San Francisco Group *for* Evidence-Based Psychotherapy
Intake Questionnaire

Parent/Guardian: Please complete the following questions as they apply to your child

Name of parent/guardian completing this form:_____

Address: _____

Phone: (Home) _____ (Work) _____

(Other, please specify) _____

Email: _____

Emergency Contact: (Name) _____(Phone) _____(Relationship) _____

Child's name: _____

Is this child: ☐ Your biological child ☐ Adopted ☐ Foster Child

Do you have legal custody of this child? ☐ Yes ☐ No

Child's Age: _____Child's Gender: _____Child's Date of birth: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other:_____

Religious background: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Muslim ☐ Buddhist ☐ No affiliation ☐ Other_____

Referred by _____Phone:_____

Please describe, briefly, the problem(s) for which you are seeking services for your child (e.g. symptoms, intensity, and frequency):_____

_____

_____

_____

_____

Have there ever been problems like this before? ☐ Yes ☐ No

If yes, when? _____

REIMBURSEMENT: If you would like us to send you a monthly statement which you can forward to your insurance company to request reimbursement, please indicate:

Monthly statement: ☐ Yes ☐ No

Please mail the monthly statement to the following address: ☐ Home ☐ Business ☐ Other

_____

_____

Names of persons living in your home and your child's relationship to them:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent(s)/Guardian(s):

Name: _____

Education (highest degree earned): _____

Occupation: _____Age:_____

Name: _____

Education (highest degree earned):_____

Occupation: _____Age:_____

Were parents ever separated? ☐ Yes ☐ No If yes, when? _____ Did parents get divorced? ☐ Yes ☐ No

If yes, when? _____Remarry? ☐ Yes ☐ No If yes, when? _____

Siblings:

Name	Age	Grade/ Occupation	Where does s/he live?
_____			
_____			
_____			
_____			

Is there any family history of physical, emotional, or behavioral problems? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

What school does your child currently attend?_____Grade:_____

Did your child ever leave a school s/he was enrolled in prior to completion or has your child repeated a grade? ☐ Yes ☐ No

If yes, give details: _____

_____

Did your child ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)?

☐ Yes ☐ No If yes, give details: _____

_____

Has your child ever experienced or witnessed any traumas (events that felt life-threatening)? ☐ Yes ☐ No

Has your child ever had a physical fight with anyone, including a family member (e.g. throwing things, hitting, shoving, etc.)?

☐ Yes ☐ No

Has your child experienced physical or sexual abuse or assaults? ☐ Yes ☐ No

Please provide some general information on your child's work history/extracurricular activities:

_____

_____

_____

Has your child ever received any psychiatric or psychological treatment? ☐ Yes ☐ No

If yes, what type of treatment did he/she receive and how long did the treatment last:

_____

_____

Who provided this treatment to your child?

Therapist's name(s), phone number(s) and address (es): _____

_____

_____

Has your child ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties?

☐ Yes ☐ No If yes, when and why? _____

Was the hospitalization voluntary? ☐ Yes ☐ No

Has your child ever received any medication for his/her mental or emotional difficulties? ☐ Yes ☐ No

If yes, what type of medication(s) did he/she take, at what dose, and for how long?

_____

_____

Has your child ever used any illicit drugs or taken medications other than as prescribed? (e.g. marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, prescribed drugs, Ecstasy and others) ☐ Yes ☐ No

If yes, please fill out the requested information:

Type	Frequency/amount	Duration	How taken

_____

_____

_____

If your child used any substances listed above, do you feel they have caused any problems in his/her work, school or relationships?

☐ Yes ☐ No

If yes, please explain: _____

_____

Does your child drink alcohol? ☐ Yes ☐ No

If so, do you feel his/her drinking has caused any problems in your child's work, school, or relationships?

☐ Yes ☐ No

If yes, please explain: _____

_____

Has treatment for drug or alcohol abuse ever been recommended or has your child been treated for this? ☐ Yes ☐ No

If yes, please describe the circumstances and give dates.

_____

_____

Does your child currently have, or has your child had in the past, any serious, chronic or recurrent health problems or disabilities?

