

**DEPRESSION SYMPTOMS  
ASSESSMENT QUESTIONNAIRE –  
RCADS-P-MDD**

**Version for parents or caregivers of children and  
adolescents aged 3 to 17 years old**

Patient's last name		File number	
Patient's first name			
Health insurance number		Exp.	Year    Month
Date of birth	Year    Month    Day	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Address (no., street)		<input type="checkbox"/> X	
City		Postal Code	

Caregiver	Last name	First name
School Grade *		

\* 3rd grade of elementary school to 1st year of Cegep or college

► **How often do each of these things happen to your child?**

1. Answer each item based on the last month or the period of time since your child's last appointment.
2. Use the scale at the top of the table.
3. Answer each item by checking the box that represents your child's situation the best.

Items	Never	Sometimes	Often	Always
	0	1	2	3
1. My child feels sad or empty.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Nothing is much fun for my child anymore.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. My child has trouble sleeping.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. My child has problems with his (her) appetite.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. My child has no energy for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. My child is tired a lot.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. My child cannot think clearly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. My child feels worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. My child feels like he (she) doesn't want to move.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. My child feels restless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

*Revised Children's Anxiety and Depression Scale - Parent version – Major Depression Disorder Subscale - RCADS-P-MDD © 2003 Bruce F. Chorpita*

<b>Questionnaire completed by:</b>	<b>Date :</b>
Signature	Year    Month    Day

Patient's last name	Patient's first name	File number
---------------------	----------------------	-------------

**Section reserved for the practitioner**

Total raw score.....

Total number of items ..... x

Number of answered items (≥ 8)\* ..... /

Adjusted score ..... =

Score T \*\* ..... =

Is the T score greater than the clinical cut-off value of 65? .....  Yes  No

Practitioner's analysis and commentary:


- \* If 3 or more answers are missing, the score of the subscale cannot be used.
- \*\* For parents of children and adolescents aged 8 to 17 years old, use the conversion table to identify the T score of the subscale according to the patient's sex and school grade, in addition to the parent's raw score. Only the raw score can be used for children aged between 3 to 7 years old and patients aged 18 years and over.

Questionnaire reviewed by:				Date:		
Practitioner's last name	Practitioner's first name	Licence number	Signature	Year	Month	Day