**Telephone Screening Tool**

# ASPECT Screening checklist

ID ☐☐/☐☐☐

Date of screening assessment ☐☐☐☐☐☐☐☐ (d d m m y y y y)

Is your child between the ages of 7 and 16 years old (inclusive)? ☐ Yes ☐ No

Does your child have a fear or anxiety in the presence of a specific object or situation? ☐ Yes ☐ No

Please state the object or situation

PROMPT: Can you tell me more about the object or situation?

Does your child want to avoid that object or situation when they can? ☐ Yes ☐ No

Does this anxiety and avoidance affect your child's life?
(e.g. does it affect their sleep, school attendance, eating etc.) ☐ Yes ☐ No

Has this problem been present for 6 months or longer? ☐ Yes ☐ No