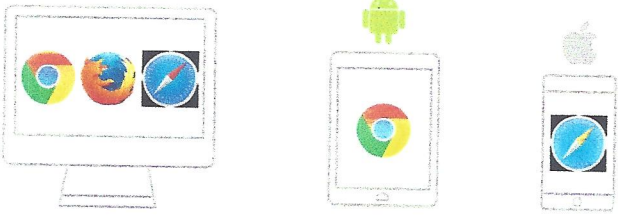
GETTING STARTED FOR PATIENTS

How to check in for your video visit

1 Use a computer or device with camera/microphone



PC and Mac
Chrome | Firefox | Safari

Android
Chrome

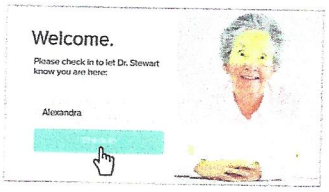
iOS
Safari

2 Enter your clinician's doxy.me web address into the browser

doxy.me/drsurpris

Please log in 10 min. before appt. time

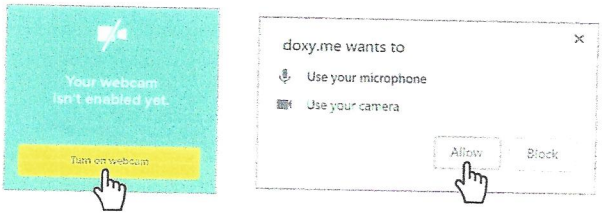
3 Type in your name and click check in



- ✓ Secure
- ✓ No software to download
- ✓ HIPAA compliant
- ✓ No registration needed

If issues with doxy, Facetime @ 516-457-1689

4 Allow your browser to use your webcam and microphone



5 Your care provider will start your visit

Call Tips

- Have a good internet connection
- Restart your device before the visit
- Use the Start Test button in the waiting room
- Need help? Send us a message https://doxy.me

Powered by doxy.me

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienEtre

Date: _____

Patient Name_____ Age_____ Date of Birth_____

Parent or Legal Guardian's Name: _____D.O.B:_____

Address:_____Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

Insurance:_____ID#_____

BIN_____ PCN_____ GROUP_____

Pharmacy:_____ Phone:_____

Address:_____Zip:_____

_____

Signature (Patient/Legal Guardian)

Attention Patients:

Along with email reminders, we will be offering text reminders for your up-coming appointments.

This is a courtesy. It remains your full responsibility to remember your appointment and give 24-hour notice if you are unable to attend.

Missed appointments will be automatically charged in full as per office policy.

Please sign below, giving us permission to send you your appointment reminders.

Cell #: _____ **OPT OUT** ☐

Email address: _____ **OPT OUT** ☐

Patient Name: _____

Signature_____ **Date:**_____

Marie G Surpris, D.O.

Phone: 631-467-0867 / Fax: 631-467-0892

Permission for Telehealth Visits

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.

You can talk to your provider from any place, including your home. You don't have to go to a clinic or hospital.

You talk to your provider by phone, computer, or tablet using video so you and your provider can see each other.

We will not record visits with your provider.

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

Your name (please print) Date

Signature

Credit Card Agreement

Please print clearly.

Patient:_____

D.O.B:_____

Address:_____

Phone:_____

CC#_____

EXPIRATION: _____

CODE: _____(3/4 digit # on back of card)

I agree for Dr. Marie Surpris to keep my credit card information on file for payments of missed and Telemedicine/ Facetime appointments.

Dates of Service:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SIGNATURE:_____

DATE:_____

21 E. Second Street, Suite 102
Riverhead, N.Y. 11901

2233 Nesconset Hwy. Suite 100
Lake Grove, N.Y. 11755

Phone 631-467-0867 Fax 631-467-0892

BienEtre

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

Office Policy

At this Evaluation Center, we strive for efficient and quality care. To ensure the best medical care possible, we have adopted the following office policy:

1. Appointments are scheduled on a **monthly** basis, unless otherwise specified. Follow-up appointments of 30- minutes-$200. If 3 months' laps between appointments then a one- hour appointment will be needed to continue treatment. Lapses longer than 3 months will result in a discharge from this practice.

2. We do not over book our appointments. **The appointment time given to you is your time- please be prompt.**

3. You may receive a courtesy **text and** email to remind you of your appointment, however, **you are responsible to remember your appointment**. Unless an appointment is cancelled with at least 24-hour notice, payment for the visit is due in full.

