early: ______

Number of hours in labor: ______

Was there anything wrong with the baby before delivery: ☐ Yes ☐ No

If yes, please explain: ______

Please check each that apply and explain:

After delivery, any difficulty with: ☐ Breathing ☐ Cord around neck ☐ Jaundice

☐ Poor suck/feeding ☐ Other: ______________________

Did the baby receive special treatments for any problems: ☐ Yes ☐ No

If yes, please explain: ______________________

Please check all that apply and explain further:

- ❑ Bilirubin lights ______________________
- ❑ Evaluation in an intensive care nursery ______________________
- ❑ Oxygen or respirator ______________________
- ❑ Seizures ______________________
- ❑ Positive drug screen, drug withdrawal ______________________
- ❑ Special feedings ______________________
- ❑ Other ______________________

CHILD HEALTH HISTORY

Please check all of the following, which this child has had, and explain as necessary:

- ❑ Hospitalizations ______________________
- ❑ Surgery ______________________
- ❑ Trauma (e.g., fractures, serious accidents) ______________________
- ❑ Head injury ______________________
- ❑ Seizures/convulsions/fits ______________________
- ❑ Headaches or migraines ______________________
- ❑ Meningitis ______________________
- ❑ Serious illness/infections/high fevers ______________________
- ❑ Asthma ______________________
- ❑ Allergies ______________________
- ❑ Medication allergies ______________________

- ❑ Ear infections How many? ______
- ❑ Hearing/vision problems ______
- ❑ Sleep problems (e.g., nightmares, sleepwalking) ______
- ❑ Toileting problems, bed wetting ______
- ❑ Temper tantrums/aggressive behavior ______
- ❑ Unusual behavior ______
- ❑ Sleep problems: ☐ Nightmares ☐ Night Terrors ☐ Snoring
  ☐ Trouble getting to sleep or staying asleep ☐ Other: ______
- ❑ Other problems ______

Current medications this child takes:

Type of Medication	For the Treatment of What Condition

Comments: ______

Child's eating habits, diet, nutrition, or growth:

Does your child eat more sugary/fatty foods than you would like? ☐ Yes ☐ No

Is your child over weight per pediatric guidelines? ☐ Yes ☐ No

Is your child under weight per pediatric guidelines? ☐ Yes ☐ No

Is your child trying to diet or restrict what s/he eats? ☐ Yes ☐ No

Does your child exhibit any peculiar eating patterns (e.g., eats very rapidly, refuses to eat vegetables, does not use utensils.)? ☐ Yes ☐ No

Any other eating eating/feeding problems or concerns?: ______

Where does your child sleep? ______

5435 College Avenue, 103, Oakland, CA 94618 • 510.652.4455 x 4 (tel) • 510.380.2988 (fax) • djo@sfbacct.com (email)

DEVELOPMENTAL HISTORY

Please check which milestones this child has achieved or can now do. Give the child's approximate age in weeks or months when s/he first could do them. If the child is unable to do a particular activity or you do not remember when, please write N/A. A baby book, dated photos and associations with various events in your life may help you remember. (e.g., Ask yourself, "Was my child walking at his/her first birthday?)

- ☐ Roll from front to back/back to front: ______________________
- ☐ Sit unsupported: ______________________
- ☐ Creep or crawl on hands and knees: ______________________
- ☐ Walk alone unsupported: ______________________
- ☐ Walk up and down stairs: ______________________
- ☐ Pedal a tricycle: ____________ ☐ Pedal a bicycle: ____________
- ☐ Reach out for a nearby object: ______________________
- ☐ Feed self with fingers: ____________ ☐ Feed self with spoon: ____________
- ☐ Drink from a cup without help: ______________________
- ☐ Undress self: ________ ☐ Dress self: ________ ☐ Tie shoes: ________
- ☐ Toilet trained: ______________________
- ☐ Babble with sounds like "baba/mama": ______________________
- ☐ Point to specific objects: ____________ ☐ Point to body parts: ____________
- ☐ Understand "no" or "stop it": ______________________
- ☐ Say a word with meaning (not just "mama" or "dada"): ______________________
- ☐ Follow a simple command: ______________________
- ☐ Put 2 or more words together in a phrase: ______________________
- ☐ Name a color correctly: ______________________
- ☐ Speech is clear to family members and strangers: ______________________

