PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH-HITCHCOCK

Use this form when you want a health care provider to send your medical records *to* D-H.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider: _____

Street Address: _____ Fax Number: ( ) _____

City: _____ State: _____ Zip: _____

RECIPIENT

to share (disclose) my health information with Dartmouth-Hitchcock at the following location(s):

☐ **Concord**	☐ **Keene**	☐ **Lebanon**	☐ **Manchester**	☐ **Nashua**	☐ **Plymouth Pediatrics**
Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-5478	Release of Information 1 Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869	Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 727-7855	71 Highland St. Plymouth, NH 03264 Ph: (603) 536-3700 Fax: (603) 536-5384

If mailing my information, please return requested records to the following department/section or provider:

_____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

- ☐ Discharge Summary
- ☐ Emergency Department Reports
- ☐ Immunizations
- ☐ Inpatient Progress Notes
- ☐ Laboratory/Pathology reports
- ☐ Operative Reports
- ☐ Outpatient Visit (Office) Notes
- ☐ School physical forms
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Other_____
- ☐ Records from a specific provider: _____

For the following purpose: _____

SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth-Hitchcock at the location noted above UNLESS I place my initials in the applicable space next to the type of records:**

- _____ Mental health treatment records
- _____ Sexually Transmitted Disease (STD) treatment records
- _____ Genetic testing
- _____ Alcohol/drug abuse treatment records
- _____ HIV/AIDS test results

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Dartmouth-Hitchcock and _____ **[SENDER NAME]** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. Your sending health care provider may require fees to process your request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Affiliated Covered Entity

Use this form when you want records and/or verbal communication sent FROM DHMC

Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Phone: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

FACILITY:

Please check the current location of the records you want shared:

☐ Alice Peck Day ☐ Cheshire Medical Center ☐ DH-Concord ☐ DHMC-Lebanon ☐ DH-Manchester ☐ DH-Nashua

☐ Other: _____

RECIPIENT: I authorize the entities listed above to release my information to:

Name of Person or Entity: _____ Phone Number: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

PURPOSE:

☐ Medical care ☐ Payment of health insurance claim ☐ Workers' Comp ☐ Legal ☐ Personal ☐ Disability determination

☐ Life insurance application ☐ Transfer of Care ☐ Other (please specify): _____

INFORMATION TO BE SHARED:

☐ VERBAL COMMUNICATION

☐ MEDICAL RECORDS

The records to be released will cover the time period from _____ to _____

☐ Records from a specific provider: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ School/Camp Form	☐ Other: _____
☐ Inpatient Notes	☐ Lab/Path Reports	☐ Radiology Reports	_____
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	_____
☐ Billing	☐ Immunizations	☐ Photos	

Delivery: ☐ Patient Portal (myD-H) (*FREE!*) ☐ Pickup ☐ Mail to Recipient ☐ Fax Number: (_____) _____

Format: ☐ Paper ☐ CD

DURATION & REVOCATION:

My authorization is valid for one year from the date of my signature below, unless I specify a different date here: _____.
My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

I understand that:

- A fee for the cost of processing this request may be charged.
- D-H ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- D-H ACE members may utilize a business associate/authorized agent to assist in fulfilling this request.

SENSITIVE HEALTH INFORMATION This form authorizes D-H ACE members to release the following types of information, **UNLESS** you place your initials in the space provided:

_____ psychiatric treatment records	_____ sexually transmitted disease (STD) treatment records
_____ genetic testing	_____ substance use disorder treatment records from a 42 CFR Part 2
_____ HIV/AIDS test results	program

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

"Dartmouth-Hitchcock Health (D-HH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct from Dartmouth-Hitchcock Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and D-H Clinic, operating jointly as "Dartmouth-Hitchcock," Mt. Ascutney Hospital and Health Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D-H ACE comprises only of D-HH members who are currently using a single, integrated electronic medical record system, sometimes referred to as "eD-H."

