SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)

CHILD FORM (8 years and older*)

Name: ______________________________ Date: ________________

Identification #: ____________________

Below is a list of items that describe how people feel. For each item that describes you, please circle the **2** if the item is **very true or often true** of you. Circle the **1** if the item is **somewhat or sometimes true** of you. If the item is **not true** of you, please circle the **0**. Please answer all items as well as you can, even if some do not seem to concern you.

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.	0 1 2
2	I get headaches when I am at school.	0 1 2
3	I don't like to be with people I don't know well.	0 1 2
4	I get scared if I sleep away from home.	0 1 2
5	I worry about other people liking me.	0 1 2
6	When I get frightened, I feel like passing out.	0 1 2
7	I am nervous.	0 1 2
8	I follow my mother or father wherever they go.	0 1 2
9	People tell me that I look nervous.	0 1 2
10	I feel nervous with people I don't know well.	0 1 2
11	I get stomach aches at school.	0 1 2
12	When I get frightened, I feel like I am going crazy.	0 1 2
13	I worry about sleeping alone.	0 1 2
14	I worry about being as good as other kids.	0 1 2
15	When I get frightened, I feel like things are not real.	0 1 2
16	I have nightmares about something bad happening to my parents.	0 1 2
17	I worry about going to school.	0 1 2

PLEASE COMPLETE THE NEXT PAGE