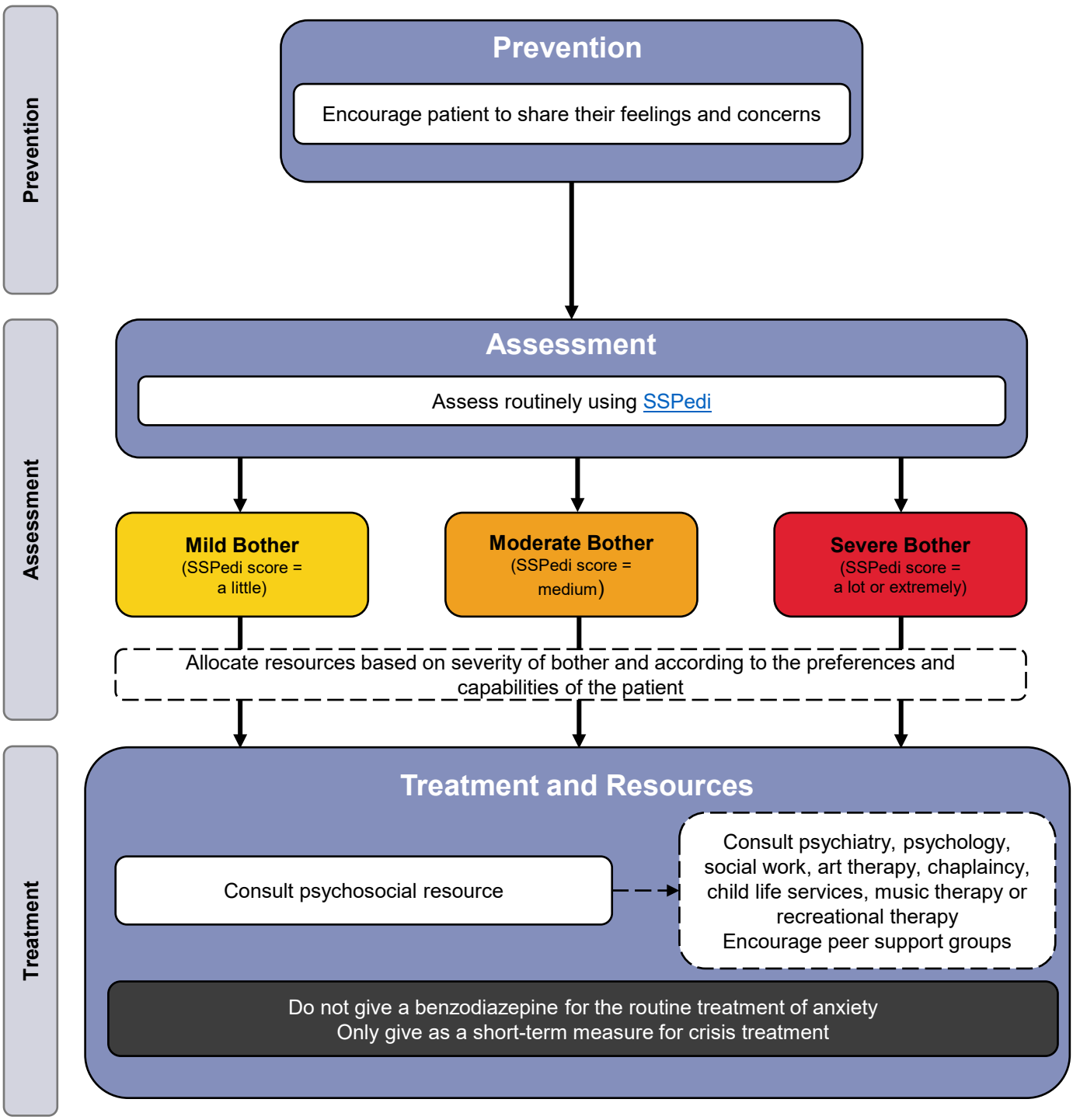
Anxiety Care Pathway



SSPedi: Symptom Screening in Pediatrics

Please tell us how much each of these things **bothered** you **yesterday or today** by ticking the circle that best describes the amount it bothered you:

	Not at all bothered	A little	Medium	A lot	Extremely bothered
Feeling disappointed or sad	○	○	○	○	○
Feeling scared or worried	○	○	○	○	○
Feeling cranky or angry	○	○	○	○	○
Problems with thinking or remembering things	○	○	○	○	○
Changes in how your body or face look	○	○	○	○	○
Feeling tired	○	○	○	○	○
Mouth sores	○	○	○	○	○
Headache	○	○	○	○	○
Hurt or pain (other than headache)	○	○	○	○	○
Tingly or numb hands or feet	○	○	○	○	○
Throwing up or feeling like you may throw up	○	○	○	○	○
Feeling more or less hungry than you usually do	○	○	○	○	○
Changes in taste	○	○	○	○	○
Constipation (hard to poop)	○	○	○	○	○
Diarrhea (watery, runny poop)	○	○	○	○	○

Please tell us about any other things that have bothered you lately by writing about them here.