Child's Name: ____________________________

Clinic #: ________________________________

Date: ___________________________________

Office Use:
Time: ❑Eval ❑Post ❑ 6 mo f/u ❑ Other

Directions: This packet contains several different questionnaires to help your doctor assess your child's anxiety symptoms. Please complete each page (front and back) in the order they appear and return them. Thank you.

Name of person completing form: ________________________

1. Relationship to child: 1. Mother 2. Father 3. Other

2. What is the Highest Education Degree earned by either the child's mother or father (please circle one):

1 Graduate School (Ph.D., M.D.,M.A)
2 College (B.A./B.S.)
3 A.A. or vocational degree
4 High school graduate
5 Some high school

3. Parents' Marital Status (please circle one)

1 Married
2 Married, living apart
3 Living together unmarried
4 Separated or Divorced
5 One parent deceased
6 Never married

4. Has the child received Medication or Therapy for the following problems?

	Medication?	Therapy?
A. Depression	1- yes 2-no	1- yes 2-no
B. Anxiety	1- yes 2-no	1- yes 2-no
C. Behavior problems	1- yes 2-no	1- yes 2-no
D. Trouble getting along with other children	1- yes 2-no	1- yes 2-no
E. ADHD	1- yes 2-no	1- yes 2-no
F. Learning problems/developmental disorders	1- yes 2-no	1- yes 2-no
G. Other mental health problems	1- yes 2-no	1- yes 2-no

We are interested in how you currently feel as a parent:

5. How confident are you that you can help your child successfully handle his/her fears and worries at this time without a therapist?

1- Not at all 2-A little 3-Somewhat 4-Mostly 5-Completely

6. How helpful do you think the following strategies are for handling your child's fears and worries?

0 = Not at all **1= A little** **2 = Mostly** **3 = Very**

A. Teaching my child relaxation strategies	0---1---2---3
B. Encouraging my child to face his/her fears	0---1---2---3
C. Providing reassurance that everything will be okay	0---1---2---3
D. Helping my child avoid difficult situations	0---1---2---3
E. Handling difficult situations for my child	0---1---2---3
F. Having my child take medication	0---1---2---3
Which do you think is the **most** helpful?	A---B---C---D—E---F

SCASP

Below is a list of items that describe children. For each item please circle the number that corresponds with the response that best describes your child. Please answer all items.

		Never	Sometimes	Often	Always
		0	1	2	3
1.	My child worries about things…………………………..	0	1	2	3
2.	My child is scared of the dark……………………………	0	1	2	3
3.	When my child has a problem, s(he) complains of having a funny feeling in his/her stomach………………	0	1	2	3
4.	My child complains of feeling afraid……………………	0	1	2	3
5.	My child would feel afraid of being on his/her own at home…………………………………………………..	0	1	2	3
6.	My child is scared when s(he) has to take a test…………	0	1	2	3
7.	My child is afraid when s(he) has to use public toilets or bathrooms……………………………………………	0	1	2	3
8.	My child worries about being away from us/me………..	0	1	2	3
9.	My child feels afraid that s(he) will make a fool of him/herself in front of people……………………………	0	1	2	3
10.	My child worries that s(he) will do badly at school……..	0	1	2	3
11.	My child worries that something awful will happen to someone in our family………………………………	0	1	2	3
12.	My child complains of suddenly feeling as if s(he) can't breathe when there is no reason for this…………..	0	1	2	3
13.	My child has to keep checking that s(he) has done things right (like the switch is off, or the door is locked)……..	0	1	2	3
14.	My child is scared if s(he) has to sleep on his/her own….	0	1	2	3
15.	My child has trouble going to school in he mornings because s(he) feels nervous or afraid…………………….	0	1	2	3
16.	My child is scared of dogs………………………………	0	1	2	3
17.	My child can't seem to get bad or silly thoughts out of his/her head……………………………………………...	0	1	2	3
18.	When my child has a problem, s(he) complains of his/ her heart beating really fast…………………………….	0	1	2	3
19.	My child suddenly starts to tremble or shake when there is no reason for this……………………………….	0	1	2	3