☐ Yes ☐ No

If yes, please describe: _____

_____

List dates of any hospitalizations your child has had for physical problems:

Date Problem

_____

_____

_____

When was your child's last physical examination by a doctor? _____

What was the outcome? _____

Has your child experienced any particular sources of stress in the last year? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment? ☐ Yes ☐ No

If yes, please give details: _____

_____

_____

_____

Is there any other background information you think would be helpful for me to know? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____ _____

Parent/Guardian's Signature Date

San Francisco Group *for* Evidence-Based Psychotherapy
Treatment/Evaluation Agreement

This document contains important information about the professional services and business policies of Anya Ho, Ph.D. and the San Francisco Group for Evidence-Based Psychotherapy. Please read it carefully and discuss any questions you have with Dr. Ho.

ASSESSMENT AND TREATMENT: Dr. Ho will provide an assessment of your difficulties and available treatment options. If she recommends and you agree, she will provide a form of evidence-based psychotherapy (cognitive-behavioral therapy or dialectical behavior therapy, most commonly), which has been shown in controlled outcome studies to be effective for a number of problems and disorders. (Dr. Ho will review the outcome data most pertinent to your situation upon request.) However, no guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety; and it may result in changes that were not originally intended (such as remaining in a relationship or job you believed you would leave). There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your situation, Dr. Ho will offer, if you would like, an estimate of the number of sessions of treatment she recommends for you. For most patients, this ranges between 5 and 40 sessions. Dr. Ho's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to the treatment that Dr. Ho can provide are available, including other types of individual psychotherapy, group, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures can be helpful in some cases, and if Dr. Ho recommends this in your case, she will let you know what her recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Dr. Ho will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Dr. Ho is a psychologist licensed to practice in California (License # PSY 21704). She graduated from the Ohio State University with a Ph.D. in Clinical Psychology in 2004. She received postdoctoral training at Judge Baker Children's Center, Harvard Medical School and was a research fellow at Boston University's Center for Anxiety and Related Disorders. She teaches and supervises trainees at University of California San Francisco and is an Assistant Clinical Professor there.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Dr. Ho to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with Dr. Ho in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled Patient's Bill of Rights, adapted from a publication by the California Department of Consumer Affairs, is attached to the end of this document. Please read it carefully and raise with Dr. Ho any questions you have about it.

HOURS/AVAILABILITY: Dr. Ho is usually available in the office from 9 a.m. until 6 or 7 p.m. on Mondays, Tuesdays, Wednesdays, and Thursdays. Therapy sessions are usually scheduled as 50-55 minute sessions weekly, or as your treatment needs dictate and you and Dr. Ho agree. Dr. Ho returns phone calls and emails daily when she is not in session. She does not carry an emergency pager and cannot promise to be reachable during the night or over weekends; however, she will make efforts to be responsive to your needs. In a crisis, you can call 911, contact your primary care physician, the local emergency room, or crisis intervention services. When Dr. Ho is out of town, she will let you know and will give you the name and telephone number of another therapist who will be available if she has concerns that she will not be reachable while away.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Ho will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information about you will be released by Dr. Ho only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Dr. Ho's judgment, you are in danger of harming yourself or are unable to care for yourself.
- if you communicate to Dr. Ho a serious threat of physical violence against another person (at which point Dr. Ho is required by law to inform both potential victims and legal authorities).
- if Dr. Ho is ordered by a court to release information as part of a legal proceeding, or as otherwise required by law.
- for teenagers under age 18, most information is kept confidential from other family members. However, parents still have a right to know *general* information about psychotherapy (i.e., the therapist's general approach to treatment, whether therapy is progressing well). In most cases, a parent's consent is necessary for psychological services to be provided, and they need to have enough information to be able to make informed choices. If you or your parents have any questions about what would and would not be confidential, please feel free to ask – so that we can clarify the issue up front in a way that is agreeable to everyone.

