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: Leila Flanagan

Date of Birth: 06/04/09 Phone Number: (802) 793-1430

Address: 1241 Taber Hill Rd.

City: Stowe State: VT Zip: 05672

SENDER

I authorize:

Name of Provider: Dr. Rebecca Ruid

Street Address: 111 Colchester Ave Fax Number: (802) 847-8961

City: Burlington State: VT Zip: 05672

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: 2020 **to** present & ongoing

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

For the following purpose: Psychiatric / Mental health care

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

DURATION & REVOCATION

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ADDITIONAL INFORMATION

I understand that: Dartmouth-Hitchcock and Dr Ruid **[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

Nancy J. DuMont
Signature of Patient or Personal Representative

12/30/22
Date

Nancy J. DuMont
Printed Name of Patient or Personal Representative

Mother
Description of Personal Representative's Authority

PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH-HITCHCOCK

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PATIENT INFORMATION

Patient Name: Leila Flanagan

Date of Birth: 06/04/09 Phone Number: (802) 793-1430

Address: 1241 Taber Hill Rd.

City: Stowe State: VT Zip: 05672

SENDER

I authorize:

Name of Provider: Dr. Andrea Tidman / Richmond Pediatrics

Street Address: 12 Burnett court Fax Number: (802) 329-2144

City: Richmond State: VT Zip: 05672

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: 06/04/09 **to** present + ongoing

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

For the following purpose: psychiatric + mental health care

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
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ADDITIONAL INFORMATION

I understand that: Dartmouth-Hitchcock and Dr. Tidman **[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

Nancy DuMont
Signature of Patient or Personal Representative

12/30/22
Date

Nancy DuMont
Printed Name of Patient or Personal Representative

Mother
Description of Personal Representative's Authority

CHaD 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: Leila Flanagan Date of Birth: 06/04/09

Age: 13

Person Completing the Questionnaire Nancy dumont
Relationship to Child: Mother

Legal Guardian(s) Nancy dumont Relationship to Child: Mother
Legal Guardian(s) _____ Relationship to Child: _____

Legal Guardian(s) email address: nancyjdumont@gmail.com

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

Please note if the Legal Guardian is not attending the appointment we must speak with them before scheduling. Please put contact number here: (802) 793-1430

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

OCD
PTSD
ANXIETY
Depression

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

If yes, what is the name of the Agency? LAMOILLE COUNTY MENTAL HEALTH
Name of Service Coordinator: N/A
Service Coordinator Phone Number: EMERGENCY ONLY - LEILA HAS A PSYCHOLOGIST THROUGH UVM

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
DR. Rebecca Ruid, UVM	2020-2023
DR. ANDREA TIDMAN, Richmond P.ED.	2022

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: Nancy dumont Relation: mother Occupation: Realtor
Home Phone: _____ Work Phone: _____ Cell Phone: (802)793-1430

Parent #2
Name: Edward Flanagan Relation: Father Occupation: Store owner
Home Phone: _____ Work Phone: ~~(802)253-8004~~ Cell Phone: 802 595-0969

Please circle your preferred contact number(s) above

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

Emergency Contact:

Name: Derek Schnee Phone Number: (802)696-2540

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

Name	Age	Relationship	Contact Info
Nancy dumont	49	mother	(802)793-1430

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 unknown

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: Stowe Middle School, Stowe Elementary

Prior School(s): Shelburne Elementary School (K-3)
Stowe Elementary School (3-5)

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:

Anxiety
Adjustment disorder
OCD (unsure if officially diagnosed but receiving treatment for behaviors)

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
Sertraline	75mg in the AM	PCP	6/30/22	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

Any additional comments or information not addressed in this questionnaire:

