

# How are things?

Date: / / **20**

Time:   h   m

Please put a circle around the word that shows how often each of these things happen to your child. There are no right or wrong answers.

		0	1	2	3
1	When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
2	My child suddenly feels as if he/she can't breathe when there is no reason for this	Never	Sometimes	Often	Always
3	When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
4	My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
5	When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
6	All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
7	My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
8	My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
9	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always

Relationship to child/ young person (tick below):

Mother

Father

Other (please specify):

.....

NHS ID:

.....

Service allocated  
case ID

.....

SUM:

