

Child/Adolescent Diagnostic Assessment (TO BE COMPLETED BY PARENT/CAREGIVER)

PART 1 – Please provide the following information in preparation your interview with your mental health clinician.

DATE _____

[illegible]

Living situation

Parent's Home <input type="checkbox"/> RENT <input type="checkbox"/> OWN	Residential Care/Treatment Facility** <input type="checkbox"/> HOSPITAL <input type="checkbox"/> RESIDENTIAL CARE <input type="checkbox"/> TEMPORARY HOUSING <input type="checkbox"/> NURSING HOME	Other** <input type="checkbox"/> FRIEND'S HOME <input type="checkbox"/> HOMELESS <input type="checkbox"/> RELATIVE/GUARDIAN'S HOME
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**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household					
Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Does the client live in more than one household?

☐ **NO** If no, skip to "Additional Family Members"

☐ **YES** If yes, complete the secondary household information below.

Secondary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Family members who live in both households

☐ ONLY CHILD

☐ CHILD and (list):

Additional family members

☐ NO, parents or sibling other than those listed in primary or secondary households

☐ YES, list family members:

Custody and parenting plan

☐ LIVES WITH BOTH PARENTS (biological or adoptive) in same household

☐ SINGLE PARENT

☐ SHARED CUSTODY – parents in different households

☐ OTHER (describe):

Developmental issues

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had bleeding during second three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had bleeding during last three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had toxemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had to take medications Specify any medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Got injured or hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gained less than 15 lbs. (7 kgs.) Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Took narcotic drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drank alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had an infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Smoked during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Length of pregnancy: _____ months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other pregnancy problems/illnesses Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Birth/Early Infancy	Yes	No	Unknown		
Born prematurely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Born with cord around neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Injured during birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Had trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Turned blue (cyanosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was a twin or triplet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Had an infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Had seizures (fits, convulsions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Needed oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was very jittery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
High fevers (over 103° F. or 39° C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble with hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble with vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Lead poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other poisoning or overdose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other serious illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Overactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Head banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Rocking in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Self-destructive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Difficulty in being comforted or consoled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Stiffness or rigidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Looseness or floppiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Crying often and easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Shyness with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Extreme reaction to noise or sudden movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Attention problems	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Understand the main ideas of things but misses important details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Does work or performs many tasks carelessly without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Learns a new skill well one day and then can't seem to do it a few days later	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Receives very unpredictable (inconsistent) grades or test scores in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Can work well only on things he/she really enjoys doing or thinking about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Often doesn't notice when he/she makes mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Seems not to realize when he/she is disturbing someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Doesn't do much better after punishment or correction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Makes comments about or is distracted by background noises or unimportant things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Seems to want things right away and/or is hard to satisfy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Annoys or bothers other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Behavior is variable and hard to predict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is a troublemaker; bullies others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often very quiet or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often "down" on himself/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Speaks unclearly, stutters, or stammers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Wets bed or pants often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Soils underwear or has accidents with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often too neat or orderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often too concerned about cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Often plays with matches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Destroys objects at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Destroys objects away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is fearless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is not liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Feels ill on school mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Has eating problems (either overeats or undereats)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is preoccupied with food or diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is part of a clique or gang that causes trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other behaviors not noted above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever had concerns about your child's sexual development or behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN					
<hr/>					
<hr/>					
<hr/>					
<hr/>					
<hr/>					

Child's school functioning

Education classification	
Does your child receive special education services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, has your child ever been tested and determined not to need services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Regular education classroom, no special services <input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, check all that apply below.	
<input type="checkbox"/> Early Childhood Spec. Ed./Developmental Delay	<input type="checkbox"/> Special learning disability
<input type="checkbox"/> Special Learning Disability	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Other health impaired
<input type="checkbox"/> Speech or Language Impaired	<input type="checkbox"/> Unsure
<input type="checkbox"/> Physically Impaired	<input type="checkbox"/> Current 504 plan
<input type="checkbox"/> Emotional/Behavioral Disorder	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Developmental/Cognitive Disability	_____
COMMENTS ON EDUCATIONAL CLASSIFICATION	
<hr/>	
<hr/>	
<hr/>	

Child's legal history

Does your child have a history of legal charges? <input type="checkbox"/> NO <input type="checkbox"/> YES
IF YES, DESCRIBE CHARGES
Is the child currently on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES
Has the child ever been on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES
Has the child ever been court-ordered into chemical health or mental health treatment? <input type="checkbox"/> NO <input type="checkbox"/> YES

