

**PANIC DISORDER SYMPTOMS
ASSESSMENT QUESTIONNAIRE –
RCADS-P-PD**

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. When my child has a problem, he (she) gets a funny feeling in his (her) stomach.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. My child suddenly feels as if he (she) can't breathe when there is no reason for this.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. When my child has a problem, his (her) heart beats really fast.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. My child suddenly starts to tremble or shake when there is no reason for this.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. When my child has a problem, he (she) feels shaky.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. All of a sudden my child will feel really scared for no reason at all.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. My child suddenly becomes dizzy or faint when there is no reason for this.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. My child's heart suddenly starts to beat too quickly for no reason.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. My child worries that he (she) will suddenly get a scared feeling when there is nothing to be afraid of.	<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 – Panic Disorder Subscale - RCADS-P-PD © 2003
Bruce F. Chorpita

Questionnaire completed by:	Date :
Signature	Year Month Day

Patient's last name	Patient's first name	File number
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Section reserved for the practitioner

Total raw score.....

Total number of items x

Number of answered items (≥ 7)* /

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