



Anxiety Treatment Center, LLC

CHILD INTAKE PACKET

ASSENT FOR THERAPY SERVICES

Welcome to the Anxiety Treatment Center, LLC. This packet contains a lot of questions that will help us get to know you better.

The purpose of meeting with a counselor or therapist is to get help with problems that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to someone about these problems. Or, you may be here because your parent, doctor, or school counselor thinks it will be helpful.

When you come for your first visit, your therapist will ask you questions and listen to you to understand you and your problems better. At the end of the first meeting, your therapist will share ideas about what you, your parents, and your therapist can do together to make things better. We want you to feel free to ask as many questions as you want. Some questions you could ask are: Do I have a problem? If so, what is it called? How common is it? What can I do about it?

Part of successful treatment includes being open and honest with your therapist, and trying out the things that are discussed during treatment sessions in your daily life. Parent participation can be an important part of treatment and your therapist will discuss your concerns with your parents. The things that you share with your therapist cannot be shared with other adults, like your doctors, teachers, or school counselor without your parent's permission. Information cannot be kept private if your therapist thinks that you or someone else is in danger, or you are being abused or neglected. If you ever want to know whether your therapist can keep certain information private, just ask!

Please sign below to indicate that you have read and agree to the above information:

Child's Signature

Date

The purpose of these questions is to help us get more information about you and your concerns. Please answer all of these questions to the best of your ability. If you do not understand a question, please circle it and ask us about it.

Name: _____

Age: _____

What kind of problem(s) would you like us to help you with?

How long has this been going on?

What have you done to cope? Has it been helpful?

What do you hope to gain from this evaluation and therapy?

CGI SELF RATING

Over the past week, how bad is the problem you would like us to help you with? (Circle one)

1	2	3	4	5	6	7
There is no problem	Barely a problem	A little problem	A medium problem	A pretty bad problem	A very bad problem	An extremely bad problem

These questions ask whether anxiety or other problems have MESSED UP things. MESSED UP means the problems you are having make it hard for you to do well in school, do things with your friends, get along with your family, or do chores at home. For each area, circle the number that best describes your situation now.

SCHOOLING: Because of my problems, my schooling is messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (cannot go to school)

SOCIAL LIFE/LEISURE ACTIVITIES (with other people at parties, socializing, visiting, outings, participation in clubs/activities): Because of my problems, my social life is messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

FAMILY LIFE/HOME RESPONSIBILITIES (relating to family members, doing household chores, following family rules): Because of my problems, my family life/home responsibilities are messed up:

0	1	2	3	4	5	6	7	8	9	10
Not at All	A little			Somewhat			A lot			Very Severely (I never do these)

HEALTH HABITS

Sleep

Average hours of sleep per night: _____

Please check any sleep problems that you have experienced in the past month:

- Difficulty falling asleep Difficulty getting out of bed
 Difficulty staying asleep Not feeling rested in the morning

Appetite/Eating

Have you experienced any changes in your eating or appetite? Yes No

If YES, please describe: _____

Do you think your weight is what it should be for someone your age? Yes No

Do you worry a lot about your weight? Yes No

Please check any behaviors that you have engaged in during the past month:

- Difficulty controlling your eating Binging/Eating a lot of food at one time
 Dieting, using medications or laxatives, exercising a lot, or vomiting to control your weight/avoid weight gain

Substance Use

Do you drink alcohol? Yes No

If yes, *how much* and *how often* do you drink? _____

Do you use tobacco products? Yes No

If yes, *how often* do you use tobacco products? _____

Do you use other substances? Yes No

If yes, *which substances* and *how often* do you use these substances? _____

Have you ever ridden in a car driven by someone who was "high" or had been using alcohol or drugs?
--

<input type="checkbox"/> Yes <input type="checkbox"/> No
--

RISK ASSESSMENT

1. Have you ever had feelings or thoughts that you didn't want to live? Yes No

If YES, please answer the following. If NO, please skip to the next question.

How often do you have these feelings? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? Yes No

If YES, please describe: _____

Do you currently feel that you don't want to live? Yes No

Have you ever tried to kill or harm yourself before? Yes No

2. Have you ever hurt your body (e.g., cut, carve, burn, scratch really hard, punch) on purpose but without wanting to end your life? Yes No

If YES, please answer the following. If NO, please skip to the next question.