Health Information Services Approval: 6/13/2019 Privacy Office Approval: 6/13/2019 EFMC Approval: 6/13/2019

What in this packet: We are enclosing a number of things for you to fill out. This is a list of what is in the packet and what to do with each thing. If you have questions or are having trouble completing any of it, please call us to let us know at 603-650-7075.

Questionnaire: Please fill out this questionnaire in as much detail as you can. It helps us to prepare for your visit and use our time to address your concerns and questions.

Note: If you have been seen in our Child Clinic before and this is a re-evaluation, you can leave out past information and update for what is currently going on; current problems, services, care, medications, etc.

Release of Information: We have enclosed three release forms. A copy of the evaluation will automatically be sent to the referring provider/ PCP.

One release is for us to receive information from school. If we need to share any information with a school we will discuss that with your beforehand, as we are very careful about what might go into a child's school records. We ask for a teacher email so that we can send rating scales (see below), and we also want any testing or assessments done by the school, as well as IEPs or 504 plans. Please ask the school to send us these if your child has had them.

If your child has a therapist, case manager, service coordinator, or other provider that we might want to speak with, please fill out a Release form for them.

If you need more forms, you can call 603-650-7075 to request them, or you can ask at the evaluation for more to be sent following the appointment.

Rating Scales: Rating scales are extremely important for helping us to document symptoms, monitor treatment progress, and help with making diagnoses.

You will see a few rating scales included in this packet, including some with a copy for the teacher to fill out. If you want more people to fill them out, call us at 603-650-7075 and we can send more out.

About two weeks before your appointment, you will get a notice through myDH that there are some rating scales to fill out. Because sometimes there is a long wait between sending in this packet and your first appointment, we ask that you do these few rating scales so we know what is most current. If your appointment is less than two months after you send in the packet you can ignore the myDH scales. If it has been at least two months, please complete them.

Online rating scale: The Child Behavior Checklist, otherwise known as the ASEBA, is an important rating scale that helps us with diagnosis. This scale is done on-line. In order to get the scale to you we will need your email address, and that of any other guardians or caretakers you think would be able to provide useful information. There is a teacher scale as well, and we will ask you to provide us with an email so we may get the scale to the teacher. It is also helpful if you let the teacher know to expect it.

Children's Hospital at Dartmouth-Hitchcock

CHaD Departments of Pediatric Development and Child Psychiatry

Child/Adolescent Intake Information

This questionnaire will help us provide you and your child with the best possible treatment.

Please fill out all of the questions as completely as possible.

Name of patient: _____ Date of Birth: _____

Age: _____

Person Completing the Questionnaire _____
Relationship to Child: _____

Legal Guardian(s)_____ Relationship to Child: _____
Legal Guardian(s)_____ Relationship to Child: _____

Legal Guardian(s) email address:_____

Where did your child live when he/she was born? City: _____ State: _____

Please note if the Legal Guardian is not attending the appointment we must speak with them before scheduling. Please put contact number here: _____

What are the major concerns or questions you would like addressed in this evaluation?

_____
_____
_____
_____
_____

Are you connected to your local area agency? **Yes No**

If yes, what is the name of the Agency? _____
Name of Service Coordinator: _____
Service Coordinator Phone Number: _____

Do you have specific concerns about:

How your child will do at the visit? **Yes No**

Your child's language skills? **Yes No**

Your child's motor skills? **Yes No**

Your child's eating habits? **Yes No**

Use of drugs or alcohol or other non-prescription drugs? **Yes No**

Your child's sleep? **Yes No**

Your child's school performance? **Yes No**

If you marked "Yes" for any listed above please use the space on the next page to explain:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Has your child had any other evaluations or assessments for these problems?
If so, please tell us who did it and when. (*Include school, any agencies, doctors, therapists, etc.*)

