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	My child feels afraid of being alone at home	Never	Sometimes	Often	Always
2	My child worries about being away from me	Never	Sometimes	Often	Always
3	My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
4	My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
5	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
6	My child worries when in bed at night	Never	Sometimes	Often	Always
7	My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always

Relationship to child/ young person (tick below):

Mother ○

Father ○

Other (please specify): ....

SUM:

NHS ID: ....

Service allocated case ID ....

Questions © 2003 Bruce F. Chorpita, Ph.D