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PATIENT INFORMATION AND CONSENT

Our practice offers a Collaborative Care program for eligible patients to help support behavioral health management. Collaborative Care brings together other members of the health care team to work with the patient's primary care provider, including a behavioral healthcare manager and a psychiatrist.

Patients who are enrolled in collaborative care:

- Receive regular check-ins with the behavioral health care manager to monitor their progress.
- Benefit from the expertise of a psychiatrist who shares recommendations with the patient's primary care provider about their treatment plan and care.
- May see better results and improvement in their condition, compared to not being enrolled in the collaborative care program.
- May be more likely to receive timely behavioral health management within their medical home compared to being referred to an outside mental health provider or clinic.

I understand that:

- My participation in the collaborative care program is voluntary.
- I can stop participating at any time.
- I am required to cancel an appointment I cannot attend 24 hours or more before appointment time unless it is an emergency. Three missed appointments whether by no show or cancellation less than 24 hours notice or lack of communication with phone calls/texts/email/mailed letter will result in deactivation from the program. Reactivation is at counselor discretion.
- The average enrollment time in the program is approximately 6 months, but may vary depending on my treatment needs.
- Participating in the program does not take the place of my regular behavioral health visits with my primary care provider.
- My primary care provider and I are responsible for making all medical management decisions.
- I may still be referred to an outside mental health provider if my primary care provider determines that my condition would be more appropriately managed with a specialist.
- My insurance plan will be billed monthly while I am enrolled in the program. Some of this cost may be passed along to me by my insurance plan.
- The psychiatrist consultant provides recommendations only to my primary care provider and the behavioral healthcare manager. The consultant does not bill my insurance. The consultant does not meet with me while I am enrolled in the program.

I understand that failure to call to cancel appointments at least 24 hours in advance unless it is an emergency may result in being placed as inactive in the counseling program which will require being put back on the waiting list to be seen again. Also, I understand that Angela will try to contact me three times by two methods and if I do not respond I will be placed as inactive.

___ (initial)

I voluntarily consent to participating in the Dayspring Family Medicine Collaborative Care program.

___ (initial)

I give consent to Dayspring Family Medicine to share medically necessary information with the psychiatrist consultant while I am enrolled in the Collaborative Care program.

___ (initial)

I understand that my patient's rights under HIPAA which protect my health information apply while I am enrolled in the Collaborative Care program, just as they do in any of my visits or interactions as a patient of Dayspring Family Medicine.

___ (initial)

Patient Signature/ Parent or Guardian Signature (if minor)

Date

Patient Name/ Parent or Guardian Name (if minor)

Patient's Primary Care Provider

Behavioral Health Care Manager

CHILD INTAKE FORM

Name: _____ DOB: _____ Age: _____

School: _____ Grade: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION:

Name; Relationship (parent, sibling); Age; Type (bio, step); Living with you?; Problem Description

CHILD'S DEVELOPMENT

Did your child have health problems at birth? Yes _____ No _____

If yes, describe: _____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure _____ If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse? Yes _____ No _____ Not sure _____

If yes, describe: _____

Emotional/Behavioral/Chemical Issues

(Has your child recently or currently experienced the following?) Recent Suicidal thoughts

Difficulty sleeping Depression Loneliness Hopelessness Self-harm

Crying often Frightening dreams or thoughts Often annoyed Frequent loss of temper

Difficulty completing tasks Difficulty expressing feelings Violent or destructive behavior

Nervousness, anxiety, or worry Difficulty remembering Difficulty relaxing Difficulty concentrating

Difficulty making decisions Mental Confusion Difficulty making friends Difficulty with eating

Has your child ever been in court or picked up by the police? Yes _____ No _____ If yes, describe:

Do you think your child has tried cigarettes, sniffing, alcohol or drugs? Yes _____ No _____ If yes, describe: _____

Does your child have a cell phone Yes _____ No _____

How many hours of screen time does your child engage in daily? _____

PEER RELATIONS

- 1. Is your child socially: outgoing shy depends on the situation.
- 2. Has your child experienced any bullying? Yes No
- 3. Is your child involved in any organized social activities (e.g. sports, scouts, music)? Yes No

List activities _____

SCHOOL HISTORY

- 1. Has your child ever been held back a grade? Yes No If yes, what grade and what was the reason you choose to hold your child back: _____
- 2. What are the grades your child receives at school? _____
- 3. Do you feel your child is doing the best he/she can at school? Yes No
- 4. Are there any behavior problems at school? Yes No If yes, please explain: _____
- 5. How many schools has your child attended? _____

