

Patient Health Questionnaire (PHQ-9)

Patient Name: _____

Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked off any problem on this questionnaire so far, 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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 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 - 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.*

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SCARED Rating Scale Scoring Aide

Use with Parent and Child Versions

Question	Somatic	Generalized Anxiety	Separation	Social	School Avoidance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
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33					
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35					
36					
37					
38					
39					
40					
41					
Total	Cutoff = 7	Cutoff = 9	Cutoff = 5	Cutoff = 8	Cutoff = 3

0 = not true or hardly true
 1 = somewhat true or sometimes true
 2 = very true or often true

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.

Total anxiety ≥ 25