ANXIETY EVALUATION FORM- DSM-IV

Patient's name: _____ Date: _____

A1. Does your child have excessive anxiety or worry about certain events or activities (such as attending school or school performance)? _____

A2. Does this worry occur more days than not? _____

A3. Has your child been anxious or worried for longer than 6 months? _____
For how long if less than six months? _____

B. Does your child find it difficult to control their worry? _____

C. Is your child's anxiety or worry associated with any of the following?
(Please mark all that apply)

____ restlessness or feeling keyed up or on edge
____ being easily fatigued
____ difficulty concentrating or mind going blank
____ irritability
____ muscle tension
____ sleep disturbance (difficulty staying asleep, or restless unsatisfying sleep)

D. Is your child's anxiety solely focused (excessive) around any of the following?
(Please mark one or any that apply)

____ worried about having a panic attack
____ worried about being embarrassed in public
____ worried about being contaminated by germs
____ worried about being away from home or close relatives
____ worried about gaining weight
____ worried about having a serious illness
____ worried about a traumatic experience in their life

D2. Does your child have multiple physical complaints? _____

E. Does your child's anxiety, worry, or physical symptoms cause significant impairment in his or her social, occupational, or school functioning? _____

_____

F. Does your child take any medications? _____

F1. Does you child use illegal drugs or alcohol or do you suspect this? _____

F2. Does your child have any medical conditions (e.g., hyperthyroidism)? (Please list)

_____

F3. Does you child have any Developmental Disorders? (Please list) _____