CBT Practice - Glen Oaks NHPP
Kaufmann Building
75-59 263rd Street
Glen Oaks, NY 11004
Phone: (718) 470-8755

Welcome to the Northwell Health Physician Partners Cognitive Behavioral Therapy Practice at Glen Oaks.

Thank you for making time to complete the initial paperwork to begin the intake process. We look forward to working with you.

This packet includes questionnaires for both parents and their children/adolescents to complete.

There are **three** sections for **Parents** to complete about their Child/Adolescent:

- Pre-Intake Background Questionnaire
- Vanderbilt Assessment Scale
- RCADS (Orange version)

There is **one** questionnaire for **Children (Age 8+) & Adolescents** to complete **themselves**. If you child has difficulty reading the questions, you may read questionnaire to them, but do not answer on their behalf.

- RCADS (Green Version)

Please make sure that you and your child/adolescent complete all required forms and return no later than 72 hours prior to your scheduled intake.

If forms are not received, at least 72 hours prior to your scheduled intake, your appointment will be canceled, and you will be placed back on the waitlist.

Thank you,

The CBT Practice

Child/Adolescent Intake Background Questionnaire
(To be completed by parent/guardian of child)

Name of Child/Adolescent: _____ Date completing form: ____/____/____

Name(s) of Parent(s)/Guardian(s):_____

Who completed this form? _____

Child/Adolescent Date of Birth: ____/____/____ Age: _____Gender: ☐ Male ☐ Female ☐ Other (please specify):

_____

Race/Ethnicity: _____

Grade: _____ School: _____

Current Address: _____

Contact Information:

Home Phone:	_____	☐ Preferred	May we leave a message? ☐ Yes ☐ No
Cell1:	_____	☐ Preferred	May we leave a message? ☐ Yes ☐ No May we text? ☐ Yes ☐ No
Cell2:	_____	☐ Preferred	May we leave a message? ☐ Yes ☐ No May we text? ☐ Yes ☐ No
Other:	_____	☐ Preferred	May we leave a message? ☐ Yes ☐ No
Preferred Email:	_____	☐ Preferred	May we email you? ☐ Yes ☐ No

Parent(s)/Guardians Occupations: _____

Is a Parent/Guardian a Northwell Employee? ☐ Yes ☐ No

Referral Information & Reasons for Seeking Services

1. Referred by (if any): _____

2. Briefly describe the main reasons you are seeking help for your child. Why were you referred? How long has this been a problem?_____

3.Current psychiatrist and phone number: _____

4. Current therapist name and phone number: _____

Mental Health History (All questions pertain to your Child)

5. History of Present Illness: Please list any **current** mental health diagnoses or problems:

_____

_____

6. Please list any **previous** mental health diagnoses or problems:

_____

7 Please list any **current** psychiatric medications, dosages, and the date started: _____

8. Please list any **previous** psychiatric medications, dosages, and the dates started and stopped:

9.. Has your child ever been in psychotherapy? ☐ Yes ☐ No

If yes, please list the dates, type of psychotherapy, name of therapist, and the reasons for seeking psychotherapy: _____

10. Has your child ever been hospitalized for mental health issues or had any other intensive treatment for them? *If so, please list the location, dates, and reason(s):*

Sometimes people get so distressed that they have thoughts about hurting or killing themselves or others.

	Safety Information		**If Yes, when did this happen?**		
		Never	**<6 mos**	**<12 mos**	**12+ mos**
11.	Has your child ever expressed **thoughts** of wanting to hurt or kill **themselves**?				
12.	Has your child ever attempted suicide?				
13.	If yes, how?				
14.	Has your child ever significantly harmed **themselves** on purpose (i.e. cut, burn)?				
15.	If yes, how?				
16.	Has your child ever expressed thoughts of wanting to seriously harm or kill **anyone else**?				
17.	Has your child ever **attempted** to seriously harm or kill **anyone else**?				
18.	Has your child ever physically assaulted anyone?				

19. Is there a gun at home? ☐ Yes ☐ No

20. If yes, how is the gun stored?_____

Medical History

21. Please list any current medical conditions your child has: _____

22. Please list any current non-psychiatric medications, dosages, and the dates started: _____

23. Please list any major surgeries your child has had: _____

24. Please describe your child's current physical activities, if any: _____

_____

Family Mental Health History

25. Please list any family members who have struggled with any psychiatric or addiction issues. What are/were their mental health diagnoses?

