

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

Version for children and adolescents
aged 8 to 18 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)			
City		Postal Code	

School Grade *	
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* 3rd grade of elementary school to 1st year of Cegep or college

► **How often do each of these things happen to you?**

1. Answer each item based on the last month or the period of time since your last appointment.
2. Use the scale at the top of the table.
3. Answer each item by checking the box that represents your situation the best.

Items	Never	Sometimes	Often	Always
	0	1	2	3
1. I feel sad or empty.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Nothing is much fun anymore.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. I have trouble sleeping.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. I have problems with my appetite.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. I have no energy for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. I am tired a lot.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. I cannot think clearly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. I feel worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. I feel like I don't want to move.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. I feel restless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Revised Children's Anxiety and Depression Scale –Major Depression Disorder Subscale - RCADS-MDD
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Patient's last name	Patient's first name	File number
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Questionnaire completed by:	Date :
Signature	Year Month Day

Section reserved for the practitioner	
Total raw score.....	<input type="text"/>
Total number of items x	<input type="text" value="10"/>
Number of answered items (≥ 8)* /	<input type="text"/>
Adjusted raw score =	<input type="text"/>
Score T ** =	<input type="text"/>
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:	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

* If 3 or more answers are missing, the score of the subscale cannot be used.

** Use the conversion table to identify the depression symptoms (MDD) T score according to the patient's sex, school grade and raw score. A T score cannot be determined for children below 3rd grade of elementary. Use adjusted raw score only.

Questionnaire reviewed by:				Date:		
Practitioner's last name	Practitioner's first name	Licence number	Signature	Year	Month	Day