When was the last time you intentionally hurt yourself? _____

Approximately on how many total occasions have you intentionally hurt yourself? _____

How old were you the first time you intentionally hurt yourself? _____

On what areas of your body have you intentionally hurt yourself? _____

3. Have you ever had feelings or thoughts of hurting or harming someone else?

Yes No

4. Have you ever been involved with the legal system? Yes No

If YES, please describe: _____

5. Have you ever been abused? (check all that apply)

Verbally Physically Emotionally Sexually Neglected

MASC²

Multidimensional Anxiety Scale for Children, Second Edition
By John S. March, M.D., MPH

These sentences ask how you might have been thinking, feeling, or acting recently. For each item, please circle **how often the sentence is true about you**.

Circle **OFTEN** if a sentence is true about you a lot of the time.
Circle **SOMETIMES** if a sentence is true about you some of the time.
Circle **RARELY** if a sentence is true about you once in a while.
Circle **NEVER** if a sentence is hardly ever true about you.

Remember, there are no right or wrong answers, just answers about how you might have been feeling recently.

1.	I feel tense or uptight.	never	rarely	sometimes	often
2.	I usually ask permission to do things.	never	rarely	sometimes	often
3.	I worry about other people laughing at me.	never	rarely	sometimes	often
4 .	I get scared when my parents go away.	never	rarely	sometimes	often
5 .	I keep my eyes open for danger.	never	rarely	sometimes	often
6.	I have trouble getting my breath.	never	rarely	sometimes	often
7.	The idea of going away to camp scares me.	never	rarely	sometimes	often
8 .	I get shaky or jittery.	never	rarely	sometimes	often
9.	I try to stay near my mom or dad.	never	rarely	sometimes	often
10 .	I'm afraid that other kids will make fun of me.	never	rarely	sometimes	often
11.	I try hard to obey my parents and teachers.	never	rarely	sometimes	often
12.	I get dizzy or faint feelings.	never	rarely	sometimes	often
13.	I check things out first.	never	rarely	sometimes	often
14.	I worry about getting called on in class.	never	rarely	sometimes	often
15.	I'm jumpy.	never	rarely	sometimes	often
16.	I'm afraid other people will think I'm stupid.	never	rarely	sometimes	often
17.	I keep the light on at night.	never	rarely	sometimes	often
18.	I have pains in my chest.	never	rarely	sometimes	often

19.	I avoid going to places without my family.	never	rarely	sometimes	often
20.	I feel strange, weird, or unreal.	never	rarely	sometimes	often
21.	I try to do things other people will like.	never	rarely	sometimes	often
22.	I worry about what other people think of me.	never	rarely	sometimes	often
23.	I avoid watching scary movies and TV shows.	never	rarely	sometimes	often
24.	My heart races or skips beats.	never	rarely	sometimes	often
25.	I stay away from things that upset me.	never	rarely	sometimes	often
26.	I sleep next to someone from my family.	never	rarely	sometimes	often
27.	I feel restless and on edge.	never	rarely	sometimes	often
28.	I try to do everything exactly right.	never	rarely	sometimes	often
29.	I worry about doing something stupid or embarrassing.	never	rarely	sometimes	often
30.	I get scared riding in the car or on the bus.	never	rarely	sometimes	often
31.	I feel sick to my stomach.	never	rarely	sometimes	often
32.	I get nervous if I have to perform in public.	never	rarely	sometimes	often
33.	Bad weather, the dark, heights, animals, or bugs scare me.	never	rarely	sometimes	often
34.	My hands shake.	never	rarely	sometimes	often
35.	I check to make sure things are safe.	never	rarely	sometimes	often
36.	I have trouble asking other kids to play with me.	never	rarely	sometimes	often
37.	My hands feel sweaty or cold.	never	rarely	sometimes	often
38.	I feel shy.	never	rarely	sometimes	often
39.	I have trouble making up my mind about simple things.	never	rarely	sometimes	often
40.	I get upset over the thought that I might get sick.	never	rarely	sometimes	often
41.	I have bad or silly thoughts that I can't stop.	never	rarely	sometimes	often
42.	I have to do things over and over again for no reason.	never	rarely	sometimes	often