Please have copies of the assessments returned with this form, or sent to us

Name/Place of evaluator	When

Family

Please check if child is _____ adopted or _____ in foster care?
If you checked one of the following please indicate what age the child came to live in the current household _____

Parents (*if parents are separated, please circle which parent the child lives with most of the time*)

Parent #1
Name: _____ Relation: _____ Occupation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent #2
Name: _____ Relation: _____ Occupation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle your preferred contact number(s) above

May we leave a message at the above numbers for you? **Yes** **No**

Emergency Contact:

Name: _____ Phone Number: _____

Who is in the current household? (*Who lives with the child*)

Name	Age	Relationship	Contact Info

Other immediate family members (*Not living at home*)

Name	Age	Relationship	Contact Info

If parents are separated, does the non-custodial parent want to be involved in the treatment of the child?

Yes No

If yes, will both parents be able to attend the evaluation?

Yes No

Child's Schooling

Please list any daycare or schools that your child has attended:

Current School: _____

Prior School(s): _____

Child's Treatment History

Please list any diagnoses that your child has received for behavioral, developmental or mental health problems below. This could include things like Learning Problems; Attention Deficit Disorder; Anxiety; Depression; Sensory Processing Dysfunction; Tics; Autism Spectrum Disorder:

_____
_____
_____
_____
_____
_____
_____
_____

Please list any medications your child is currently taking for behavioral or emotional problems.

Medicine	How Taken?	Doctor	Since When?	Does it help
Ex: Ritalin	5 mg in the morning and 5 mg after school.	PCP	Started 2 years ago	**Yes No**
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

List any other medications your child has taken in the past for any mental health or behavior problems

Medicine	How Taken?	Doctor	Since When?	Does it help
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Please bring all labeled medicine to your appointment

Please check all of the services your child has received:

Service	Receiving Now	Received In Past	Name/Location
Early Intervention			
School 504**			
School IEP **			
School behavior plan			
Home based services			
School based case management***			
DCYF involvement			
Individual therapy			
Family therapy			
Speech therapy			
Physical therapy			
Occupational therapy			
Genetic screening			
Developmental eval/services			
Neurology eval/treatment			
Mental health or Social Services Case Management ***			
Other:			

** Please enclose a copy of all assessments and current plans
*** Case Managers and Service Managers are encouraged to attend the appointment with you. Please invite them.

Child's Medical History

How long was your pregnancy with your child? _____ Full Term (*Born within two weeks of date due*)

_____ Born Premature at ___ weeks

_____ Unknown

Were there any complications during your pregnancy? **Yes** **No**
If yes, please explain:

_____
_____
_____
_____
_____

What was your child's weight at birth? _____

APGAR scores _____/_____ ___ Unknown

Did you have any problems at birth? **Yes No Unknown**
If yes, please explain:

_____
_____
_____
_____
_____

Early Development

As an infant or toddler did your child have trouble attaching or binding to either parent? **Yes No**
If yes, please explain:

_____
_____
_____
_____
_____

Were developmental milestones all on time? (*sitting up, walking, talkling, etc.*) **Yes No Unknown**
If no, please explain:

_____
_____
_____
_____
_____

Has your child ever had any of the following health problems?	**Yes**	**No**	**Unknown**	**When/Comments**
Seizure or convulsions				
Head injury with loss of consciousness				
Serious infection(s)				
Asthma				
Heart Murmurs				
Other Heart problems				
Serious Injury				
Surgery				
Problems with growth				

Add any details here:

_____
_____
_____
_____
_____

Please list any serious illness, operations, or hospitalizations not listed above:

Child's Age When Ill	Type of Illness/Injury	Treatment

Please list any medications your child is currently taking for medical and health purposes:

Medicine	When Started	Doctor	For What Condition

Family History

Please check any of the following that is known or suspected in biological relations:

