

# 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"/>

**NEXT PAGE** ➔

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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, Marlene Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

# PHQ-9 modified for Adolescents (PHQ-A)

Name: \_\_\_\_\_ Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed?  Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

Yes                       No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all       Somewhat difficult       Very difficult       Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

Yes                       No

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?

Yes                       No

**\*\*If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.**

Office use only

PHQ-9 (A)

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child  was on medication  was not on medication  not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

**Explain/Comments:****For Office Use Only**

Total Symptom Score for questions 1–18: \_\_\_\_\_

Average Performance Score for questions 19–26: \_\_\_\_\_

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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