In the event that group therapy services are provided, you are expected to keep materials shared in the group confidential. Dr. Ho cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Ho will provide you with a monthly statement you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Ho will include this information on your statement. Dr. Ho will generally send this statement to you directly. If for some reason you and Dr. Ho agree that she will communicate directly with your insurance company, please be aware that when information is sent to an insurance company, Dr. Ho has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Ho cannot assure that they will do so. Some share information with a national medical information data bank for the purposes of determining eligibility for life, disability, health, and other insurance. Before Dr. Ho sends any information to an insurance company, she will talk with you about what she has written and she will obtain your written permission to release the information. You do have a choice about whether to authorize the

release of information requested by an insurance company, but if you refuse to consent to releasing it, most insurance programs will not pay for services.
You and Dr. Ho may elect to communicate via e-mail. If you do, it is important to remember that if Dr. Ho is obtaining information only via e-mail, she is making clinical judgments on the basis of limited and imperfect information. She may not receive e-mail in a timely fashion, so if your communication is urgent, it may be best to also try the telephone. If you choose to correspond with Dr. Ho through e-mail, she will make every effort to keep the correspondence confidential, but she cannot guarantee the confidentiality of e-mail communications. If you communicate with Dr. Ho via e-mail, you agree to accept the risk that a breach of confidentiality may occur.

RECORD-KEEPING: Dr. Ho maintains a clinical chart for each patient. Information in the chart includes a description of your condition, your diagnosis, treatment goals, treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Ho also keeps records of any consent, release, assessment, or other forms completed in the course of your treatment. Clinical records are kept in a locked file cabinet and on a computer in Dr. Ho's office. The hard drive that includes the material from your clinical record is stored in a locked file cabinet when Dr. Ho is not in the office.

TAPING OF SESSIONS: It can occasionally be clinically useful to videotape or audiotape therapy sessions, but this will never be done without the knowledge and consent of all parties and an agreement about how the material will be used and kept secure.

CONSULTATION: Dr. Ho may wish to consult with other professionals, especially her colleagues at the San Francisco Group for Evidence-Based Psychotherapy, about treatment planning for your case. The consultation process is meant to benefit you by improving upon your treatment. Your signature below gives Dr. Ho permission to do this, provided that she takes reasonable efforts to protect your identity.

RESEARCH, WRITING, TEACHING: Dr. Ho and others at the San Francisco Group for Evidence-Based Psychotherapy may conduct research, training, and supervision, and write for professional and lay audiences. Your signature below gives Dr. Ho permission to use information about you and your treatment in any of these ways, provided that she takes reasonable efforts to protect your identity.

FEES: Dr. Ho's fee is $200 per 50-minute session. Longer or shorter sessions are generally pro-rated from this fee. If you meet with Dr. Ho on the telephone for a 50-55 minute session, you will be charged the standard session fee. Of course, there will be no charge for contacts made to schedule appointments, or other brief emails and phone interactions, but if you require substantial contact over email or telephone in between sessions, you may be charged for this time at the above (pro-rated) rate. If you request that Dr. Ho prepare paperwork for you (for example, a treatment summary for another source), she may bill for the time that this requires. She generally will not bill for time spent consulting with other current or previous treatment providers unless under unusual circumstances, as she considers this to be part of your treatment, but she may bill for time spent talking with parties whose counsel is believed to be peripheral to the treatment (for example, attorneys you may retain for purposes of outside litigation and with whom you request that she speak).

IF YOU ARE INVOLVED IN LITIGATION IN WHICH YOUR EMOTIONAL STATE OR PARTICIPATION IN THERAPY MAY BE RELEVANT: Dr. Ho prefers not to be involved in any litigation that you may participate in, even as a witness for emotional damages, because her participation in lawsuits can severely compromise your confidentiality, may inadvertently work

against your case, and is not believed to be therapeutic. Should her participation be required either by your side or by the opposing side, you will be responsible for reimbursing her at the forensic rate of $275/hour for all time spent in the legal process, including report-writing, consultation with attorneys, testifying, and travel. This will be true regardless of her exact assigned role within the process, whether it be fact witness, expert witness, percipient expert or treating expert, etc.

PAYMENT: Payment is due at the time of each session unless another arrangement has been made. Dr. Ho will provide you with a monthly statement if you request one.

CANCELLATIONS AND MISSED APPOINTMENTS: If an appointment is missed or cancelled without 48 hours notice, you will be charged for the session. Please be aware that insurance companies will not generally reimburse for a cancelled session. The cancellation policy is not meant to feel punitive, but is enforced out of a desire to be fair and consistent with all clients and to protect Dr. Ho's time, which she generally cannot use to help someone else without adequate notice.

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source.

ENDING TREATMENT: You may withdraw from treatment at any time. Dr. Ho recommends that you discuss your plan to terminate treatment with her before taking action, so that she has an opportunity to offer her recommendations and referral options if they are needed.