Illness	**Siblings**	**Biological Mother**	**Biological Mother's Family**	**Biological Father**	**Biological Father's Family**
Mental Illness					
Substance Abuse (Drugs or alcohol)					
Learning Disabilities					
Anxiety Problems					
Epilepsy or other neurologic problems					
Heart Disease					
Genetic Disorder					
Attention Problems					
Autism Spectrum Disorder					
Other Developmental Disorder					
Mood Disorder (Depression, Bipolar)					
Other					

Provide additional info for anything checked, including what the diagnosis is and any other info that might be important:

Any additional comments or information not addressed in this questionnaire:

Do you have any concerns on how this visit itself will go? Please explain:

Child's Pediatrician: _____

Physician's Telephone number: ( )

Physician's Fax Number: ( )

Address: _____

Please mail copies of the most recent reports, ISFP, any applicable/related information.

John N. Constantino, MD

Assessment ID _____

SRS™-2 AutoScore™ Form School-Age ○ MALE ○ FEMALE

INSTRUCTIONS

For each question, please darken the circle that best describes this child's behavior **over the past 6 months.**

Child's name _____ _____ Child's age in years _____

Rater's name _____ Date of rating _____

Relationship to rated individual ☐ Mother ☐ Father ☐ Other custodial adult ☐ Teacher ☐ Other specialist

Grade _____ School or clinic _____

PLEASE PRESS HARD WHEN MARKING YOUR RESPONSES.

1 = NOT TRUE 2 = SOMETIMES TRUE 3 = OFTEN TRUE 4 = ALMOST ALWAYS TRUE

1. Seems much more fidgety in social situations than when alone. ① ② ③ ④
2. Expressions on his or her face don't match what he or she is saying. ① ② ③ ④
3. Seems self-confident when interacting with others. ① ② ③ ④
4. When under stress, he or she shows rigid or inflexible patterns of behavior that seem odd. ① ② ③ ④
5. Doesn't recognize when others are trying to take advantage of him or her. ① ② ③ ④
6. Would rather be alone than with others. ① ② ③ ④
7. Is aware of what others are thinking or feeling. ① ② ③ ④
8. Behaves in ways that seem strange or bizarre. ① ② ③ ④
9. Clings to adults, seems too dependent on them. ① ② ③ ④
10. Takes things too literally and doesn't get the real meaning of a conversation. ① ② ③ ④
11. Has good self-confidence. ① ② ③ ④
12. Is able to communicate his or her feelings to others. ① ② ③ ④
13. Is awkward in turn-taking interactions with peers (for example, doesn't seem to understand the give-and-take of conversations). ① ② ③ ④
14. Is not well coordinated. ① ② ③ ④
15. Is able to understand the meaning of other people's tone of voice and facial expressions. ① ② ③ ④
16. Avoids eye contact or has unusual eye contact. ① ② ③ ④
17. Recognizes when something is unfair. ① ② ③ ④
18. Has difficulty making friends, even when trying his or her best. ① ② ③ ④
19. Gets frustrated trying to get ideas across in conversations. ① ② ③ ④
20. Shows unusual sensory interests (for example, mouthing or spinning objects) or strange ways of playing with toys. ① ② ③ ④
21. Is able to imitate others' actions. ① ② ③ ④
22. Plays appropriately with children his or her age. ① ② ③ ④
23. Does not join group activities unless told to do so. ① ② ③ ④
24. Has more difficulty than other children with changes in his or her routine. ① ② ③ ④
25. Doesn't seem to mind being out of step with or "not on the same wavelength" as others. ① ② ③ ④
26. Offers comfort to others when they are sad. ① ② ③ ④
27. Avoids starting social interactions with peers or adults. ① ② ③ ④
28. Thinks or talks about the same thing over and over. ① ② ③ ④
29. Is regarded by other children as odd or weird. ① ② ③ ④
30. Becomes upset in a situation with lots of things going on. ① ② ③ ④
31. Can't get his or her mind off something once he or she starts thinking about it. ① ② ③ ④
32. Has good personal hygiene. ① ② ③ ④

Continue on back page

PLEASE PRESS HARD WHEN MARKING YOUR RESPONSES.

