

DEPARTMENT OF THE ARMY  
EVANS ARMY COMMUNITY HOSPITAL  
FORT CARSON, CO 80913

CHILD DEVELOPMENT QUESTIONNAIRE  
27 JULY 1999

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS AND  
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- 1. AUTHORITY:** Title 10, United States Code: Sections 133, 1071-87, 3012, 5031, and 8012; Title 5, United States Code. Section 301; and Executive Order 9397.
- 2. PRINCIPLE PURPOSE:** To provide a procedure to facilitate and document all health care needs.
- 3. ROUTINE USES:** To provide, plan and coordinate health care; aid in preventive health programs; compile statistical data; conduct research; teach; identify medical needs of family members for future assignment coordination; adjudicate claims and determine benefits; conduct authorized investigations; evaluate care rendered; refer patients or family units to other military and civilian health agencies; provide continuity of care; minimize duplication of effort and furnish accurate information to all health providers.
- 4. MANDATORY OR VOLUNTARY DISCLOSURE:** Disclosure is voluntary; however, failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care or social work providers. If the requested information is not furnished, comprehensive health care may not be possible, but care will not be denied. This all-inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical treatment purposes and will become a permanent part of your health care record.

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Under the provisions stated above, I hereby acknowledge that I have been advised of the foregoing and **authorize the release of any and all medical information relevant to this referral.** I understand that by **consenting to the evaluation** I agree to **permit my child's school and the medical providers to fully share all relevant medical and educational information regarding my child.** It is understood that progress notes, observation reports, provider and teacher impressions, medical diagnoses, and treatment recommendations will be sent to the child's parents, school and medical providers as appropriate.

\_\_\_\_\_,     /    /      
(Signature of Parent or Guardian)      (Date)

## DEMOGRAPHIC DATA

Today's Date \_\_\_\_\_ Referral Date \_\_\_\_\_  
Referral Source \_\_\_\_\_ Referral Reason \_\_\_\_\_

*Fill in all blanks. Write "NA" if information is "Not Applicable" to you.*

*If you have already given similar information, indicate the source and provide a copy to your provider.*

**Child's Name** \_\_\_\_\_ Nickname \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ Nationality / Race \_\_\_\_\_ Religion \_\_\_\_\_  
School Child Attends (or would attend if school age) \_\_\_\_\_ Grade \_\_\_\_\_  
Date arrived in Colorado \_\_\_/\_\_\_/\_\_\_ Date of next projected move/PCS \_\_\_/\_\_\_/\_\_\_  
Family Member Prefix (i.e.: 01=1st child) \_\_\_\_\_ Sponsor's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Child's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Health Care Plan \_\_\_\_\_  
Primary Medical Care Facility: \_\_\_\_\_ Primary Care Giver/Team \_\_\_\_\_  
Where are child's medical records maintained? \_\_\_\_\_  
Housing Area \_\_\_\_\_ Sponsor's Unit \_\_\_\_\_  
Home Address \_\_\_\_\_ Unit Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Telephone \_\_\_\_\_ Sponsor's Duty Phone \_\_\_\_\_  
Best Time to Call Home \_\_\_\_\_ Sponsor's FAX # \_\_\_\_\_  
E-mail address Work \_\_\_\_\_, Home \_\_\_\_\_

**Sponsor's Name** \_\_\_\_\_ Active Duty YES NO Rank \_\_\_\_\_  
DOB \_\_\_/\_\_\_/\_\_\_ Ethnic Background \_\_\_\_\_ Religion \_\_\_\_\_  
Service / Employer (AR, AF, DoD, etc.) \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Highest Completed School Level \_\_\_\_\_ Degree? \_\_\_\_\_  
Occupation/MOS \_\_\_\_\_  
Duty Station \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Active Duty YES NO Rank \_\_\_\_\_  
Spouse's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Service / Employer \_\_\_\_\_  
DOB \_\_\_/\_\_\_/\_\_\_ Ethnic Background \_\_\_\_\_ Religion \_\_\_\_\_  
Relationship to Child \_\_\_\_\_  
Highest Completed School Level \_\_\_\_\_ Degree? \_\_\_\_\_  
Occupation \_\_\_\_\_  
Duty/Work Station \_\_\_\_\_  
Duty/Work Phone \_\_\_\_\_ FAX Number \_\_\_\_\_  
E-mail Address Work \_\_\_\_\_, Home \_\_\_\_\_  
Mailing Address (if different from sponsor) \_\_\_\_\_