43.	I get really upset about dirt, germs, chemicals, radiation, or sticky things.	never	rarely	sometimes	often
44.	I feel that I have to wash or clean more than I really need to.	never	rarely	sometimes	often
45.	I fear I'll be responsible for something bad happening.	never	rarely	sometimes	often
46.	I have to check that nothing terrible has happened.	never	rarely	sometimes	often
47.	I have to check things several times or more.	never	rarely	sometimes	often
48.	I count things for no reason.	never	rarely	sometimes	often
49.	I get too concerned with sin or wrongdoing.	never	rarely	sometimes	often
50.	I have to repeat things until it feels just right.	never	rarely	sometimes	often

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CDI²
 Children's Depression Inventory 2nd Edition
 By Maria Kovacs, Ph.D.

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick **one** sentence that describes you best for the past **two weeks**. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this **X** next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how the form works. Try it.
 Put a mark next to the sentence that describes you best.

Example:

I READ BOOKS ALL THE TIME

I READ BOOKS ONCE IN A WHILE

I NEVER READ BOOKS

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

1. <input type="checkbox"/> I am sad once in a while. <input checked="" type="checkbox"/> I am sad many times. <input type="checkbox"/> I am sad all the time.	5. <input type="checkbox"/> I am important to my family. <input checked="" type="checkbox"/> I am not sure if I am important to my family. <input type="checkbox"/> My family is better off without me.
2. <input checked="" type="checkbox"/> Nothing will ever work out for me. <input type="checkbox"/> I am not sure if things will work out for me. <input type="checkbox"/> Things will work out for me O.K.	6. <input checked="" type="checkbox"/> I hate myself. <input type="checkbox"/> I do not like myself. <input type="checkbox"/> I like myself.
3. <input type="checkbox"/> I do most things O.K. <input checked="" type="checkbox"/> I do many things wrong. <input type="checkbox"/> I do everything wrong.	7. <input checked="" type="checkbox"/> All bad things are my fault. <input type="checkbox"/> Many bad things are my fault. <input type="checkbox"/> Bad things are not usually my fault.
4. <input type="checkbox"/> I have fun in many things. <input checked="" type="checkbox"/> I have fun in some things. <input type="checkbox"/> Nothing is fun at all.	8. <input type="checkbox"/> I do not think about killing myself. <input checked="" type="checkbox"/> I think about killing myself but would not do it. <input type="checkbox"/> I want to kill myself.

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

<p>9. <input type="checkbox"/> I feel like crying every day. <input type="checkbox"/> I feel like crying many days. <input type="checkbox"/> I feel like crying once in a while.</p>	<p>17. <input type="checkbox"/> Most days I do not feel like eating. <input type="checkbox"/> Many days I do not feel like eating. <input type="checkbox"/> I eat pretty well.</p>
<p>10. <input type="checkbox"/> I feel cranky all the time. <input type="checkbox"/> I feel cranky many times. <input type="checkbox"/> I am almost never cranky.</p>	<p>18. <input type="checkbox"/> I do not worry about aches and pains. <input type="checkbox"/> I worry about aches and pains many times. <input type="checkbox"/> I worry about aches and pains all the time.</p>
<p>11. <input type="checkbox"/> I like being with people. <input type="checkbox"/> I do not like being with people many times. <input type="checkbox"/> I do not want to be with people at all.</p>	<p>19. <input type="checkbox"/> I do not feel alone. <input type="checkbox"/> I feel alone many times. <input type="checkbox"/> I feel alone all the time.</p>
<p>12. <input type="checkbox"/> I cannot make up my mind about things. <input type="checkbox"/> It is hard to make up my mind about things. <input type="checkbox"/> I make up my mind about things easily.</p>	<p>20. <input type="checkbox"/> I never have fun at school. <input type="checkbox"/> I have fun at school only once in a while. <input type="checkbox"/> I have fun at school many times.</p>
<p>13. <input type="checkbox"/> I look O.K. <input type="checkbox"/> There are some bad things about my looks. <input type="checkbox"/> I look ugly.</p>	<p>21. <input type="checkbox"/> I have plenty of friends. <input type="checkbox"/> I have some friends but I wish I had more. <input type="checkbox"/> I do not have any friends.</p>
<p>14. <input type="checkbox"/> I have to push myself all the time to do my schoolwork. <input type="checkbox"/> I have to push myself many times to do my schoolwork. <input type="checkbox"/> Doing school work is not a big problem.</p>	<p>22. <input type="checkbox"/> My schoolwork is alright. <input type="checkbox"/> My school work is not as good as before. <input type="checkbox"/> I do very badly in subjects I used to be good in.</p>
<p>15. <input type="checkbox"/> I have trouble sleeping every night. <input type="checkbox"/> I have trouble sleeping many nights. <input type="checkbox"/> I sleep pretty well.</p>	<p>23. <input type="checkbox"/> I can never be as good as other kids. <input type="checkbox"/> I can be as good as other kids if I want to. <input type="checkbox"/> I am just as good as other kids.</p>
<p>16. <input type="checkbox"/> I am tired once in a while. <input type="checkbox"/> I am tired many days. <input type="checkbox"/> I am tired all the time.</p>	<p>24. <input type="checkbox"/> Nobody really loves me. <input type="checkbox"/> I am not sure if anybody loves me. <input type="checkbox"/> I am sure that somebody loves me.</p>