If you discontinue meeting with Dr. Ho for a period of four weeks or more without warning or without an agreement for "as needed" sessions, she will typically attempt to contact you. If she is unable to reach you, she will assume that you have elected to terminate your treatment and she will close your case. Of course, should you wish to resume your treatment, she will be happy to discuss that option with you at any time.

*****

I have read and understood this agreement and the Patient Bill of Rights and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print):
_____

Signature of patient:
_____Date_____

Name of parent/guardian (please print):
_____

Signature of parent/guardian:
_____Date_____

Patient Bill of Rights

You have the right to:

Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
Receive respectful treatment that will be helpful to you.
A safe environment, free from sexual, physical, and emotional abuse.
Ask questions about your therapy.
Refuse to answer any question or disclose any information you choose not to reveal.
Request that the therapist inform you of your progress.
Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
Refuse a particular type of treatment or end treatment without obligation or harassment.
Refuse electronic recording (but you may request it if you wish).
Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
Report unethical and illegal behavior by a therapist.
Receive a second opinion at any time about your therapy or therapist's methods.
Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.5.24.01

Date: _____ **Name/ID:** _____

RCADS

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things	Never	Sometimes	Often	Always
2. I feel sad or empty	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. Nothing is much fun anymore	Never	Sometimes	Often	Always
7. I feel scared when I have to take a test	Never	Sometimes	Often	Always
8. I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9. I worry about being away from my parents	Never	Sometimes	Often	Always
10. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11. I have trouble sleeping	Never	Sometimes	Often	Always
12. I worry that I will do badly at my school work . .	Never	Sometimes	Often	Always
13. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15. I have problems with my appetite	Never	Sometimes	Often	Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. I feel scared if I have to sleep on my own. . . .	Never	Sometimes	Often	Always
18. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19. I have no energy for things	Never	Sometimes	Often	Always
20. I worry I might look foolish	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I worry that bad things will happen to me	Never	Sometimes	Often	Always

23. I can't seem to get bad or silly thoughts out of my head.	Never	Sometimes	Often	Always
24. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25. I cannot think clearly	Never	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. I worry that something bad will happen to me . .	Never	Sometimes	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29. I feel worthless	Never	Sometimes	Often	Always
30. I worry about making mistakes	Never	Sometimes	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening. . .	Never	Sometimes	Often	Always
32. I worry what other people think of me	Never	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35. I worry about what is going to happen	Never	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. I think about death	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39. My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. I feel like I don’t want to move	Never	Sometimes	Often	Always
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. I worry when I go to bed at night	Never	Sometimes	Often	Always
46. I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47. I feel restless	Never	Sometimes	Often	Always

Date: _____ **RCADS-P**

Name/ID: _____ **Relationship to Child:** _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child feels sad or empty	Never	Sometimes	Often	Always
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
6. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7. My child feels scared when taking a test	Never	Sometimes	Often	Always
8. My child worries when he/she thinks someone is angry with him/her.	Never	Sometimes	Often	Always
9. My child worries about being away from me	Never	Sometimes	Often	Always
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11. My child has trouble sleeping	Never	Sometimes	Often	Always
12. My child worries about doing badly at school work	Never	Sometimes	Often	Always
13. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14. My child suddenly feels as if he/she can't breathe when there is no reason for this.	Never	Sometimes	Often	Always
15. My child has problems with his/her appetite	Never	Sometimes	Often	Always
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18. My child has trouble going to school in the mornings because of feeling nervous or afraid.	Never	Sometimes	Often	Always
19. My child has no energy for things	Never	Sometimes	Often	Always
20. My child worries about looking foolish	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23. My child can't seem to get bad or silly thoughts out of his/her head.	Never	Sometimes	Often	Always

24. When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25. My child cannot think clearly	Never	Sometimes	Often	Always
26. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28. When My child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29. My child feels worthless	Never	Sometimes	Often	Always
30. My child worries about making mistakes	Never	Sometimes	Often	Always
31. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. My child worries what other people think of him/her	Never	Sometimes	Often	Always
33. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35. My child worries about what is going to happen	Never	Sometimes	Often	Always
36. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. My child thinks about death	Never	Sometimes	Often	Always
38. My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39. My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. My child worries when in bed at night	Never	Sometimes	Often	Always
46. My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47. My child feels restless	Never	Sometimes	Often	Always