Participant number:
Assessment:
Date:

Diary 1

One component of this study is to provide the NHS with information about the costs of different treatments and the overall impact this has on the use of other health and social services, as well as medications, time off work and time off school for children. In order to do this we would like you to use this diary to record you and your child's use of such services, and treatments that you and your child have had.

This is a 'Diary' (or record) of your use of services, medications and time off work and school between now and your next assessment appointment, for any cause. It is for your use only, to fill in each time you come into contact with any of the health professionals or use any of the facilities listed over the page. We would also like you to keep a record of any prescription drugs and medications taken as well as days off work and school.

For example: If you or your child visits the GP surgery we would like you to **tick one of the circles** on the line 'Family Doctor (GP)'. One tick = one visit. If you are prescribed a drug then we would like to know the name of it and whether it is for you or your child.

This Diary covers the period from Study Entry to your next trial assessment. At your next assessment we will ask you about your 'resource use' during this time period. **Please remember to bring your diary along to this appointment so that you may use it to complete this questionnaire.**

We will give you new diaries every time a 'resource use' questionnaire has been completed so that you can use the diary to keep a record of your use of services ready to complete the next questionnaire.

N.B: Please **do not** include any appointments related to the study itself such as the therapy sessions.

Berkshire Child Anxiety Clinic

University of Reading

Berkshire Research Ethics reference number: 07/H0505/156-157-176
University of Reading Ethics reference number: 07/48-49-50
Version 1.4 (31.07.08)

Starting from when you entered the trial, should you or your child come into contact with any of the people/facilities listed below, please **tick** one of the circles.

	YOU: *If the contact/visit was* ***for yourself,*** *tick one of the circles in this section:*	**YOUR CHILD:** *If the contact/visit was* ***for your child,*** *tick one of the circles in this section:*
Family Doctor (GP)	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Social Worker	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Practice nurse	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Psychologist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Psychiatrist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Community Psychiatric Nurse	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Education Welfare Officer	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Educational Psychologist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Family Liaison Officer (School)	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Teacher (other than usual contact)	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Paediatrician (children's doctor)	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Audiology	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Speech and language	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Opthalmology	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Hospital A&E department	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Occupational Therapist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Paediatric Dietician	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Paediatric Physiotherapist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Paediatric Play Specialist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Family Therapist	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Community Children's Nurse	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Child & Adolescent Mental Health Nurse	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Primary Mental Health Worker	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Housing Department	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Citizens Advice Bureau	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Family centre	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Home-start	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Alcohol or drug counselling	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Other (please specify) * _ _ _ _ _ _ _ _ _ _ _	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍
Other (please specify) *_ _ _ _ _ _ _ _ _ _ _	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍	❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍

*** If you can only remember the name of the person you saw then please write the name down.**

Drug Treatments

In this following section we would like to know whether you or your child have been prescribed, or purchased, any drugs or medications. Please keep a record below of any drugs/medications and whether it was prescribed by your GP or purchased yourself:

Drug name	Prescription	Duration of Treatment	For yourself or your child *(circle)*
____________	Yes/No	____________________	Yourself/child
____________	Yes/No	____________________	Yourself/child
____________	Yes/No	____________________	Yourself/child
____________	Yes/No	____________________	Yourself/child

Time off work and School

Finally, we are interested in whether you have taken any time off work or your usual activities and whether you child has had to have days off school due to ill health.

If you **are** in paid employment please keep a record of the days off work you take due to you or your child's ill health:

Please tick one circle for every day you take off due to ill health: ❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍

If you are **not** in paid employment please keep a record of the days, if any, of your usual activities you have had to give up due to you or your child's ill health:

Please tick one circle for every day you take off your usual activities (e.g. child care, hobbies, shopping):

❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍

Your Child: Time off School

Please keep a record of the number of whole days your child has off school

❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍

Number of **half** days off school

❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍❍

Travel Costs

Finally, if you have incurred any travel expenses since your last assessment as a result of the treatment we have provided please enter the approximate amount:

Nb: Please don't divulge the number of treatment sessions you have received to your research assistants!

Your use of Health and Social Services in the last 8 weeks

SERVICES THAT YOU AND YOUR CHILD HAVE USED IN THE LAST 8 WEEKS

Have you or your child had any visits or visited any of the following services since you joined the study? If so, please write the number of visits for yourself or your child in the appropriate box. If you cannot remember the exact number of visits, don't worry, please just give your best guess. Please ignore any services that you have not used. If you have used the diary about your use of services we sent you at the beginning of the study then please use that to fill in the answers below. Please do not include any appointments related to the trial itself such as the CBT therapy sessions. Thank you.

Visits to/from	Yourself	Your Child
Example GP	*1*	*3*
Family Doctor (GP)		
Social Worker		
Practice nurse		
Psychologist		
Psychiatrist		
Community Psychiatric Nurse		
Education Welfare Officer		
Educational Psychologist		
Family Liaison Officer (School)		
Teacher (other than usual contact)		
Paediatrician (children's doctor)		
Obstetrician (woman's doctor)		
Audiology		
Speech and language		
Opthalmology		

Hospital A & E Department		
Occupational Therapist		
Paediatric Dietician		
Paediatric Physiotherapist		
Paediatric Play Specialist		
Family Therapist		
Community Children's Nurse		
Child & Adolescent Mental Health Nurse		
Housing Department		
Citizens Advice Bureau		
Family Centre		
Home-start		
Alcohol or drug counselling		
Other (Please specify)		

Drug treatments

In this following section we would like to know whether you or your child have been prescribed, or purchased, any drugs or medications in the last 8 weeks.

Please note the name of the drug/medication and whether it was prescribed by your GP or purchased yourself:

Drug name **Prescription** **Duration of treatment** **For yours**

____________ Yes/No _________________ Yourself/child

____________ Yes/No _________________ Yourself/child

____________ Yes/No _________________ Yourself/child

____________ Yes/No _________________ Yourself/child

Time off work and School

Finally, we are interested in whether you have taken any time off work or your usual activities and whether you child has had to have days off school due to ill health in the last 8 weeks.

Are you in paid employment? Yes/No *(circle)*

If yes, have you taken time off work in the last 8 weeks due to ill health? **Yes/No** *(circle)*
If yes, please state how many: [ ] **Days**

If you are not in paid employment please state the number of days, if any, of your usual activities (e.g. child care, hobbies, shopping) you have had to give up in the last 8 weeks due to ill health: [ ] **Days**

Time off school
Has your child had to have days off school in the last 8 weeks due to ill health? **Yes/No** *(circle)*
If yes, please state how many: [ ] **Days**

Travel costs
Finally, if you have incurred any travel expenses in the last 8weeks as a result of your CBT treatment please enter the approximate amount: [ ]

Thank you for completing this questionnaire. If you have any queries or concerns please do not hesitate to contact *** Tel:**