1 = NOT TRUE 2 = SOMETIMES TRUE 3 = OFTEN TRUE 4 = ALMOST ALWAYS TRUE

33. Is socially awkward, even when he or she is trying to be polite. ① ② ③ ④
34. Avoids people who want to be emotionally close to him or her. ① ② ③ ④
35. Has trouble keeping up with the flow of a normal conversation. ① ② ③ ④
36. Has difficulty relating to adults. ① ② ③ ④
37. Has difficulty relating to peers. ① ② ③ ④
38. Responds appropriately to mood changes in others (for example, when a friend's or playmate's mood changes from happy to sad). ① ② ③ ④
39. Has an unusually narrow range of interests. ① ② ③ ④
40. Is imaginative, good at pretending (without losing touch with reality). ① ② ③ ④
41. Wanders aimlessly from one activity to another. ① ② ③ ④
42. Seems overly sensitive to sounds, textures, or smells. ① ② ③ ④
43. Separates easily from caregivers. ① ② ③ ④
44. Doesn't understand how events relate to one another (cause and effect) the way other children his or her age do. ① ② ③ ④
45. Focuses his or her attention to where others are looking or listening. ① ② ③ ④
46. Has overly serious facial expressions. ① ② ③ ④
47. Is too silly or laughs inappropriately. ① ② ③ ④
48. Has a sense of humor, understands jokes. ① ② ③ ④
49. Does extremely well at a few tasks, but does not do as well at most other tasks. ① ② ③ ④
50. Has repetitive, odd behaviors such as hand flapping or rocking. ① ② ③ ④
51. Has difficulty answering questions directly and ends up talking around the subject. ① ② ③ ④
52. Knows when he or she is talking too loud or making too much noise. ① ② ③ ④
53. Talks to people with an unusual tone of voice (for example, talks like a robot or like he or she is giving a lecture). ① ② ③ ④
54. Seems to react to people as if they are objects. ① ② ③ ④
55. Knows when he or she is too close to someone or is invading someone's space. ① ② ③ ④
56. Walks in between two people who are talking. ① ② ③ ④
57. Gets teased a lot. ① ② ③ ④
58. Concentrates too much on parts of things rather than seeing the whole picture. For example, if asked to describe what happened in a story, he or she may talk only about the kind of clothes the characters were wearing. ① ② ③ ④
59. Is overly suspicious. ① ② ③ ④
60. Is emotionally distant, doesn't show his or her feelings. ① ② ③ ④
61. Is inflexible, has a hard time changing his or her mind. ① ② ③ ④
62. Gives unusual or illogical reasons for doing things. ① ② ③ ④
63. Touches others in an unusual way (for example, he or she may touch someone just to make contact and then walk away without saying anything). ① ② ③ ④
64. Is too tense in social settings. ① ② ③ ④
65. Stares or gazes off into space. ① ② ③ ④

DARTMOUTH-HITCHCOCK MEDICAL CENTER

Child's Name: _____ Date: _____ Parent's Name. _____

Mood and Feelings Questionnaire: Parent Version

This form is about how your child might have been feeling or acting recently
For each question, please check how much she or he has felt or acted this way in the past 2 weeks.
If a sentence was true most of the time, circle 2 = TRUE If it was only sometimes true, circle 1 = SOMETIMES If a sentence was not true, circle 0 = NOT TRUE.