4. We expect payment in full at the time of your visit. We accept credit cards and checks payable to Dr. Marie Surpris. If a check is returned with insufficient funds, only a cash or certified check will be accepted thereafter.

5. A charge of $20 for bank fees is required for any check returned.

6. To adequately monitor treatment and compliance with medication policy, scripts will be called in only for a one week supply or at the doctor's discretion.

A credit card number must be provided and on file for Telemedicine, phone or missed appointments.

Marie G. Surpris, D.O.

Patient Initial: _____

631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienEtre

Policy for Missed Appointments

It is important for all patients to attend all appointments scheduled. Missed or cancelled appointments are counterproductive and slow down the treatment. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.

Our policy is to hold you responsible for all missed appointments not cancelled 24 hours in advance. **All missed appointments will be billed In full directly with your credit card on file.**

If needed **the option of a phone conference for 30 minutes at the time of the appointment can be made and prescriptions will then be electronically prescribed.**

I have read and **understand** the above statement. I understand that I will be billed for all avoidable missed appointments and late communications. I agree to be responsible for paying for them.

A credit card # must be provided and on file for phone, Telemedicine and missed appointments.

_____ _____

Client or Parent/ Guardian's Signature Date

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienÊtre

MEDICAL INFORMATION REQUEST

DATE: _____

TO: _____

TEL: _____

PATIENT: _____

Dear Doctor,

Please forward any recent bloodwork (within the past year) for this patient to the above fax number.

Thank you for your cooperation.

Marie G. Surpris, D.O.

(*) Please forward this form to your doctor.

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienÊtre

CONSENT FOR RELEASE OF INFORMATION

Date: _____

Name of Patient: _____

D.O.B.:_____

Extent or nature of information to be disclosed:

_____

From: (Doctor, Therapist or Organization disclosing information):

Name:_____Tel.#_____

Address:_____

Name:_____Tel.#_____

Address:_____

To: Dr. Marie G. Surpris, D.O.

I understand that I have the right to revoke this consent at any time except to the extent that action has been taken thereon. I also understand that my consent will expire when acted upon, or six (6) months from this date, whichever occurs first.

I understand that such disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of the patient records, when applicable. Title 42 prohibits you from making any future disclosure of this information without my specific written consent, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____

Signature of Parent/Guardian Date

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

LIFE HISTORY QUESTIONNAIRE (Child)

Date:_____

Last Name: _____**First Name:** _____

D.O.B: _____**Age:** _____ **Gender:** *M* □ *F* □

CHIEF CONCERNS

Please describe the reason you are consulting for your child:

MEDICAL HISTORY (if you check a box, please give details below):

- ☐ Any operations?
- ☐ Any hospitalizations
- ☐ Any allergies
- ☐ Asthma?
- ☐ Chronic ear infections?
- ☐ Any major illnesses?
- ☐ Any serious accidents or head injuries?
- ☐ Any bad reactions to medicines
- ☐ Any seizures?
- ☐ Family medical problems
- ☐ Any activity restrictions
- ☐ Wears glasses or contacts?
- ☐ Uses a hearing aid?
- ☐ Other medical problems

_____

_____

_____

Current Medical Care:

Primary Care Doctor/Pediatrician:_____ Tel._____

Date of last physical exam: _____ (If possible bring a copy)

Current Mental Health Professional (s): Does not apply ☐

1._____ Tel._____
Profession_____
Counseling or therapy?_____ Medication?_____ Group?_____
Other service?_____ Date started:_____

2._____ Tel._____
Profession_____
Counseling or therapy?_____ Medication?_____ Group?_____
Other service?_____ Date started:_____

Current Medications:
List all medicines your child is currently taking, both psychiatric and other (e.g., for asthma, allergies, contraception, etc.)

Name of Medication	Dose	Date began	Reason for medication	Response (benefits & side effects)

Was your child ever **hospitalized** before? Please give place, dates, and reasons.

_____

_____

CHILD'S SCHOOL

School:_____ Grade:_____

Address: _____

_____ Telephone:_____

Type of Program: Regular Ed.:_____ Special Ed (specify type): _____

Special Services (check all that child receives):

- ☐ Resource Room
- ☐ Speech/language
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Counseling
- ☐ 1:1 Para
- ☐ Adaptive Physical Education
- ☐ Other_____

School Personnel involved with child:

	Name	Phone (if known)
Teacher:	_____	_____
Guidance Counselor:	_____	_____
School Psychologist:	_____	_____
Resource room teacher:	_____	_____
Speech therapist:	_____	_____
Other:	_____	_____

At the moment, do you feel your child.. (check one):

[1].. is appropriately placed in his/her current class_____

[2].. needs a different placement for another reason (please specify) _____

_____

After-school program?