Comments: ______________________

____

FAMILY HISTORY

Pregnancies: List each pregnancy and outcome (i.e., full term, pre-mature, stillborn, miscarriage):

Year	Outcome	Male/Female	Health Problems

Biologic Parents Information:

	Age	Health Problems
Yourself	_______	___________________________
		___________________________
Spouse/Parent	_______	___________________________
		___________________________

Please check all of the following problems for which any immediate relatives (e.g., grandparents, brothers, sisters, aunts, uncles) have been diagnosed and/or treated:

- ☐ Inherited/genetic conditions: ___________________________
- ☐ Birth defects: ___________________________
- ☐ Cerebral palsy/neuromuscular disorders: ___________________________
- ☐ Slow or retarded development: ___________________________
- ☐ Learning disabilities/dyslexia: ___________________________
- ☐ Neurologic condition: ___________________________
- ☐ Hearing/vision problems: ___________________________
- ☐ Thyroid or other hormone disorders: ___________________________
- ☐ Cancer: ___________________________
- ☐ Hyperactivity/attention deficit disorder (ADHD): ___________________________
- ☐ Chronic headache or migraines: ___________________________
- ☐ Alcoholism or drug abuse: ___________________________
- ☐ Anxiety or chronic worry: ___________________________
- ☐ Panic attacks or phobias: ___________________________
- ☐ Motor tics or Tourette's syndrome: ___________________________
- ☐ Depression: ___________________________
- ☐ Bipolar or manic depressive illness: ___________________________
- ☐ Schizophrenia, schizoaffective disorder, or chronic mental illness: ___________________________
- ☐ Eating disorders (anorexia nervosa, bulimia nervosa, binge eating): ___________________________
- ☐ Autism, Asperger's syndrome, non-verbal learning disorder: ___________________________
- ☐ Slow or delayed development: ___________________________
- ☐ Hair pulling, nail biting, skin picking: ___________________________
- ☐ Other emotional problems/nervous breakdown: ___________________________

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Date: ___________

RCADS-P

Name/ID: ________________

Relationship to Child: ______________

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child feels sad or empty	Never	Sometimes	Often	Always
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
6. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7. My child feels scared when taking a test	Never	Sometimes	Often	Always
8. My child worries when he/she thinks someone is angry with him/her.	Never	Sometimes	Often	Always
9. My child worries about being away from me	Never	Sometimes	Often	Always
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11. My child has trouble sleeping	Never	Sometimes	Often	Always
12. My child worries about doing badly at school work	Never	Sometimes	Often	Always
13. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14. My child suddenly feels as if he/she can't breathe when there is no reason for this.	Never	Sometimes	Often	Always
15. My child has problems with his/her appetite	Never	Sometimes	Often	Always
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18. My child has trouble going to school in the mornings because of feeling nervous or afraid.	Never	Sometimes	Often	Always
19. My child has no energy for things	Never	Sometimes	Often	Always
20. My child worries about looking foolish	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23. My child can't seem to get bad or silly thoughts out of his/her head.	Never	Sometimes	Often	Always

24. When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25. My child cannot think clearly	Never	Sometimes	Often	Always
26. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28. When My child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29. My child feels worthless	Never	Sometimes	Often	Always
30. My child worries about making mistakes	Never	Sometimes	Often	Always
31. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. My child worries what other people think of him/her	Never	Sometimes	Often	Always
33. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35. My child worries about what is going to happen	Never	Sometimes	Often	Always
36. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. My child thinks about death	Never	Sometimes	Often	Always
38. My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39. My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. My child worries when in bed at night	Never	Sometimes	Often	Always
46. My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47. My child feels restless	Never	Sometimes	Often	Always

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: ______________________________________

Date: ______________________________________

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for 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.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

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

SCORING:

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

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**.

