

**DEPRESSION SYMPTOMS
ASSESSMENT QUESTIONNAIRE –
RCADS-P-MDD**

**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.

	Never	Sometimes	Often	Always
Items	0	1	2	3
1. My child feels sad or empty.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Nothing is much fun for my child anymore.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. My child has trouble sleeping.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. My child has problems with his (her) appetite.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. My child has no energy for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. My child is tired a lot.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. My child cannot think clearly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. My child feels worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. My child feels like he (she) doesn't want to move.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. My child feels restless.	<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 – Major Depression Disorder Subscale - RCADS-P-MDD © 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	10
Number of answered items (≥ 8)* /	
Adjusted score =	
Score T ** =	
Is the T score greater than the clinical cut-off value of 65?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Practitioner's analysis and commentary:

* If 3 or more answers are missing, the score of the questionnaire 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