Child's trauma history

Children's Protective Services (CPS) involvement with family <input type="checkbox"/> NO <input type="checkbox"/> YES
IF YES, DESCRIBE
NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)
<input type="checkbox"/> NONE REPORTED
NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY
<input type="checkbox"/> NONE REPORTED
Has your child ever experienced any of the following?
<input type="checkbox"/> Physical abuse <input type="checkbox"/> Domestic violence/abuse <input type="checkbox"/> Physical neglect <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Sexual abuse/molestation <input type="checkbox"/> Community violence <input type="checkbox"/> None of the above

Child's mental health treatment history

Previous mental health treatment <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, please list reason for treatment, and dates:
Reason	Dates
Currently on any medication(s)? <input type="checkbox"/> NO <input type="checkbox"/> YES	
IF YES, PLEASE LIST AND BRING MEDICATIONS TO NEXT APPOINTMENT	

PRIMARY CARE PHYSICIAN			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
OTHER PRESCRIBING PHYSICIAN(S)			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? <input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have any other issues or concerns about your child you would like to have addressed? <input type="checkbox"/> NO <input type="checkbox"/> YES
COMMENTS

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s)	P = Primary household	S = Secondary household	B = Both
Parent-child conflict	<input type="checkbox"/> NONE – MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Issues with supervision and monitoring of child	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> USUALLY	<input type="checkbox"/> INCONSISTENTLY <input type="checkbox"/> RARELY
Cooperation between parents regarding child-rearing	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> USUALLY	<input type="checkbox"/> INCONSISTENTLY <input type="checkbox"/> RARELY <input type="checkbox"/> NOT PERTINENT
Parent positive activities with child	<input type="checkbox"/> FREQUENT	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> INFREQUENT
Parent satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
Child satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)			

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) <input type="checkbox"/> NO SIBLINGS	P = Primary household	S = Secondary household	B = Both
Child-sibling conflict	<input type="checkbox"/> NONE – MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Sibling(s) positive activities with child	<input type="checkbox"/> FREQUENT	<input type="checkbox"/> OCCASIONAL	<input type="checkbox"/> INFREQUENT
Sibling(s) satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
Child satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)			

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) <input type="checkbox"/> NOT APPLICABLE P = Primary household S = Secondary household B = Both			
Marital or couples conflict	<input type="text"/> NONE – MILD	<input type="text"/> MODERATE	<input type="text"/> SEVERE
Marital or couples satisfaction	<input type="text"/> SATISFIED	<input type="text"/> NEUTRAL	<input type="text"/> DISSATISFIED
COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)			

Other Family Concerns			If yes, indicate:		
	No	Yes	Parent	Sibling	Other
Family member health problems	<input type="checkbox"/>	<input type="checkbox"/>			
Family member disability	<input type="checkbox"/>	<input type="checkbox"/>			
Family member legal issues	<input type="checkbox"/>	<input type="checkbox"/>			
Family financial concerns	<input type="checkbox"/>	<input type="checkbox"/>			
Family member alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Family member substance abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Family member anxiety	<input type="checkbox"/>	<input type="checkbox"/>			
Family member depression	<input type="checkbox"/>	<input type="checkbox"/>			
Family member ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Family member mania	<input type="checkbox"/>	<input type="checkbox"/>			
Family member schizophrenia/other psychosis	<input type="checkbox"/>	<input type="checkbox"/>			
Significant family stressors (moves, deaths, divorce, loss of employment)	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENT ON OTHER FAMILY CONCERNS AND INFORMATION RELATING TO FINANCIAL STATUS (Specify problems that impact child's needs.)

Screen for Child Anxiety Related Disorders (SCARED)

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

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 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"/>	PN
2. My child gets headaches when he/she am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
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"/>	SC
4. My child gets scared if he/she sleeps away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. My child worries about other people liking him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When my child gets frightened, he/she feels like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. My child is nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. My child follows me wherever I go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that my child looks nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. My child feels nervous with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. My child gets stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. My child worries about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. My child worries about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When my child gets frightened, he/she feels like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. My child has nightmares about something bad happening to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. My child worries about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When my child gets frightened, his/her heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. He/she child gets shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. My child has nightmares about something bad happening to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP

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"/>	GD
22. When my child gets frightened, he/she sweats a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
23. My child is a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
24. My child gets really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
25. My child is afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
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"/>	SC
27. When my child gets frightened, he/she feels like he/she is choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
28. People tell me that my child worries too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
29. My child doesn't like to be away from his/her family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
30. My child is afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
31. My child worries that something bad might happen to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
32. My child feels shy with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
33. My child worries about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
34. When my child gets frightened, he/she feels like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
35. My child worries about how well he/she does things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
36. My child is scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
37. My child worries about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
38. When my child gets frightened, he/she feels dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
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"/>	SC
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"/>	SC
41. My child is shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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 =**

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.

Strengths and Difficulties Questionnaire

P 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour over the last six months.

Your child's name

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas:
emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

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

SCORING:

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

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**.

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

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

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

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

**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.*