REDEMPTION COUNSELING

MINOR CLIENT INFORMATION

NAME: _____ DOB_____AGE_____ GENDER M or F
(Last) (First) (MI)

ADDRESS: _____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (CELL) _____ (HOME) _____ (WK)_____
MAY CONTACT: YES or NO YES or NO YES or NO
LEAVE MESSAGE: YES or NO YES or NO YES or NO

LIVING ARRANGEMENTS:

	Live with mom & dad		Live mostly with mom		Live mostly with dad		Share time equally with mom & dad

MOM'S NAME: _____ DOB_____AGE_____ GENDER M or F
(Last) (First) (MI)
ADDRESS: _____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (HM) _____ (CELL) _____ (WK)_____
MAY CONTACT: YES or NO YES or NO YES or NO
LEAVE MESSAGE: YES or NO YES or NO YES or NO

Email address: _____ Last completed grade _____ Occupation _____

DAD's NAME: _____ DOB_____AGE_____ GENDER M or F
(Last) (First) (MI)
ADDRESS: _____
(Street) (Apt #) (City) (State) (Zip Code)

PHONE: (HM) _____ (CELL) _____ (WK) _____
MAY CONTACT: YES or NO YES or NO YES or NO
LEAVE MESSAGE: YES or NO YES or NO YES or NO

Email address: _____ Last completed grade _____ Occupation _____

MEDICAL INFORMATION

All information must be filled out and signed prior to participation in Redemption Counseling Services.

Name: _____ M _____ F _____ Birthday: _____ / _____ / _____

Please check the box if your child has ever had a history of:

	Yes	No		Yes	No
Hyperactivity			Hearing Loss or Ringing		
Impulsivity			Digestive/Bowel Problems		
Frequent headaches/Migraines			Breathing Problems		
Binging/Purging/Anorexia			Neck, back Pain or Problems		
Cancer			High Blood Pressure		
Chills or hot flashes			Allergies		
Menstrual Irregularities			Stroke/Chest pains		
Sexual Trauma or abuse			Joint pain		
STD			Diabetes		
Cancer/Tumor/Leukemia			Anemia/Blood disease		
Heart Disease/Murmur			Fainting Spells/Dizziness		
Loss of Consciousness			Seizures/Epilepsy		
Eye Disease			Insomnia		
Kidney Disease/Stones			Thyroid problems		
Stomach Ulcers/pain			Social Fears		

MEDICAL DETAILS

How would you rate your child's level of fitness? (Please circle) Below Average Average Advanced

What do they currently do for physical fitness?

_____

_____

What would you state as your child's personal strengths, interests or pastimes?

_____

_____

_____

Are they currently taking any medications? If yes, please list name, dosage, and frequency:

_____

_____

Does your child have any drug sensitivities? _____

Primary care Physician: _____ Phone #: _____

Please tell us about any medical conditions the child may have or any physical or mental handicaps:

_____

_____

Has your child been hospitalized for any accidents or conditions? Please list child's age and dates:

_____

_____

_____

REASON FOR COUNSELING?

_____

_____

_____

_____

Has there been prior counseling? Yes or No With whom/ When _____

_____

Previous mental health diagnosis: _____

Any previous hospitalization for psychiatric problems? (Y or N) _____ When:_____ Where: _____

Please tell us about any medical conditions you may have or physical handicaps:

_____

_____

_____

Is there any other information you would like to provide that may be helpful for the clinician?:

_____

_____

_____

RECENT CONCERNS OR CHANGES IN PATTERNS

	Sleeping Patterns		Eating Patterns		Weight Change up or down
	Energy level		Disposition changes		Stress
	Other		Other		Other
	Other		Other		Other

FAMILY INFORMATION:

BIRTH FAMILY RELATIONSHIP	NAME	HEALTH (GOOD, FAIR, POOR)	ALIVE (Y OR N)	AGE	OCCUPATION / GRADE LEVEL
FATHER					
MOTHER					
STEPFATHER					
STEPMOTHER					
SIBLING					
SIBLING					
SIBLING					
SIBLING					

RELIGIOUS BACKGROUND

Does the child regularly attend a faith community? Y or N _____Congregation_____

EARLY CHILDHOOD HISTORY

Mother's pregnancy planned (y or n) _____ Weight gain _____ Length of pregnancy _____

Mother's health at birth of child (excellent, good, poor) _____

Did Mom use alcohol during pregnancy _____ Tobacco _____ Other substances _____

Father's health at birth of child (excellent, good, poor) _____

DELIVERY DETAILS

	Premature		Induced		Instrument used in delivery
	Caesarean		Breech		Jaundice
	Cord around neck		Length of delivery		Other

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

NAME: _____ PHONE (HM) _____ (CELL) _____ (WK) _____

Signature of Person Completing Form: _____ Date: _____

Signature of Client (if age 13 or older): _____ Date: _____

REDEMPTION COUNSELING

DISCLOSURES FOR INFORMED CONSENT, FINANCIAL CONSENT, & COMMUNICATION METHOD CONSENT

This document outlines Tim and Debra's training, the confines of the therapeutic relationship, and explains our financial policies. It also discusses ways that we can contact you in the future and establishes your consent for treatment at Redemption Counseling ("RC").

