

### **What is it?**

It is the a questionnaire that assesses allergic rhinitis and asthma control in children between 6 and 12 years old.

Asthma and rhinitis are diseases of the airways that often coexist and the control of one affects the control of the other. Therefore, the simultaneous assessment of both diseases is recommended. To account for this need, the CARAT project ([www.caratnetwork.org](http://www.caratnetwork.org)) developed one version for adults, that is recommended by ARIA Initiative ([www.whiar.org](http://www.whiar.org)) from World Health Organization, and now developed this version for school-age children.

### **Terms of use**

The use of this questionnaire in clinical decisions is on the responsibility of the decision maker. Any patient treatment decisions should be based on sound clinical judgment in the context of any applicable institutional protocols. We do not provide any warranties or conditions of any kind.

CARAT© Kids use for individual purposes (e.g. supporting clinical assessment at a patient consultation) is free and does not requires any authorization. The use of the questionnaire by any research group, to aggregate data from different patients, requires a communication to the CARAT group. For-profit organizations or the use of the questionnaire with commercial/marketing purposes will require case-by-case authorization from the CARAT group.

It is expressly forbidden any change (layout, content or delivery format) unless approved by the authors.

More information in:

**[www.caratnetwork.org](http://www.caratnetwork.org)**

(To be filled out by the child)

Please mark with an  the answer that better describes the way you felt because of your allergic respiratory illness : asthma / rhinitis **during the last 2 weeks.**

Name: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Because of your allergic respiratory illness : asthma / rhinitis during the last 2 weeks



1. Have you had **stuffy nose**?

Yes  No



2. Have you **sneezed**?

Yes  No



3. Have you had **runny nose**?

Yes  No



4. Have you had **shortness of breath**?

Yes  No



5. Have you had a **high pitch sound in chest or wheezing**?

Yes  No



6. Have you had **cough**?

Yes  No



7. **During exercise or when you laugh**, have you had cough, wheezing or chest tightness?

Yes  No



8. Have you had **tiredness/difficulty in doing your activities** because of your allergic respiratory illness : asthma / rhinitis?

Yes  No

Addition of answers Yes

Now is time for parents! 

(To be filled out by the parents or guardian)

Please mark with an  the answer that better describes the your son /daughter felt because of the allergic respiratory illness : **asthma / rhinitis during the last 2 weeks.**

Name (son/daughter): \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Date: \_\_/\_\_/\_\_\_\_

During the last 2 weeks, has your son /daughter



**1. Had woke up in the middle of the night** because of the allergic respiratory illness : asthma / rhinitis?

Yes  No



**2. Had complaints / symptoms in the morning when he/she wakes up** because of the allergic respiratory illness : asthma / rhinitis?

Yes  No



**3. Had to miss school or other activities** because of the allergic respiratory illness : asthma / rhinitis?

Yes  No



**4. Had to use / increase the use of medicines because he / she was worse of** the allergic respiratory illness : asthma / rhinitis?

Yes  No



**5. Thad to go to the doctor** because he / she was worse of the allergic respiratory illness : asthma / rhinitis?

Yes  No

Addition of answers Ye  
(parents/guardian)

**Total**  
(child+parents)