

Pediatrics PANS/PANDAS Screening Questionnaire

Patient Name	Date	

Please check the best response for each of the following questions as it pertains to you (or to your child). Your provider will discuss your answers with you.

Have you experienced (or has your child experienced) a sudden onset of	YES	NO
1. Urinary frequency, increased daytime "accidents", or new onset enuresis (involuntary urination)?		
2. Choreiform movements of hands (i.e., "piano playing" finger movements)?		
3. Sleep disturbances (e.g., difficulty falling asleep, night terrors, frequent waking)?		
4. Separation anxiety (e.g., at bedtime, at school, or not wanting to leave the parent's side)?		
5. Obsessive or compulsive behaviors, or Obsessive-Compulsive Disorder (OCD)?		
6. Tics or repetitive behaviors that are involuntary or difficult to control (e.g., eye blinking, shrugging shoulders, tapping, jerking or rolling the head, clearing the throat, sniffing or coughing in the absence of a cold/illness, etc.)?		
7. Changes in handwriting?		
8. Cognitive changes (e.g., abrupt change in grades, attention span, testing abilities, etc.)?		
9. Aggression (e.g., raging, self-injurious behaviors)?		
10. Disordered eating habits (e.g., abrupt onset of anorexia nervosa, bulimia nervosa, binge eating disorder, or eating disorder not otherwise specified)?		

Physician Scoring:

- Tally up the number of "Yes" responses.
- If the number of "Yes" responses is 0-1, PANS/PANDAS diagnosis is not likely.
- If the number of "Yes" responses is 2 or more, patient should be seen for possible throat and/or rectal strep swabs. Consider treatments for PANS/PANDAS.