		NOT TRUE	SOME-TIMES	TRUE
1	He/she felt miserable or unhappy	0	1	2
2	He/she didn't enjoy anything at all.	0	1	2
3	He/she felt so tired he/she just sat around and did nothing.	0	1	2
4	He/she was very restless.	0	1	2
5	He/she felt he/she was no good anymore	0	1	2
6	He/she cried a lot	0	1	2
7	He/she found it hard to think properly or concentrate	0	1	2
8	He/she hated him/herself	0	1	2
9	He/she felt he/she was a bad person	0	1	2
10	He/she felt lonely.	0	1	2
11	He/she thought nobody really loved him/her.	0	1	2
12	He/she thought he/she could never be as good as other kids.	0	1	2
13	He/she felt he/she did everything wrong	0	1	2
14	He/she was less hungry than usual	0	1	2
15	He/she ate more than usual.	0	1	2
16	He/she felt grumpy and cross with you	0	1	2
17	He/she didn't sleep as well as he/she usually sleeps	0	1	2
18	He/she slept a lot more than usual	0	1	2
19	He/she thought there was nothing good for him/her in the future	0	1	2
20	He/she thought that life wasn't worth living	0	1	2
21	He/she thought about killing him/herself	0	1	2

DHMC Department of Psychiatry
1 Medical Center Drive ▪ Lebanon, NH 03756
603-650-4724 FAX: 603-650-0819

GAD-7

For Youth at least 11 years old to complete

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

	Over the last 2 weeks, how often have you been bothered by each of the following problems?	**(0) Not at All**	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid, as if something awful might happen	0	1	2	3
8	If you are experiencing any of the problems on this form, **how difficult** have these problems made it for you to do work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very Difficult [ ] Extremely Difficult				

PHQ-9 Adolescent Report

For Youth at least 11 years old to complete

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

	*How often have you been bothered by each of the following symptoms during **the past 2 weeks**. For each symptom, put an "**X**" in the box beneath the answer that bests describes how you have been feeling.*	(0) Not at All	(1) Several Days	(2) More than Half the Days	(3) Nearly Every Day
1	Feeling down, depressed, irritable or hopeless?	0	1	2	3
2	Little interest or pleasure in doing things?	0	1	2	3
3	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4	Poor appetite, weight loss, or over-eating?	0	1	2	3
5	Feeling tired, or having little energy?	0	1	2	3
6	Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7	Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? ...Or the opposite-- being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

10	In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes? [ ] Yes [ ] No
11	If you are experiencing any of the problems on this form, **how difficult** have these problems made it for you to do work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very Difficult [ ] Extremely Difficult
12	Has there been a time in the **past month** when you have had serious thoughts about ending your life? [ ] Yes [ ] No
13	Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? [ ] Yes [ ] No

DHMC Department of Psychiatry
1 Medical Center Drive • Lebanon, NH 03756
603-650-4724 FAX: 603-650-0819

PHQ-9 Parent Report

Child:_____ Rater:_____ Date:_____

	*How often has your child been bothered by each of the following symptoms during **the past 2 weeks**. For each symptom, put an "**X**" in the box beneath the answer that bests describes how your child has been feeling.*	(0) Not at All	(1) Several Days	(2) More than Half the Days	(3) Nearly Every Day
1	Feeling down, depressed, irritable or hopeless?	0	1	2	3
2	Little interest or pleasure in doing things?	0	1	2	3
3	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4	Poor appetite, weight loss, or over-eating?	0	1	2	3
5	Feeling tired, or having little energy?	0	1	2	3
6	Feeling bad about him/herself - feeling like a failure, or that he/she has let him/herself or the family down?	0	1	2	3
7	Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? ...Or the opposite-- being so fidgety or restless that he/she was moving around a lot more than usual?	0	1	2	3
9	Thoughts that he/she would be better off dead, or of hurting him/herself in some way?	0	1	2	3

10	In the **past year**, has he/she felt depressed or sad most days, even if he/she felt okay sometimes? [ ] Yes [ ] No
11	If he/she is experiencing any of the problems on this form, **how difficult** have these problems made it for him/her to do work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very Difficult [ ] Extremely Difficult
12	Has there been a time in the **past month** when he/she has had serious thoughts about ending his/her life? [ ] Yes [ ] No
13	Has he/she **EVER**, in his/her WHOLE LIFE, tried to kill him/herself or made a suicide attempt? [ ] Yes [ ] No

DHMC Department of Psychiatry
1 Medical Center Drive • Lebanon, NH 03756
603-650-4724 FAX: 603-650-0819

Patient's Name:_____ Date:_____

The CRAFFT Screening Questions

For patients 11 years and older to complete

Please answer all questions honestly.