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

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

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

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

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 Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Child/Adolescent Psychiatry Screen (CAPS)

Child's Name:______________________________ Date of Birth :______________ Male _____ Female _____
Form Completed By:______________________________ Relationship to Child:______________________________

For each item below, check the one category that best describes your child ***during the past 6 months.***
None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior. ***Past*** = the child used to have significant problems with this behavior, ***but not during the past 6 months.***

	None	Mild	Moderate	Severe	*Past*
1. Has difficulty separating from parents* (* = or major caregiver/guardian)	____	____	____	____	____
2. Worries excessively about losing or harm occurring to parents*	____	____	____	____	____
3. Worries about being separated from parent* (getting lost or kidnapped)	____	____	____	____	____
4. Resists going to school or elsewhere because of fears of separation	____	____	____	____	____
5. Resists being alone or without parents*	____	____	____	____	____
6. Has difficulty going to sleep without parent nearby	____	____	____	____	____
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation	____	____	____	____	____
8. Has discrete periods of intense fear that peak within 10 minutes	____	____	____	____	____
9. Has excessive, unreasonable fear of a specific object or situation	____	____	____	____	____
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)	____	____	____	____	____
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)	____	____	____	____	____
12. Has recurrent, distressing recollections of past difficult or painful events	____	____	____	____	____
13. Worries excessively about multiple things (e.g., school, family, health, etc.)	____	____	____	____	____
14. Goes to the bathroom at inappropriate times or places	____	____	____	____	____
15. Makes noises, and is often unaware of them	____	____	____	____	____
16. Makes repetitive, sudden, nonrhythmic movements	____	____	____	____	____
17. Fails to pay close attention to details or makes careless mistakes	____	____	____	____	____
18. Has difficulty sustaining attention during play or school activities	____	____	____	____	____
19. Does not seem to listen when spoken to directly	____	____	____	____	____
20. Does not follow through on instructions; fails to finish schoolwork/chores	____	____	____	____	____
21. Has difficulty organizing tasks and activities	____	____	____	____	____
22. Loses things necessary for tasks are activities (toys, pencils, etc.)	____	____	____	____	____
23. Is easily distracted easily by irrelevant stimuli	____	____	____	____	____
24. Is forgetful in daily activities	____	____	____	____	____
25. Is fidgety or squirms in seat	____	____	____	____	____
26. Has difficulty remaining seated	____	____	____	____	____
27. Runs or climbs excessively; is restless	____	____	____	____	____
28. Talks excessively	____	____	____	____	____
29. Blurts out answers before questions have been completed	____	____	____	____	____
30. Has difficulty waiting turn	____	____	____	____	____
31. Interrupts or intrude on others	____	____	____	____	____
32. Episodes of unusually elevated or irritable mood	____	____	____	____	____
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)	____	____	____	____	____
34. During this episode, is more talkative than usual/seems pressured to keep talking	____	____	____	____	____
35. During this episode, races from thought to thought	____	____	____	____	____
36. During this episode, is very distractible	____	____	____	____	____
37. During this episode, excessively involved in things (too religious, hypersexual)	____	____	____	____	____
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)	____	____	____	____	____
39. Depressed or irritable mood most of the day, most days for at least 1 week	____	____	____	____	____
40. Loss of interest in previously enjoyable activities	____	____	____	____	____
41. Notable change in appetite (not when dieting or trying to gain weight)	____	____	____	____	____
42. Difficulty falling or staying asleep, or sleeping excessively through the day	____	____	____	____	____

