Please complete this form and show it to your doctor or other healthcare professional.

Do you have Separation Anxiety Disorder?

1. Do you (or your child) experience recurrent, excessive distress when expecting to be away from home or from certain family members?  
   - YES  
   - NO

2. Do you (or your child) worry excessively and frequently about losing family members or about harm that could come to them?  
   - YES  
   - NO

3. Do you (or your child) worry excessively and frequently about getting lost, being kidnapped, or some other event that would cause separation from certain family members?  
   - YES  
   - NO

4. Do you (or your child) feel reluctant or unwilling to go to school or other places because of fear of separation from certain family members?  
   - YES  
   - NO

5. Are you (or your child) excessively and frequently fearful or reluctant to be alone or without certain family members, even at home?  
   - YES  
   - NO

6. Do you (or your child) frequently feel reluctant or unwilling to go to sleep without being near certain family members or to sleep away from home?  
   - YES  
   - NO

7. Do you (or your child) have repeated nightmares about being separated from home or certain family members?  
   - YES  
   - NO

8. Do you (or your child) frequently experience or complain of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when anticipating separation from home or certain family members?  
   - YES  
   - NO

9. Have these concerns lasted at least four weeks?  
   - YES  
   - NO

10. Did these concerns begin before the age of 18?  
    - YES  
    - NO

11. Do anxiety, worry, physical symptoms, or reluctance to be separated from certain family members cause you (or your child) to feel very distressed?  
    - YES  
    - NO

12. Do anxiety, worry, physical symptoms, or reluctance to be separated from certain family members cause significant impairment in your (or your child's) social life, school, work, or other important areas of functioning?  
    - YES  
    - NO
You or your child *might* have Separation Anxiety if all of the following are true:

- You answered YES to at least four of questions 1-8
- You answered YES to questions 9 and 10
- You answered YES to either question 11 or 12

Note: This questionnaire is for informational purposes only and is not intended to function as a psychological or psychiatric assessment. Diagnosis of psychiatric disorders requires a careful evaluation by a trained professional.

To get help for this condition or to receive a comprehensive assessment, please call The Institute of Living's Anxiety Disorders Center at (860) 545-7685.