We like to remind our clients that they are the consumer in the therapeutic relationship. What that means is that it is important that you determine if we are the right provider to meet your needs based on our therapeutic style, training, and treatment modalities. We want to ensure that our relationship with you meets your needs. Please see the information below and ask any questions you have in your initial intake session to make an informed decision.

COUNSELOR BACKGROUND AND TRAINING

Tim Bartlett, M.S. is a licensed Mental Health Counselor in the state of Washington. – (#LH60287144). He received his B.A. in English Literature from Western Washington University in 1994. In 1998, Tim graduated with a Master's of Science in Marital and Family Therapy (MSMFT) from Fuller Theological Seminary. He earned a Child Mental Health Specialist Designation (CMHS) through additional postgraduate training and supervision focused on child and adolescent therapy techniques. Tim's primary areas of focus include marital counseling, infidelity recovery, family counseling, parenting issues, adolescent and child counseling, depression and anxiety, workplace stress, and trauma recovery for children and adults. Tim particularly enjoys working with his clients to enhance their ability to clearly communicate their feelings and needs in their primary relationships. Tim's primary treatment modality is cognitive behavioral therapy. His counseling approach is to assist clients with the transformation of inaccurate thoughts, beliefs and self-perceptions that contribute to negative emotions, actions, and reactions. He employs a strengths-based model grounded in encouragement, goal setting, accountability, and practical feedback. Working together with his clients, he identifies their core skills, talents and unrealized spiritual potential to bring about positive change and emotional healing.

Debra Bartlett M.A. is a Washington State Mental Health Counselor (#LH60516273). She earned her B.A. in Business Administration with a minor in Psychology in 1990 and her M. A. in Professional Psychology in 1997 from Azusa Pacific University. In 2003, Debra obtained her School Counseling Credential, E.S.A., at City University. Debra's areas of focus include child and adolescent counseling, parenting concerns, anxiety and depression, communication skills, boundary and assertiveness training, grief and loss, and marital counseling including co-therapy with her husband Tim Bartlett. She enjoys helping clients grow to their full potential by offering personality assessment which allows deeper insight to their God-given temperaments. Debra's primary treatment modality is cognitive behavioral therapy. Her approach to counseling is focused on helping her client's identify their core beliefs and values, so that their actions are aligned with their goals. Another area of focus is to assist her clients to identify root causes of pain from childhood that lead to destructive patterns in their current life experiences. Her goal is to assist clients with the transformation of inaccurate thoughts, beliefs and self-perceptions that lead to self-doubt, a diminished sense of personal value, and poor decisions.

ABOUT INSURANCE BILLING

If you have come to therapy with a plan to use your health insurance, there are a few things that you need to know. Insurance companies require that we provide a medically necessary diagnosis in order to bill for services. Most insurance companies do not pay the therapy costs for general personal or family problems that do not produce medically viable symptomology. Your therapist will be able to determine if there are symptoms present which qualify for a medically necessary diagnosis. If those symptoms are not present, you will be billed for the session costs out of pocket.

Be advised, that a few insurance carriers require us to coordinate care with your primary care physician and/or a behavioral care manager in order to approve visits. This prior authorization process must be approved prior to the first session in order to receive insurance payments. While we seek to do our best to research the coverage in your plan, each medical insurance plan is different and we encourage you to contact your provider to identify the specific mental health benefits of your insurance plan.

We are able to bill most insurance providers, but are not preferred by all network providers (we do not accept Medicare or Medicaid). Please present a valid insurance card and driver's license at your first appointment. You are responsible for a copayment at each visit and we will bill your insurance directly for the allowable balance. Any outstanding balances, co-payments and deductibles are due prior to your appointment or immediately following. You are responsible for the payment if your health insurance does not cover services provided.

FINANCIAL POLICY

Payment: Our fees are as follows: The initial evaluation is $200 and will take approximately 75 to 90 minutes. Subsequent sessions are for 55 minutes and are billed at $155.00. If you are currently experiencing financial hardship, discuss this with your therapist so we may attempt to accommodate your need.

Payment Options: We prefer that our clients pay via check. We also accept cash payment, and Debit/Credit Cards are also accepted. If we cannot contact you regarding an unpaid balance, please be aware that we may use an outside collection agency.