No ☐ Yes ☐

Where:_____ Dates: _____

How helpful: [1] Very helpful ☐ [3] Not really helpful ☐

[2] Somewhat helpful ☐ [4] Had a bad effect ☐

Private tutoring or academic remediation outside of school?

No ☐ Yes ☐

FAMILY

Parents: *(Adoptive parents should provide as much information in this section as they know about birth parents, and enter "unknown" for items they don't have information about).*

Biological **mother's** name_____ Age: _____

Reside with child? [1] Yes ☐ [2] No ☐ [3] Deceased ☐ (date)_____
Occupation:_____ Highest education_____

Relationship with child: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Uninvolved ☐

Please note any history of mother (continue on back if needed):

[1] School or learning problems _____

[2] Psychological treatment (please note dates, type of problem, and medications, if any) _____

_____

[3] Psychiatric hospitalization_____

[4] Alcohol or drug abuse_____

[5] Legal problems _____

[6] Life-threatening or other serious illness in past _____

Biological **father's** name_____ Age:_____

Reside with child? [1] Yes ☐ [2] No ☐ [3] Deceased ☐ (date)_____

Occupation:_____ Highest education_____

Relationship with child: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Uninvolved ☐

Please note any history of father (continue on back if needed):

[1] School or learning problems _____

[2] Psychological treatment (please note dates, type of problem, and medications, if any) _____

_____

[3] Psychiatric hospitalization_____

[4] Alcohol or drug abuse_____

[5] Legal problems _____

[6] Life-threatening or other serious illness in past _____

Parents are currently:

[1] Married ☐ [2] Unmarried ☐ [3] Separated ☐ [4] Divorced ☐

Date_____ [5] Father remarried? ☐ Date _____

[6] Mother remarried ☐ Date_____

Other children at home? Yes ☐ No ☐

Name	Age	Relation	School & Grade or occupation	Sp. Ed. Services?	Mental Health Services?

Previous Evaluation and Treatment: Does not apply ☐

Please list below any professionals you may have consulted in the past regarding your child's development or behavior.

Name of Doctor, Agency Hospital, etc.	Location (City, State)	Dates (Mo/Yr)	Briefly explain service provided

Please list below all psychiatric **medications** your child has taken in the past:

Name of Medication	Highest Dose	Dates	Reason for Medication	Benefits and side effects

DEVELOPMENTAL HISTORY

Birth and Early Childhood:

Duration of Pregnancy (in weeks):_____

Did the mother experience any of the following?

- ☐ Emotional problems
- ☐ Toxemia/Infection
- ☐ Accident or injury
- ☐ Drug use
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Threatened miscarriage
- ☐ Took any prescription medication_____

Labor: Duration_____

Any problems, specify _____

_____

Delivery:
- ☐ Vaginal
- ☐ C-section
- ☐ Any problems, specify _____

_____

Newborn Period: ☐ Normal ☐ Any problems, specify : _____

_____

Infant Temperament (check all that apply):

- ☐ Easy baby_____
- ☐ Slow to warm up (give examples)_____
- ☐ Difficult baby (give examples) _____
- ☐ Eating problems (specify)_____
- ☐ Sleeping problems (specify)_____
- ☐ Colic (if yes, for how long)_____
- ☐ Baby did not enjoy body contact _____
- ☐ Baby had swallowing or sucking problem_____
- ☐ Baby was "limp" or stiff_____
- ☐ Baby was overly sensitive to sound _____

Developmental skills and Maturation:

If you can recall, indicate the approximate age at which your child accomplished each of the following milestones. If you cannot recall his or her age, check early, normal or late.

	Age	Early	Normal	Late
Motor Development				
Crawled	_____	____	_____	____
Stood	_____	____	_____	____
Walked	_____	____	_____	____
Ran	_____	____	_____	____
Rode a tricycle	_____	____	_____	____
Tied shoes	_____	____	_____	____
Fed self	_____	____	_____	____
Dressed self	_____	____	_____	____

	Age	Early	Normal	Late
Language				
Spoke first word	_____	____	_____	____
Named objects	_____	____	_____	____
Put two and three Words together	_____	____	_____	____

Have there been any concerns about your child's growth? _____

_____

For females: Has she begun menstruating? No ☐ Yes ☐ starting at age _____Where

There any problems associated with the onset of menstruation?_____

Educational History:

Please list the schools your child attended.