Remember, for each group, pick out the sentence that describes you best in the **PAST TWO WEEKS**.

<p>25. <input type="radio"/> It is easy for me to get along with friends.</p> <p><input type="radio"/> I get into arguments with friends many times.</p> <p><input type="radio"/> I get into arguments with friends all the time.</p>	<p>27. <input type="radio"/> Most days I feel like I can't stop eating.</p> <p><input type="radio"/> Many days I feel like I can't stop eating.</p> <p><input type="radio"/> My eating is O.K.</p>
<p>26. <input type="radio"/> I fall asleep during the day all the time.</p> <p><input type="radio"/> I fall asleep during the day many times.</p> <p><input type="radio"/> I almost never fall asleep during the day.</p>	<p>28. <input type="radio"/> It is easy for me to remember things.</p> <p><input type="radio"/> It is a little hard to remember things.</p> <p><input type="radio"/> It is very hard to remember things.</p>

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SCREENING QUESTIONNAIRE

This section will ask you about problems that you may have had. Please respond to each question by circling "Yes," "No," or "Maybe/Unsure."

CIRCLE ONE:

SR: Do you get very nervous or scared about having to go to school? YES NO MAYBE/UNSURE

SR: Do you stay home from school because you are nervous or scared? YES NO MAYBE/UNSURE

AG: Are you afraid to go places like shopping malls or crowded places, because you are afraid of having an uncomfortable feeling in your body, such as dizziness or a fast-beating heart, and then you wouldn't be able to escape or get help? YES NO MAYBE/UNSURE

PTSD: Have you ever experienced or seen a terrible or very dangerous event such as assault, sexual abuse, seeing someone badly injured or killed, accidents, or disasters? YES NO MAYBE/UNSURE

MaE: Have you ever felt unusually "high" or cranky for several days at a time? YES NO MAYBE/UNSURE

AD: Do you often make little mistakes, such as on school work, chores, or other things that you do? YES NO MAYBE/UNSURE

AD: When you are supposed to be paying attention YES NO MAYBE/UNSURE

to one thing, do you find yourself paying attention to other things?

AD: Do people often complain that you don't listen or pay attention? YES NO MAYBE/UNSURE

AD: Do you find that you just can't finish things that others ask you to do, such as chores, homework, and so on? YES NO MAYBE/UNSURE

AD: Do you usually have a lot of trouble staying in your seat? YES NO MAYBE/UNSURE

AD: Do you get yelled at because you run around a lot or climb on things, such as the furniture? YES NO MAYBE/UNSURE

AD: Do you often feel restless, like you need to keep moving or doing something? YES NO MAYBE/UNSURE

AD: Do you have trouble playing quietly? YES NO MAYBE/UNSURE

AD: Do you have trouble sitting and doing things quietly by yourself? YES NO MAYBE/UNSURE

AD: Are you almost always moving your hands and feet? YES NO MAYBE/UNSURE

AD: Do you often feel restless? YES NO MAYBE/UNSURE