Family Member	**Diagnoses**	**Family Member**	**Diagnoses**
Biological Mother		Paternal Grandparent 1	
Biological Father		Paternal Grandparent 2	
Guardian 1 (specify)		Maternal Grandparent 1	
Guardian 2 (specify)		Maternal Grandparent 2	

Family Member	Diagnoses	Family Member	Diagnoses
Sibling 1 (age, specify)			
Sibling 2 (age, specify)			
Sibling 3 (age, specify)			

Social, Psychosocial & Developmental History

26. Has your child used substances such as alcohol, marijuana, or other drugs? If so, which?

_____

27. Pregnancy Information: Mother's Age at Child's Birth_____ How long was pregnancy? _____

28. Birth complications: _____

29. Did your child have any delays in walking or speaking? ☐ Yes ☐ No

30. Did your child have any other developmental delays? *If so, please describe:* _____

_____

31. Is your child/adolescent sexually active? ☐ Yes ☐ No

Educational History

32. Please describe your child's current academic performance: _____

_____

33. Is your child in special education classes in school? ☐ Yes ☐ No

34. If Yes, what is the class size?

35. Has your child ever had any learning difficulties or impairments? ☐ Yes ☐ No

36. If yes, please describe: _____

37. Has your child ever undergone any psychological evaluations/assessments? ☐ Yes ☐ No

*(If so, **please bring a copy of the report to the intake session)***

38. Does your child have an **Individualized Education Plan (IEP)** or **504 Plan** in school? ☐ **IEP** ☐ **504**

*(If so, **please bring a copy of the plan to the intake session)***

39. If Your child has an IEP, what is their Department of Education Classification?

☐	Autism	☐	Learning Disability	☐	Visual Impairment (includes Blindness)
☐	Deafness/ Deaf-Blindness / Hearing Impairment	☐	Orthopedic Impairment	☐	Traumatic Brain Injury
☐	Emotional Disturbance	☐	Other Health Impairment	☐	Multiple Disabilities
☐	Intellectual Disability	☐	Speech or Language Impairment	☐	

40. Has your child ever been bullied in school (*Please describe*): _____

_____

_____

41. Does your child experience any impairments in his/her social skills? (*Please describe*): _____

_____

_____

42. Does your child exhibit any behavioral difficulties in school? (*Please describe*): _____

_____

_____

43. Does your child exhibit any behavioral difficulties at home? (*Please describe*): _____

_____

_____

44. Has your child ever experienced a dangerous traumatic event? (*If so, please describe the event and when it took place):* _____

_____

_____

Personal and Social History

45. How is your child doing socially? : _____

_____

46. What are your child's hobbies and interests? _____

_____

_____

47. Please describe your child's strengths: _____

_____

48. Does your child have other siblings? *If so, please indicate genders and ages*: _____

_____

49. Child's current living situation? (*own/rent, house/apartment, with whom*): _____

_____

50. Child's parents' marital status: _____

51 Culture: Please describe your child's racial or ethnic identity, sexual oriental, spirituality/religion, & gender identity

_____

. _____

52. How would you describe **<u>your own</u>** religious affiliation/spiritual faith, if any? (*Please specify*): _____

53. How do you hope your child benefits from psychotherapy? _____

54. How will you know that psychotherapy is "working?"

To be completed by parent/guardian of child:

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping 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 books)	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 about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before 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 on 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 get out of trouble or to avoid obligations (ie, "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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

To be completed by parent/guardian of child:

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued**

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

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
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; complains that "no one loves him or 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

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

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11-19/rev1102

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

To be completed by Parent/Guardian of Child:

RCADS

NHS ID: .....

Child/ Young Person's NAME:

.....

Relationship to Child/Young Person : .....

Date: ☐☐/☐☐/ 20☐☐ **Time:** ☐☐h☐☐m

Please put a circle around the word that shows how often each of these things happens to your child. There are no right or wrong answers.

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

To be Completed by Child/Adolescent if Age 8+.

RCADS

NHS ID: .....

Child/ Young Person's NAME:

.....

Date: ☐☐/☐☐/ 20☐☐ **Time:** ☐☐ h ☐☐ m

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1	I worry about things	Never	Sometimes	Often	Always
2	I feel sad or empty	Never	Sometimes	Often	Always
3	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6	Nothing is much fun anymore	Never	Sometimes	Often	Always
7	I feel scared when I have to take a test	Never	Sometimes	Often	Always
8	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9	I worry about being away from my parent	Never	Sometimes	Often	Always
10	I am bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11	I have trouble sleeping	Never	Sometimes	Often	Always
12	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	I have problems with my appetite	Never	Sometimes	Often	Always
16	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
18	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19	I have no energy for things	Never	Sometimes	Often	Always
20	I worry I might look foolish	Never	Sometimes	Often	Always

Patient Name: _____ **DOB:** _____

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