School Name	Location	Dates	Grades	Comments

Did your child experience any difficulties starting school? _____

Any learning disabilities identified? _____

Any grades repeated? _____

Has your child had special tutoring outside of school? _____

Social and Leisure:

How does your child get along with other children? _____

_____

What activities does he or she enjoy?_____

_____

List your child's talent, special abilities, and strengths. _____

_____

Does your child belong to any groups, teams or organizations? _____

_____

FAMILY PSYCHOLOGICAL HISTORY

It is helpful to know if the child's relatives have any history of mental health difficulties. Please think about the child's siblings, grandparents, aunts and uncles, first cousins, and other significant relatives and recall if they had any of the psychological difficulties mentioned in the first column. If you are not sure what type of problem it was, just check the bottom row.

	Parents	Siblings	Grand-parents	Aunts/ Uncles	Cousins
Schizophrenia					
Depression					
Bipolar disorder of Manic-Depression					
Very anxious or nervous					
Alcohol abuse					
Drug abuse					
Autism					
Obsessive-compulsive					
Mental retardation					
Panic attacks					
Bahavior problems					
Learning problems					
Tics					
Attention-Deficit Hyperactivity					
Legal problems					
Had a problem, but not sure what it was					

Marie G. Surpris, D.O.
Child, Adolescent and Adult Psychiatrist

(631) 467-0867 Fax (631) 467-0892

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS

CHILD FORM (8 years and older)

NAME_____ **DATE:**_____

Below is a list of items that describe how people feel. For each item that describes you, please circle the **2** if the item is **very true or often true** of you. Circle the **1** if the item is **somewhat or sometimes true** of you. If the item is **not true** of you, please circle the **0**. Please answer all of the items as well as you can, even if some do not seem to concern you.

0 = Not True or Hardly Ever True **1= Somewhat True or Sometimes True**
2= Very True or Often true

1	When I feel frightened, it is hard to breathe.	0	1	2
2	I get headaches when I am at school.	0	1	2
3	I don't like to be with people I don't know well.	0	1	2
4	I get scared if I sleep away from home.	0	1	2
5	I worry about other people liking me.	0	1	2
6	When I get frightened, I feel like passing out.	0	1	2
7	I am nervous.	0	1	2
8	I follow my mother or father wherever they go.	0	1	2
9	People tell me that I look nervous.	0	1	2
10	I feel nervous with people I don't know well.	0	1	2
11	I get stomachaches at school.	0	1	2
12	When I get frightened, I feel like I am going crazy.	0	1	2
13	I worry about sleeping alone.	0	1	2
14	I worry about being as good as other kids.	0	1	2
15	When I get frightened, I feel like things are not real.	0	1	2
16	I have nightmares about something bad happening to my parents.	0	1	2
17	I worry about going to school.	0	1	2
18	When I get frightened, my heart beats fast.	0	1	2

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)

CHILD FORM (8 years and older)

0 = Not True or Hardly Ever True 1= Somewhat True or Sometimes True
2= Very True or Often true

19	I get shaky.	0	1	2
20	I have nightmares about something bad happening to me.	0	1	2
21	I worry about things working out for me.	0	1	2
22	When I get frightened, I sweat a lot.	0	1	2
23	I am a worrier.	0	1	2
24	I get really frightened for no reason at all.	0	1	2
25	I am afraid to be alone in the house.	0	1	2
26	It is hard for me to talk with people I don't know well.	0	1	2
27	When I get frightened, I feel like I am choking.	0	1	2
28	People tell me that I worry too much.	0	1	2
29	I don't like to be away from my family.	0	1	2
30	I am afraid of having anxiety (or panic) attacks.	0	1	2
31	I worry that something bad might happen to my parents.	0	1	2
32	I feel shy with people I don't know well.	0	1	2
33	I worry about what is going to happen in the future.	0	1	2
34	when I get frightened, I feel like throwing up.	0	1	2
35	I worry about how well I do things.	0	1	2
36	I am scared to go to school.	0	1	2
37	I worry about things that have already happened.	0	1	2
38	When I get frightened, I feel dizzy.	0	1	2
39	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	0	1	2
40	I feel nervous about going to parties, dances or any place where there will be people that I don't know well.	0	1	2
41	I am shy.	0	1	2

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

(631) 467-0867 Fax (631) 467-0892

CHILD DEPRESSION INDEX

NAME_____ **DATE**_____

Please (✓) one answer from each item.