THERAPIST INFORMATION

Therapist Availability: While we seek to be available to our clients by telephone for emergencies, there are times we will not be available. In the event your therapist cannot be reached, crisis assistance can be obtained by calling Chelan-Douglas RSN @ 1-800-852-2923 or by dialing 911. Your therapist will try to give prior notice of times they will be out of the office for any extended period of time.

Appearing in Court: Therapists at Redemption Counseling do not qualify as expert witnesses and are not in the practice of appearing in court on behalf of patients for any reason. If you are seeking a therapist to assist with a court case, we will try to help by referring you to a therapist who provides this expertise.

LIMITS OF CONFIDENTIALITY

I understand that all information regarding this work will remain confidential and will not be shared with others outside Redemption Counseling without my consent. I understand that my counselor may receive consultation for my case with other counselors at RC on an occasional basis. I also understand that there are conditions under which this confidentiality must be broken and information be shared with appropriate individuals outside of RC. These conditions are as follows:

- If there is suspicion that a child is being abused.
- If there is evidence of physical abuse of an elder or dependent adult.
- If I am making serious physical threats against others or myself.
- If your therapist is called to court via subpoena (you have a limited privilege to determine what can be kept confidential in such cases.)
- If a complaint is filed against your therapist with the Washington Department of Health or a board.
- If you file a Worker's Compensation Claim.

CONSENT OR DECLINATION OF ELECTRONIC COMMUNICATIONS

I am cautioned that e-mail and texting are not a reliably confidential means of communication. In addition, I understand that my counselor cannot ensure that e-mail and text messages will be received or responded to immediately. I understand that e-mail and text are not the appropriate way to communicate confidential, urgent, or emergency information.

ACTION: Please indicate via initialing which communication methods you authorize:

_____ Emailed appointment reminders and counselor response to client communications via email.
My email address is:_____

_____ Phone communications including leaving voice mail messages.
The phone number(s) I authorize are: _____

_____ Text - I understand the risks of texting, but choose this form of communication at no risk to RC.
The text number I authorize is: _____

Printed Name: _____ **Client Signature:** _____

OR

☐ I decline all electronic communication methods. Client Signature**:** _____

STATEMENT OF UNDERSTANDING

- I understand I am responsible for all charges for counseling services delivered through this office and that payment is expected at the time of service.
- I understand checks returned for insufficient funds will incur a charge of $25.
- I understand I am responsible to appear for scheduled appointments. I understand if I miss an appointment without providing 24 hours notice, I will be charged for that time.
- If I fail to show for two consecutive appointments without notice, I may be referred elsewhere for services. This is dependent on the circumstance of both the client and the mental health provider.
- I understand there is a possibility of risks and benefits which may occur in counseling. I am giving consent to my voluntary participation in these outlined procedures in which I and/or family will participate in therapy at Redemption Counseling, including confidentiality and exceptions of confidentiality.
- I understand that my therapist will attempt to not approach me or address me by name in a public setting unless I choose to approach or address him/her first.
- I understand I have the right to seek a second opinion at any time, or seek additional or alternative referrals.
- I understand that, if in the course of receiving counseling services, if I should feel unsafe, self-destructive, suicidal, homicidal, etc., I will notify my therapist and take appropriate action, including hospitalization, to protect my health and safety.

I acknowledge I have read and received a copy of this INFORMED CONSENT and agree to the guidelines above.

Signature of Client _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Signature of Therapist _____ Date: _____

REDEMPTION COUNSELING

NOTICE OF PRIVACY PRACTICES

Note: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. Effective Date: January 1, 2016.

Redemption Counseling only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of the client's healthcare information. Use and disclosure of protected health information (PHI) is for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for the following purposes.

TREATMENT

Use and disclose health information to:

· Provide, manage or coordinate care - this relates to how your therapist manages your health care data to care for you.

· Consultants - this applies to the sharing of data with other professionals as needed for your care.

· Referral sources - this relates to conversing with outside businesses to release information or transfer it to them in order to provide optimum care for you in therapy and for the benefit of treatment.

PAYMENT

Use and disclose health information to:

· Verify insurance and coverage - this applies to disclosing your basic health information to obtain information regarding your insurance benefits.

· Process claims and collect fees - this applies to disclosing your basic health diagnosis, DOB, etc., to obtain your insurance benefits and coverage for mental health services.

HEALTHCARE OPERATIONS

Use and disclose health information for:

· Review of treatment procedures - this would apply to the review of the treatment plan as needed to maintain HIPAA compliance standards.

· Review of business activities - this applies to needs from agencies to show appropriate HIPAA business compliance.

· Certification - this applies to information needed to maintain insurance credentials with the state of WA.

· Staff training - this applies to the sharing of data, but not names to coordinate with other therapists in the office.