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

Child's Pediatrician: Dr. Andrea Tidman / Dr. Paul Parker

Physician's Telephone number: (802) 434-5090

Physician's Fax Number: (802) 329-2144

Address: 12 Burnett Ct.
Richmond, VT 05477

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

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	X	X	Dr. Rebecca Ruid, UVM
Family therapy (mom)	X	X	Michael Gilman, Montpelier
Speech therapy			
Physical therapy	X	X	Phoenix PT, Williston
Occupational therapy			
Genetic screening			
Developmental eval/services			
Neurology eval/treatment			
Mental health or Social Services Case Management ***		X	Copley ER Screener (Morrisville) on call
Other: School "EST" Educational Support Team plan	X	X	Stowe, VT

** 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? X 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: pre eclampsia, I was given magnesium Leila was at risk due to this but OK

What was your child's weight at birth? 7lbs 6oz

APGAR scores ____/____ X Unknown (normal)

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		X		
Head injury with loss of consciousness		X		concussion (no loc)
Serious infection(s)		X		
Asthma		X		
Heart Murmurs		X		heart palpitations
Other Heart problems		X		Costochondritis (past)
Serious Injury		X		
Surgery		X		
Problems with growth		X		

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
Iron	2022	Matthew Shiel	low iron/ferritin
Gabapentin (topical)	2022	Jane Conolly	Pain (gyno)
lidocaine (topical)	2022	Jane Conolly	pain (gyno)

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)			X	X	X
Learning Disabilities					
Anxiety Problems		X	X	X	X
Epilepsy or other neurologic problems					
Heart Disease			X		X
Genetic Disorder					
Attention Problems					
Autism Spectrum Disorder					
Other Developmental Disorder					
Mood Disorder (Depression, Bipolar)			X		X
Other					

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

OCD - COUSIN Maternal
COUSIN paternal (unknown to mother) Mental health issues

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PATIENT INFORMATION

Patient Name: Leila Flanagan

Date of Birth: 06-04-09 Phone Number: (802) 793-1430

Address: 1241 Taber Hill Rd.

City: Stowe State: VT Zip: 05672

SENDER

I authorize:

Name of Provider: Stowe Middle School / LSSU

Street Address: 413 Barrows Rd. Fax Number: (802) 253-6911

City: Stowe State: VT Zip: 05672

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

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HEALTH INFORMATION TO BE SHARED

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

For the following purpose: Mental health care

SENSITIVE HEALTH INFORMATION

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ADDITIONAL INFORMATION

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SIGNATURE

Nancy dumont
Signature of Patient or Personal Representative

12/30/22
Date

Nancy dumont
Printed Name of Patient or Personal Representative

Mother
Description of Personal Representative's Authority

WPS

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 Leila Flanagan — Child's age in years 13

Rater's name Nancy dumont — Date of rating 1/5/23

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

Grade 8 — School or clinic Stowe Middle School

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

PHQ-9 Adolescent Report

For Youth at least 11 years old to complete

Name: Leila Flanagan Date of Birth: 6/4/09 Today's Date: 1/5/2023

	*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 [X] Extremely Difficult
12	Has there been a time in the **past month** when you have had serious thoughts about ending your life? [ ] Yes [X] No
13	Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? [ ] Yes [X] No

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: Leila Flanagan Date of Birth: June 4 2009 Today's Date: 1/5/2023

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 [x] Extremely Difficult				

DARTMOUTH-HITCHCOCK MEDICAL CENTER

PHQ-9 Parent Report

Child: Leila Flanagan Rater: Nancy dumont Date: 1/5/23

	*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? [X] 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 [X] 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 [X] No
13	Has he/she **EVER**, in his/her WHOLE LIFE, tried to kill him/herself or made a suicide attempt? [ ] Yes [X] No

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

DARTMOUTH-HITCHCOCK MEDICAL CENTER

Patient's Name: Leila Flanagan Date: 1/5/23

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?	☒ maybe my dad	☐
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?	☒	☐

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Child's Name: Leila Flanagan Date: 1/5/23 Parent's Name. Nancy duMont

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

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Parent Vanderbilt Rating Scale

Child's name: Leila Flanagan

Date of birth: 06/04/09 Age: 13 Date: 1/5/23

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	

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