Item 1 I am sad once in a while.___ I am sad many times.__ I am sad all the time.___	Item 2 Nothing will ever work out for me.___ I am not sure if things will work out for me.___ Things will work out for me O.K.___
Item 3 I do most things O.K.___ I do many things wrong. ___ I do everything wrong.___	Item 4 I have fun in many things. ___ I have fun in some things.___ Nothing is fun at all.___
Item 5 I am bad all the time.___ I am bad many times.___ I am bad once in a while.___	Item 6 I feel like crying every day.___ I feel like crying many days. ___ I feel like crying once in a while.___
Item 7 I hate myself.__ I do not like myself.___ I like myself.__	Item 8 All bad things are my fault.___ Many bad things are my fault.___ Bad things are not usually my fault.___
Item 9 I do not think about killing myself.___ I think about killing myself but I would not do it.___ I want to kill myself.___	Item 10 I think about bad things happening to me once in a while.___ I worry that bad things will happen to me.___ I am sure that terrible things will happen to me.___
Item 11 Things bother me all the time.___ Things bother me many times.___ Things bother me once in a while.___	Item 12 I like being with people.___ I do not like being with people many times.__ I do not want to be with people at all.___

Item 13
I cannot make up my mind about things.____
It is hard to make up my mind about things.___
I make up my mind about things easily.___

Item 14
I look O.K.___
There are some bad things about my looks. ___
I look ugly.___

Item 15
I have to push myself all the times to do my schoolwork.___
I have to push myself many times to do my schoolwork.___
Doing schoolwork is not a big problem.___

Item 16
I have trouble sleeping every night.___
I have trouble sleeping many nights.___
I sleep pretty well.___

Item 17
I am tired once in a while.___
I am tired many days.___
I am tired all the time.___

Item 18
Most days I do not feel like eating.___
Many days I do not feel like eating.___
I eat pretty well.___

Item 19
I do not worry about aches and pains.___
I worry about aches and pains many times.___
I worry about aches and pains all the time.___

Item 20
I do not feel alone.___
I feel alone many times.___
I feel alone all the time.___

Item 21
I never have fun at school.___
I have fun at school only once in a while.___
I have fun at school many times.___

Item 22
I have plenty of friends.___
I have some friends but I wish I had more.___
I do not have any friend.___

Item 23
My schoolwork is alright.___
My schoolwoek is not as good as before.___
I do very badly in subjects I used to be good in .__

Item 24
I can never be as good as other kids.___
I can be as good as other kids if I want to.___
I am just as good as other kids.___

Item 25
Nobody really loves me.___
I am not sure if anybody loves me.___
I am sure that somebody loves me.___

Item 26
I usually do what I am told.___
I do not do what I am told most times.___
I never do what I am told.___

Item 27
I get along with people. ___
I get into fights many times. ___
I get into fights all the time.___

ADHQ (Self- Report)

Last Name_____ First Name_____ Date_____

Birth date_____ Age_____ Grade_____

1. Did you ever have trouble staying in your seat? At school? At work? At home? (e.g. during dinner)? Yes □ No □

2. Were you always moving in your chair? Were you always told to stop or to sit still? Yes □ No □

3. Was it ever difficult for you to play quietly? Did you ever get in trouble for not playing quietly? Yes □ No□

4. Did you talk a lot? All the time? More than other kids? Was it ever a problem? Yes □ No □

5. Did you often do one thing and then start something else without finishing the first thing? (e.g. house chores) What about starting on a game and running off to do something else? Yes □ No□

6. Did you ever have trouble paying attention? Do you usually have trouble keeping your mind on schoolwork or a project? Yes □ No□

7. Did you ever have trouble finishing things (e.g. homework, chores)? Did you have trouble following instructions? Did the teacher ever have to tell you what to do after the rest of the class had already started doing it? Yes □ No□

8. Could almost anything get your mind off of what you were doing? At school? At work? In a game? When there were noises or people moving around in the room, did you have trouble sticking to what you were doing? Yes □ No□

9. Did you talk when others were talking without waiting until they were finished? Do you do this a lot? Yes □ No□

10. Did you ever give answers to questions before someone finished asking? Did you call out answers in school without the teacher called on you? Yes □ No□

11. Was it hard for you to wait your turn while playing with other kids? Did you push in line? Was it hard to wait in line at the store or at the movies? Yes □ No□

12. Did you get in trouble because you rushed into doing things without thinking about what might happen? Like running into the street without looking? Yes □ No□

13. Did you often lose things? (e.g. toys, books, etc.)? How often? What about losing papers from school, like permission slips? Yes □ No□

14. Did your parents or your teachers ever complain that you did not listen to them? How often? Yes □ No□

Marie G. Surpris, D.O.
Child, Adolescent and Adult Psychiatrist

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)

PARENT FORM

DATE:_____

Last Name:_____ **First name**_____

Below is a list of items that describe how people feel. For each item that describes your child, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, please circle the **0**. Please answer all of the items as well as your child can, even if some do not seem to concern your child.