DISCIPLINE

Are there any concerns regarding discipline? Yes ___ No ___ If yes, please explain: _____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern: _____

COUNSELING HISTORY

Has your son or daughter previously seen a counselor? Yes No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling? _____

Does your son or daughter have a previous mental health diagnosis? Yes _____ No _____

Name of medication _____ Was it helpful? Y/N

Family History

Significant family illness: _____

Does any parent/caregiver have difficulties with nervousness, anxiety, or depression? Yes _____ No _____ if yes, please explain: _____

Does any parent/caregiver have difficulties with anger, e.g. losing temper easily, verbally abusive, being violent when angry? Yes ____ No ____ If yes, please explain: _____

PARENT'S HISTORY PARENT'S MARITAL STATUS

(this refers to the biological parents relationship)

Single Married Divorced Cohabiting Divorce in process Separated Widowed

If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent? Mother ____%, Father ____%

Biological Father's Name: _____ Age: _____

Current Status: Single Married Divorced Separated Widowed Other

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

Biological Mother's Name: _____ Age: _____

Current Status: Single Married Divorced Separated Widowed Other

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

Name:

DOB:

Date:

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation.

Food	Yes	No
Within the past 12 months, did you worry that your food would run out before you got money to buy more food?		
Within the past 12 months, did the food you bought just not last and you didn't have money to get more		
Housing/Utilities		
Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Other Assistance		
Do you need help finding clothing, support, substance abuse assistance, or pregnancy assistance?		

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Short Mood and Feelings Questionnaire

This form is about how your child may 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 two weeks*.

If a sentence was true about your child most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired that s/he just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

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

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	0	0	0
22.	When I get frightened, I sweat a lot	0	0	0
23.	I am a worrier	0	0	0
24.	I get really frightened for no reason at all	0	0	0
25.	I am afraid to be alone in the house	0	0	0
26.	It is hard for me to talk with people I don't know well	0	0	0
27.	When I get frightened, I feel like I am choking	0	0	0
28.	People tell me that I worry too much	0	0	0
29.	I don't like to be away from my family	0	0	0
30.	I am afraid of having anxiety (or panic) attacks	0	0	0
31.	I worry that something bad might happen to my parents	0	0	0
32.	I feel shy with people I don't know well	0	0	0
33.	I worry about what is going to happen in the future	0	0	0
34.	When I get frightened, I feel like throwing up	0	0	0
35.	I worry about how well I do things	0	0	0
36.	I am scared to go to school	0	0	0
37.	I worry about things that have already happened	0	0	0
38.	When I get frightened, I feel dizzy	0	0	0
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	0	0
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	0	0	0
41.	I am shy	0	0	0

**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.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ Date: _____

Directions:

Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	My child gets headaches when he/she is at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	My child doesn't like to be with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	My child gets scared if he/she sleeps away from home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	My child worries about other people liking him/her	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	When my child gets frightened, he/she feels like passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	My child is nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	My child follows me wherever I go	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	People tell me that my child looks nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	My child feels nervous with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	My child gets stomachaches at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	When my child gets frightened, he/she feels like he/she is going crazy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	My child worries about sleeping alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	My child worries about being as good as other kids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	When he/she gets frightened, he/she feels like things are not real	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	My child has nightmares about something bad happening to his/her parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	My child worries about going to school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	When my child gets frightened, his/her heart beats fast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	He/she gets shaky	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	My child has nightmares about something bad happening to him/her	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	When my child gets frightened, he/she sweats a lot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	My child is a worrier	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	My child gets really frightened for no reason at all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	My child is afraid to be alone in the house	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26.	It is hard for my child to talk with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	When my child gets frightened, he/she feels like he/she is choking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	People tell me that my child worries too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29.	My child doesn't like to be away from his/her family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	My child is afraid of having anxiety (or panic) attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	My child worries that something bad might happen to his/her parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	My child feels shy with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33.	My child worries about what is going to happen in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34.	When my child gets frightened, he/she feels like throwing up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35.	My child worries about how well he/she does things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36.	My child is scared to go to school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37.	My child worries about things that have already happened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38.	When my child gets frightened, he/she feels dizzy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41.	My child is shy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu