Santé
et Services sociaux
Québec

Patient's last name	File number
Patient's first name	
Health insurance number	Exp. Year / Month
Date of birth: Year / Month / Day	Sex: ☐ M ☐ F ☐ X
Address (no., street)	
City	Postal Code

Caregiver	Last name	First name
School Grade *		

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

ANXIETY AND DEPRESSION SYMPTOMS ASSESSMENT QUESTIONNAIRE – RCADS-P-25

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

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 0	Sometimes 1	Often 2	Always 3
1. My child feels sad or empty.	☐ 0	☐ 1	☐ 2	☐ 3
2. My child worries when he (she) thinks he (she) has done poorly at something.	☐ 0	☐ 1	☐ 2	☐ 3
3. My child feels afraid of being alone at home.	☐ 0	☐ 1	☐ 2	☐ 3
4. Nothing is much fun for my child anymore.	☐ 0	☐ 1	☐ 2	☐ 3
5. My child worries that something awful will happen to someone in the family.	☐ 0	☐ 1	☐ 2	☐ 3
6. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds).	☐ 0	☐ 1	☐ 2	☐ 3
7. My child worries what other people think of him (her).	☐ 0	☐ 1	☐ 2	☐ 3
8. My child has trouble sleeping.	☐ 0	☐ 1	☐ 2	☐ 3
9. My child feels scared to sleep on his (her) own.	☐ 0	☐ 1	☐ 2	☐ 3
10. My child has problems with his (her) appetite.	☐ 0	☐ 1	☐ 2	☐ 3
11. My child suddenly becomes dizzy or faint when there is no reason for this.	☐ 0	☐ 1	☐ 2	☐ 3

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

Items	Never 0	Sometimes 1	Often 2	Always 3
12. My child has to do some things over and over again (like wahing hands, cleaning, or putting things in a certain order).	☐ 0	☐ 1	☐ 2	☐ 3
13. My child has no energy for things.	☐ 0	☐ 1	☐ 2	☐ 3
14. My child suddenly starts to tremble or shake when there is no reason for this.	☐ 0	☐ 1	☐ 2	☐ 3
15. My child cannot think clearly.	☐ 0	☐ 1	☐ 2	☐ 3
16. My child feels worthless.	☐ 0	☐ 1	☐ 2	☐ 3
17. My child has to think of special thoughts (like numbers or words) to stop bad things from happening.	☐ 0	☐ 1	☐ 2	☐ 3
18. My child thinks about death.	☐ 0	☐ 1	☐ 2	☐ 3
19. My child feels like he (she) doesn't want to move.	☐ 0	☐ 1	☐ 2	☐ 3
20. My child worries that he (she) will suddenly get a scared feeling when there is nothing to be afraid of.	☐ 0	☐ 1	☐ 2	☐ 3
21. My child is tired a lot.	☐ 0	☐ 1	☐ 2	☐ 3
22. My child feels afraid that he (she) will make a fool of him (herself) in front of people.	☐ 0	☐ 1	☐ 2	☐ 3
23. My child has to do some things in just the right way to stop bad things from happening.	☐ 0	☐ 1	☐ 2	☐ 3
24. My child feels restless.	☐ 0	☐ 1	☐ 2	☐ 3
25. My child worries that something bad will happen to him (her).	☐ 0	☐ 1	☐ 2	☐ 3

Revised Children's Anxiety and Depression Scale – *Short parent version* – *RCADS-P-25* © 2003 Bruce F. Chorpita

Questionnaire completed by:	**Date :**		
Signature	Year	Month	Day

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

Section reserved for the practitioner

A. Raw score for depression symptoms (items: 1,4,8,10,13,15,16,19,21,24) ……….		☐
B. Number of depression symptom items …………………………………………………	**x**	**10**
C. Number of answered depression symptom items (≥ 8)* ……………………..……….	**/**	☐
D. Adjusted depression symptom score ……………………….………………………	**=**	☐
E. Depression symptom T Score ** …………………………………..........................	**=**	☐
F. Is the T score greater than the clinical cut-off value of 65? …………………..…...		☐ Yes ☐ No
G. Total raw score for anxiety symptoms (items: 2,3,5,6,7,9,11,12,14,17,18,20, 22,23,25) …………………………………………………………………………………		☐
H. Total number of anxiety symptom items …………………………..………..………	**x**	**15**
I. Total number of answered anxiety symptom items (≥ 13)* ……………………..…..	**/**	☐
J. Adjusted total anxiety symptom score ………………………………………………	**=**	☐
K. Total anxiety symptom T Score ** …………………………………....................	**=**	☐
L. Is the total T score greater than the clinical cut-off value of 65? …………………...		☐ Yes ☐ No
M. Total raw score for anxiety and depression symptoms (lines: A and G) ……….….		☐
N. Total number of anxiety and depression symptom items ……………………….….	**x**	**25**
O. Total number of answered anxiety and depression symptom items (≥ 21) †…….	**/**	☐
P. Adjusted total anxiety and depression symptom score ……………………….….	**=**	☐
Q. Total anxiety and depression symptom T Score ** ………………………………	**=**	☐
R. Is the total T score greater than the clinical cut-off value of 65? ………..………..		☐ Yes ☐ No

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

Section reserved for the practitioner

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 scores according to the patient's sex and school grade, in addition to the parent's raw scores. Only the raw scores can be used for children aged between 3 to 7 years old and patients aged 18 years and over.

† If 5 or more answers are missing or if one of the two subscales has 3 or more missing answers, then the total anxiety and depression score cannot be used.

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