Part A

During the PAST 12 MONTHS, did you:

	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer only B1 below, then STOP.

If you answered YES to ANY (A1 to A3), answer B1 to B6 below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

DHMC Department of Psychiatry
1 Medical Center Drive ▪ Lebanon, NH 03756
603-650-4724 FAX: 603-650-0819

Parent Vanderbilt Rating Scale

Child's name:_____

Date of birth:_____ Age:_____ Date:_____

Each rating should be based on what is appropriate for the age of your child. Please rate child's behaviors observed in the past 6 months, using these frequency codes

0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

		Never	Occasionally	Often	Very Often	
1	Does not pay attention to details or makes careless mistakes (like with homework)	0	1	2	3	
2	Has difficulty sustaining attention to what needs to be done	0	1	2	3	
3	Does not seem to listen when spoken to directly	0	1	2	3	
4	Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3	
5	Has difficulty organizing tasks and activities	0	1	2	3	
6	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3	
7	Loses things necessary for tasks or activities (toys, assignments, pencils, or	0	1	2	3	
8.	Is easily distracted by noises or other stimuli	0	1	2	3	
9	Is forgetful in daily activities.	0	1	2	3	
10	Fidgets with hands or feet or squirms in seat	0	1	2	3	
11	Leaves seat when remaining seated is expected.	0	1	2	3	
12	Runs or climbs too much when remaining seated is expected	0	1	2	3	
13	Has difficulty playing quietly or beginning quiet play activities.	0	1	2	3	
14	Is "on the go" or acts as if "driven by a motor"	0	1	2	3	
15.	Talks too much.	0	1	2	3	
16.	Blurts out answers before the questions have been completed	0	1	2	3	
17	Has difficulty waiting his or her turn	0	1	2	3	
18	Interrupts or intrudes in others' conversations and/or activities	0	1	2	3	
19.	Argues with adults.	0	1	2	3	
20	Loses temper	0	1	2	3	
21	Actively defies or refuses to go along with adults' requests or rules	0	1	2	3	
22	Deliberately annoys people.	0	1	2	3	
23	Blames others for his or her mistakes or misbehaviors.	0	1	2	3	
24	Is touchy or easily annoyed by others.	0	1	2	3	
25.	Is angry or resentful	0	1	2	3	
26.	Is spiteful and wants to get even	0	1	2	3	
27.	Bullies, threatens, or intimidates others	0	1	2	3	*
28	Starts physical fights	0	1	2	3	*
29.	Lies to obtain goods or to avoid obligations (i e "cons" others)	0	1	2	3	
30.	Is truant from school (skips school) without permission.	0	1	2	3	
31.	Is physically cruel to people.	0	1	2	3	*
32.	Has stolen things that have value.	0	1	2	3	
33.	Deliberately destroys others' property	0	1	2	3	*
34	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3	*
35	Is physically cruel to animals	0	1	2	3	*
36,	Has deliberately set fires to cause damage.	0	1	2	3	
37.	Has broken into someone else's home, business, or car	0	1	2	3	
38	Has stayed out at night without permission	0	1	2	3	
39	Has run away from home overnight.	0	1	2	3	
40	Has forced someone into sexual activity	0	1	2	3	*
41.	Is fearful, anxious, or worried	0	1	2	3	
42	Is afraid to try new things for fear of making mistakes.	0	1	2	3	
43	Feels worthless or inferior.	0	1	2	3	
44	Blames self for problems, feels guilty	0	1	2	3	
45	Feels lonely, unwanted or unloved, says that "no one loves" him/her	0	1	2	3	
46.	Is sad, unhappy, or depressed	0	1	2	3	
47.	Is self-conscious or easily embarrassed	0	1	2	3	