0 = Not True or Hardly Ever True **1= Somewhat True or Sometimes True**
2= Very True or Often True

1	When my child feels frightened, it is hard for him/her to breathe.	0	1	2
2	My child gets headaches when he/she is at school.	0	1	2
3	My child does n't like to be with people he/she does n't know well.	0	1	2
4	My child gets scared if he/she sleeps away from home.	0	1	2
5	My child worries about other people liking him/her.	0	1	2
6	When my child gets frightened, he/she feels like passing out.	0	1	2
7	My child is nervous.	0	1	2
8	My child follows me wherever I go.	0	1	2
9	People tell my child that she looks nervous.	0	1	2
10	My child feels nervous with people he/she does n't know well.	0	1	2
11	My child gets stomachaches at school.	0	1	2
12	When my child gets frightened, my child feels like he/she is going crazy.	0	1	2
13	My child worries about sleeping alone.	0	1	2
14	My child worries about being as good as other kids.	0	1	2

0 = Not True or Hardly Ever True **1= Somewhat True or Sometimes True**
2= Very True or Often true

15	When my child gets frightened, he/she feels like things are not real.	0	1	2
16	My child has nightmares about something bad happening to my parents.	0	1	2
17	My child worries about going to school.	0	1	2
18	When my child gets frightened, he/her heart beats fast.	0	1	2
19	My child gets shaky.	0	1	2
20	My child has nightmares about something happening to him/herself.	0	1	2
20	My child worries about things working out for him/her.	0	1	2
22	When my child gets frightened, he/she sweats a lot.	0	1	2
23	My child is a worrier.	0	1	2
24	My child gets really frightened for no reason at all.	0	1	2
25	My child is afraid to be alone in the house.	0	1	2
26	It is hard for my child to talk with people he/she does n't know well.	0	1	2
27	When my child gets frightened, he/she feels he/she is choking.	0	1	2
28	People tell my child that he/she worries too much.	0	1	2
29	My child does n't like to be away from his/her family.	0	1	2
30	My child is afraid of having anxiety (or panic) attacks.	0	1	2
31	My child worries that something bad might happen to his/her parents.	0	1	2
32	My child feels shy with people he/she does n't know well.	0	1	2
33	My child worries about what is going to happen in the future.	0	1	2
34	When my child gets frightened, he/she feels like throwing up.	0	1	2
35	My child worries about how well he/she does things.	0	1	2
36	My child is scared to go to school.	0	1	2
37	My child worries about things that have already happened.	0	1	2
38	When my child gets frightened, he/she feels dizzy.	0	1	2
39	My child feels nervous when he/she is with other children or adults and has to do something while they watch him/her) for example: read aloud, speak, play a game, play a sport.)	0	1	2
40	My child feels nervous about going to parties, dances or any place where there will be people that he/she does n't know well.	0	1	2
41	My child is shy.	0	1	2

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

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PARENT'S QUESTIONNAIRE

Name of Child_____ **Date**_____

Please answer all questions.

Beside each item, indicate the degree of the problem by a check mark (✓)

		Not at all	Just a little	Pretty much	Very much
1	Picks at things (nails, fingers, hair, clothing).				
2	Sassy to grown-ups.				
3	Problems with making or keeping friends.				
4	Excitable, impulsive.				
5	Wants to run things.				
6	Sucks or chews (thumb; clothing; blankets).				
7	Cries easily or often				
8	Carries a chip on his shoulder.				
9	Daydreams.				
10	Difficulty in learning.				
11	Restless in the "squirmy" sense.				
12	Fearful (of new situations; new people or places; going to school).				
13	Restless, always up and on the go.				
14	Destructive.				
15	Tells lies or stories that aren't true.				
16	Shy.				
17	Gets into more trouble than others same age.				
18	Speaks differently from others same age (baby talk; stuttering; hard to understand).				
19	Denies mistakes or blames others.				
20	Quarrelsome.				
21	Pouts and sulks.				
22	Steals.				