Pediatric Anxiety - Short Form

Please respond to each item by marking one box per row.

In the past 7 days…..

	Never	Almost Never	Sometimes	Often	Almost Always
I felt nervous.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I felt scared.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I felt worried.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I felt like something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I thought about scary things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I was afraid that I would make mistakes.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I worried about what could happen to me.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
I worried when I went to bed at night.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4