Child/Adolescent Psychiatry Screen (CAPS) - continued

	None	Mild	Moderate	Severe	*Past*
43. Others notice child is sluggish or agitated most of the time	____	____	____	____	____
44. Loss of energy nearly every day	____	____	____	____	____
45. Feelings of worthlessness or inappropriate guilt nearly every day	____	____	____	____	____
46. Thinks about dying or wouldn't care if died	____	____	____	____	____
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)	____	____	____	____	____
48. Has bad things happen when under the influence of substances	____	____	____	____	____
49. Has made unsuccessful efforts to stop using a substance	____	____	____	____	____
50. Is excessively worried about gaining weight, even though underweight	____	____	____	____	____
51. If female, has stopped having menstrual cycles (after regularly having)	____	____	____	____	____
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)	____	____	____	____	____
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives)	____	____	____	____	____
54. Bullies, threatens, or intimidates others	____	____	____	____	____
55. Initiates physical fights	____	____	____	____	____
56. Uses weapons that could harm others	____	____	____	____	____
57. Has been physically cruel to animals	____	____	____	____	____
58. Has shoplifted or stolen items	____	____	____	____	____
59. Has deliberately set fires	____	____	____	____	____
60. Has deliberately destroyed others' property	____	____	____	____	____
61. Lies to obtain goods or to avoid obligations	____	____	____	____	____
62. Stays out at night despite parental prohibitions	____	____	____	____	____
63. Has run away from home overnight on at least two occasions	____	____	____	____	____
64. Is truant from school	____	____	____	____	____
65. Loses temper	____	____	____	____	____
66. Actively defies or refuses to comply with adult rules	____	____	____	____	____
67. Deliberately annoys others	____	____	____	____	____
68. Blames others for his/her mistakes or misbehavior	____	____	____	____	____
69. Easily annoyed by others	____	____	____	____	____
70. Is spiteful or vindictive	____	____	____	____	____
71. Has unusual thoughts that others cannot understand or believe	____	____	____	____	____
72. Hears voices speaking to him/her that others don't hear	____	____	____	____	____
73. Does poorly at sports or games requiring physical coordination skills	____	____	____	____	____
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)	____	____	____	____	____
75. Had delayed speech or has limited language now	____	____	____	____	____
76. Avoids eye contact during conversations	____	____	____	____	____
77. Does not follow when others point to objects	____	____	____	____	____
78. Shows little interest in others; emotionally out of sync with others	____	____	____	____	____
79. Difficulty starting, stopping conversation; continues talking after others lose interest	____	____	____	____	____
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)	____	____	____	____	____
81. Does not engage in make-believe play; plays more alone than with others	____	____	____	____	____
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)	____	____	____	____	____
83. Difficulty with transitions; may be inflexible about adhering to routines or rules	____	____	____	____	____
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.)	____	____	____	____	____
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)	____	____	____	____	____

Thank you for answering each of these items. Please list any other symptoms that concern you:

____

Children's Anxiety Life Interference Scale (Parent Form)

1. **When did anxiety first start to interfere with your child's friendships, school performance, home life or cause your child to miss out on activities?**

   Month ____________________ Year ________

2. **Do the fears and worries upset or distress your child?**

Not at all	Only a little	Sometimes	Quite a lot	A great deal
○	○	○	○	○

3. How much do fears and worries interfere with your child's everyday life in the following areas?	**Not at all**	**Only a little**	**Some**	**Quite a lot**	**A great deal**
a. Getting on with parents	○	○	○	○	○
b. Getting on with siblings	○	○	○	○	○
c. Being with friends outside of school	○	○	○	○	○
d. Performance in the classroom	○	○	○	○	○
e. Interacting with peers at recess and lunch .	○	○	○	○	○
f. Playing sport	○	○	○	○	○
g. Doing enjoyable activities like going to parties, movies or holidays	○	○	○	○	○
h. Daily activities (eg sleeping, going to school, homework, playing)	○	○	○	○	○
4. How much do your child's fears and worries interfere with your everyday life in the following areas	**Not at all**	**Only a little**	**Some**	**Quite a lot**	**A great deal**
a. Your relationship with your partner or a potential partner	○	○	○	○	○
b. Your relationship with extended family	○	○	○	○	○
c. Time spent fostering personal friendships	○	○	○	○	○
d. Your career (choice to work, how many hours you do or how often you miss work) .	○	○	○	○	○
e. The level of harmony in the family home ...	○	○	○	○	○
f. Your ability to go out to activities/events **without** your child	○	○	○	○	○
g. Your ability to go out to activities/events **with** your child	○	○	○	○	○
h. Your level of stress	○	○	○	○	○
i. Your free time	○	○	○	○	○