20.	My child worries that something bad will happen to him/her…………………………………………………..	0	1	2	3
21.	My child is scared of going to the doctor or dentist……..	0	1	2	3
22.	When my child has a problem, s(he) feels shaky………..	0	1	2	3
23.	My child is scared of heights (e.g. being on top of a cliff).	0	1	2	3
24.	My child has to think special thoughts (like numbers or words) to stop bad things from happening…………..	0	1	2	3
25.	My child feels scared if s(he) has to travel in the car, or on a bus or train………………………………………	0	1	2	3
26.	My child worries what other people think of him/her…..	0	1	2	3
27.	My child is afraid of being in crowded places (like Shopping centres, the movies, buses, busy playgrounds).	0	1	2	3
28.	All of a sudden my child feels really scared for no reason at all…………………………………………….	0	1	2	3
29.	My child is scared of insects or spiders…………………	0	1	2	3
30.	My child complains of suddenly becoming dizzy or faint when there is no reason for this……………………	0	1	2	3
31.	My child feels afraid when s(he) has to talk in front of the class…………………………………………………	0	1	2	3
32.	My child complains of his/her heart suddenly starting to beat too quickly for no reason……………………….	0	1	2	3
33.	My child worries that s(he) will suddenly get a scared feeling when there is nothing to be afraid of ……………	0	1	2	3
34.	My child is afraid of being in small closed spaces, like tunnels or small rooms…………………………………..	0	1	2	3
35.	My child has to do some things over and over again (like washing his/her hands, cleaning, or putting things in a certain order)…………………………………	0	1	2	3
36.	My child gets bothered by bad or silly thoughts or pictures in his/her head…………………………………..	0	1	2	3
37.	My child has to do certain things in just the right way to stop bad things from happening……………………….	0	1	2	3
38.	My child would feel scared if s(he) had to stay away from home overnight……………………………………	0	1	2	3

© 2000 Susan H. Spence

CAMP

The next statements refer to how children sometimes react to things that make them scared or worried. Please circle the number that shows how often your child reacts this way when s/he is around the main things that make him/her feel scared or worried. Think about how your child reacts in general to things that cause him/her fear, not just to unusual or infrequent things. Use this scale:

0 = Never, almost never, or not an issue **1 = Sometimes** **2 = Often** **3 = Almost Always**

When my child is faced with something that makes him/her feel scared or worried (like those listed on the first page)…

1. s/he tries to get away from it…..…………………………..…..0 1 2 3
2. s/he asks if s/he can do it later………………………….…….. 0 1 2 3
3. s/he tries not to go places where it is…………………….…..... 0 1 2 3
4. s/he asks me to take care of it for him/her …………………… 0 1 2 3
5. s/he tells me s/he wants to stay away from it…..……….………0 1 2 3
6. s/he tries to avoid it……………………………………….…… 0 1 2 3
7. s/he asks if s/he can do something else……………………….0 1 2 3
8. s/he says s/he will not be able to handle it……………….….0 1 2 3

CSDSP

Please circle the **number** indicating how much your child's symptoms are currently interfering with various areas of life:

The symptoms have disrupted <u>your child's</u> **schooling**:

0 1 2 3 4 5 6 7 8 9 10

Not at all Mildly Moderately Markedly Extremely

The symptoms have disrupted <u>your child's</u> **social life**:

0 1 2 3 4 5 6 7 8 9 10

Not at all Mildly Moderately Markedly Extremely

The symptoms have disrupted <u>your</u> **work**:

0 1 2 3 4 5 6 7 8 9 10

Not at all Mildly Moderately Markedly Extremely

The symptoms have disrupted <u>your</u> **social life**:

0 1 2 3 4 5 6 7 8 9 10

Not at all Mildly Moderately Markedly Extremely

The symptoms have disrupted <u>your family's</u> **home life**:

0 1 2 3 4 5 6 7 8 9 10

Not at all Mildly Moderately Markedly Extremely