DHMC Department of Psychiatry
1 Medical Center Drive ▪ Lebanon, NH 03756
603-650-4724 FAX 603-650-0819

DARTMOUTH-HITCHCOCK MEDICAL CENTER

Teacher Vanderbilt Rating Scale

Child's name: _____ DOB: _____

Teacher: _____ Class(es): _____ Date: _____

	Please rate this student's behaviors, in the context of what is appropriate for his/her age. Please use these frequency codes: 0 = Never 1 = Occasionally 2 = Often 3 = Very Often	Never	Occasionally	Often	Very Often	
1	Fails to give attention to details or makes careless mistakes in schoolwork.	0	1	2	3	
2	Has difficulty sustaining attention to tasks or activities.	0	1	2	3	
3	Does not seem to listen when spoken to directly.	0	1	2	3	
4	Does not follow through when given directions and fails to finish schoolwork (not due to oppositional behavior or failure to understand).	0	1	2	3	
5	Has difficulty organizing tasks and activities.	0	1	2	3	
6	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3	
7	Loses things necessary for tasks or activities (school assignments, pencils, books).	0	1	2	3	
8	Is easily distracted by extraneous stimuli.	0	1	2	3	
9.	Is forgetful in daily activities.	0	1	2	3	
10	Fidgets with hands or feet or squirms in seat.	0	1	2	3	
11	Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3	
12	Runs or climbs excessively in situations in which remaining seated is expected.	0	1	2	3	
13	Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3	
14	Is "on the go" or acts as if "driven by a motor".	0	1	2	3	
15	Talks excessively.	0	1	2	3	
16	Blurts out answers before questions have been completed.	0	1	2	3	
17	Has difficulty waiting in line.	0	1	2	3	
18	Interrupts or intrudes on others (e.g., butts into conversations or games).	0	1	2	3	
19	Loses temper.	0	1	2	3	
20	Actively defies or refuses to comply with adults' requests or rules.	0	1	2	3	
21	Is angry or resentful.	0	1	2	3	
22	Is spiteful and vindictive.	0	1	2	3	
23	Bullies, threatens, or intimidates others.	0	1	2	3	*
24	Initiates physical fights.	0	1	2	3	*
25	Lies to obtain goods for favors or to avoid obligations (cons others).	0	1	2	3	
26	Is physically cruel to people.	0	1	2	3	*
27	Has stolen items of non-trivial value.	0	1	2	3	
28	Deliberately destroys others' property.	0	1	2	3	*
29	Is fearful, anxious, or worried.	0	1	2	3	
30	Is self-conscious or easily embarrassed.	0	1	2	3	
31	Is afraid to try new things for fear of making mistakes.	0	1	2	3	
32	Feels worthless or inferior.	0	1	2	3	
33	Blames self for problems; feels guilty.	0	1	2	3	
34	Feels lonely, unwanted or unloved; complains that "no one loves" him or her	0	1	2	3	
35	Is sad, unhappy, or depressed.	0	1	2	3	

	Academic and Behavioral Performance Ratings: Please feel free to add comments to the back of this questionnaire if you wish. Thanks for your help in assessing this student!!	Excellent		Average		Problematic
36	Reading	1	2	3	4	5
37	Mathematics	1	2	3	4	5
38	Written Expression	1	2	3	4	5
39	Relationship with peers.	1	2	3	4	5
40	Following directions.	1	2	3	4	5
41	Disrupting class.	1	2	3	4	5
42	Assignment completion.	1	2	3	4	5
43	Organizational skills.	1	2	3	4	5

DHMC Department of Psychiatry
1 Medical Center Drive • Lebanon, NH 03756
603-650-4724 FAX: 603-650-0819