· Compliance and licensing activities - this applies to giving any information the state needs to show counseling law compliance and to maintain license validation.

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

· Mandated reporting - If the therapist believes a person is at risk to hurt themselves or harm anyone else, they are required as a mandated reporter in the state of Washington to break confidentiality. This may mean revealing information to an appropriate family member, law enforcement officer, child protective services staff member or other appropriate authorities.

· Emergencies - if the therapist believes there is an eminent need to release your information due to possible harm that may be inflicted to another person (such as domestic abuse,) abuse of a disabled or elderly person, or abuse of a child, they are mandated to report immediately to the appropriate state entity.

· Criminal damage - when there is a case involving criminal damages, your personal data may be requested by the state.

· Appointment scheduling - in cases of appointment scheduling, some personal health information will be used.

· As required by law - if a complaint is filed against your therapist, the Washington department of health may subpoena confidential medical data that is relevant to the complaint.

CLIENT RIGHTS

You as the client have rights under Washington State and Federal law.

Right to request where we contact you

· You have the right to restrict how we contact you regarding appointments if you don't want family members to know of your mental health services. *See "CONSENT OR DECLINATION OF ELECTRONIC COMMUNICATIONS" and "CLIENT INFORMATION FORM" to elect how you prefer we contact you during the course of therapy.*

Right to release your medical records

· Written authorization to release records to others - You have the right to your private health file and will need to sign a release if you want others to have access to your medical file.
· Right to revoke release in writing - You have the right to revoke this release at any time in writing.
· Revocation is not valid to the extent that you have acted in reliance on such previous authorization.

Right to inspect and copy your medical billing records

· Right to inspect and copy records - You have the right to see and receive a copy of your medical file at any time.
· Charges for copying, mailing, etc. - You may be charged copying and mailing charges to obtain your file.

Right to add information or amend your medical records

· You may request to amend your records. You can ask for changes to PHI as long as your PHI is maintained in your file. Keep in mind your therapist can deny this based on the accounting process. Please ask questions of your therapist if needed.
· Any amendments to this consent form must be in writing by Redemption Counseling and given to you as a patient.

Right to accounting of disclosures

· Redemption Counseling is required to keep your records for seven years and you have a right to know of our process to maintain confidentiality of these records.
· Exceptions: this applies to exceptions outlined herein about our disclosure policies.
· Disclosure for treatment, payment or healthcare operations - this applies to disclosures of our processes needed to receive appropriate care, payment or continued healthcare services. You may obtain this information by request.
· Disclosures pursuant to a signed release - this applies to understanding our policy regarding our signed release of information document.
· Disclosure made to client - this applies to your right to these disclosures outlined and our accounting of them.
· Disclosures for national security or law enforcement - this applies to your understanding about our need to disclose in cases related to national security or any law enforcement investigation or proceedings.

Right to request restrictions on uses and disclosures of your healthcare information

· You have the right to request restrictions on certain uses and disclosures of PHI, but **it must be in writing** and your therapist is not obligated to agree with your request. Please discuss further with your therapist.

Right to complain

· Please contact Redemption Counseling and your therapist first if you have a complaint about how your PHI and privacy rights have been protected.
· If not satisfied, you have the right to complain to the U.S. Dept. of Health and Human Services. If you have any complaints about your therapist and/or their counseling services, you may contact Washington State Department of Health, Health Systems Quality Assurance by calling 360-236-4700 or at P.O. Box 47865, Olympia, WA, 98504-7865.

Right to receive changes in policy

· You May request any future changes to this policy be given in writing and Redemption Counseling will notify you of such revisions, but maintains the right to change them at any time in compliance with laws and restrictions. This notice will go into effect January 1, 2016.
· Request to privacy officer - You have the right to request a privacy officer review of such PHI information.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected counseling information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and clinician certifications. I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my counseling information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Child: _____ Child age _____
Caregiver: _____ Date: _____

Moods and Feelings Questionnaire (7-18)

This form is about how you might have been feeling or acted recently.
Please check how much you have felt or acted this way in the past two weeks

	0 Not True	1 Sometimes	2 True
I felt miserable or unhappy.	☐	☐	☐
I didn't enjoy anything at all.	☐	☐	☐
I felt so tired I just sat around and did nothing.	☐	☐	☐
I was very restless.	☐	☐	☐
I felt I was no good anymore.	☐	☐	☐
I cried a lot.	☐	☐	☐
I found it hard to think properly or concentrate.	☐	☐	☐
I hated myself.	☐	☐	☐
I felt I was a bad person.	☐	☐	☐
I felt lonely.	☐	☐	☐
I thought nobody really loved me.	☐	☐	☐
I thought I would never be as good as other kids.	☐	☐	☐
I did everything wrong.	☐	☐	☐

Score: _____

Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995)

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

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

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
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).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012