**Biological Parent** if other than above: Name \_\_\_\_\_ DOB/Age \_\_\_/\_\_\_/\_\_\_  
Address \_\_\_\_\_  
Ethnic Background \_\_\_\_\_ Religion \_\_\_\_\_  
Highest Level of School Completed \_\_\_\_\_ Occupation \_\_\_\_\_  
Does this parent have / use visitation rights? YES NO  
Current **marital status** of child's parents (circle one) :  
Married Divorced Separated Single Parent Widowed Living Together  
With whom does the child live? \_\_\_\_\_

## FAMILY MEMBERS

List all your children (including the child being evaluated) from oldest to youngest (living or dead):

<u>Child's Full Name</u>	<u>DOB/Age</u>	<u>School Grade</u>	<u>Health or developmental problems</u>
1. _____	____/____/____, ____	_____	_____
2. _____	____/____/____, ____	_____	_____
3. _____	____/____/____, ____	_____	_____
4. _____	____/____/____, ____	_____	_____
5. _____	____/____/____, ____	_____	_____

Continue on back of last sheet if needed.

Is your child adopted?    YES    NO                      Foster Child?    YES    NO  
 At age? \_\_\_\_\_                                      Since? \_\_\_\_/\_\_\_\_/\_\_\_\_

Other people living in your home? Yes No    Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_

## FAMILY HISTORY

Please indicate with Xs on the chart below if there is a family history of any of the indicated problems.

<u>CONDITION</u>	<u>Child's Mother</u>	<u>Child's Father</u>	<u>Sibling (Who?)</u>	<u>Other (Who?)</u>
Visual Problems	_____	_____	_____	_____
Hearing Problems	_____	_____	_____	_____
Speech problems	_____	_____	_____	_____
Psychiatric Disorders	_____	_____	_____	_____
Mental Retardation	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____
Genetic Diseases	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____
Trouble learning to read (i.e. dyslexia)	_____	_____	_____	_____
Trouble with arithmetic	_____	_____	_____	_____
Trouble spelling	_____	_____	_____	_____
Penmanship difficulties	_____	_____	_____	_____
Behavior problems in childhood	_____	_____	_____	_____
In trouble as a teenager	_____	_____	_____	_____
Kept back in school/Poor grades	_____	_____	_____	_____
Coordination difficulties	_____	_____	_____	_____
Difficulty with right and left	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Seizures/Convulsions	_____	_____	_____	_____
Muscle Disease	_____	_____	_____	_____
Neurological Disease	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Kidney Disorders	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____

List Languages spoken in the home \_\_\_\_\_

## PRENATAL/PREGNANCY HISTORY

*(The following refers only to the child who is being evaluated.)*

Mother's age at the beginning of pregnancy? \_\_\_\_\_  
 Which pregnancy was this for you? \_\_\_\_\_ Was it planned? YES NO  
 Previous miscarriages, abortions, stillbirths? YES NO  
 If yes, please explain: \_\_\_\_\_

Did you take vitamins and iron tablets during pregnancy? YES NO UNSURE  
 Did you take folic acid during pregnancy? YES NO UNSURE  
 Did you take any other medications during pregnancy? YES NO UNSURE  
 If yes, please indicate the name and when you took it (i.e. 'over the counter', aspirin, pain medication, antibiotics, water pills, etc.): \_\_\_\_\_

Did you smoke cigarettes during pregnancy? YES NO  
 If yes, how many per day? \_\_\_\_\_  
 Did you drink alcohol during pregnancy? YES NO  
 If yes, how many drinks per day? \_\_\_\_\_  
 Did you use any other type of drug (i.e. street drugs)? YES NO  
 If yes, please describe: \_\_\_\_\_

What month did you first feel the baby move? \_\_\_\_\_ Was the movement (circle): Strong Mild Weak  
 During which month of the pregnancy did you start prenatal care? \_\_\_\_\_  
 Did any of the following occur during the pregnancy (Please circle all that apply):

urinary or kidney infections	fever	viral infections	morning sickness
vaginal bleeding	x-rays	special diet	threatened miscarriage
high blood pressure	toxemia	swelling	convulsions or seizures
Rh factor problem	asthma	accidents	surgical procedures
sugar or protein in urine	diabetes	heart problems	German measles (rubella)

Any other prenatal complications? YES NO  
 If yes, please explain: \_\_\_\_\_

How long was the labor? \_\_\_\_\_ How was the child delivered? \_\_\_\_\_  
 When was the baby born? (circle one): Overdue (over 40 weeks) FT (38-40 weeks) Premie \_\_\_ weeks  
 Were there any problems with the delivery for the mother? YES NO  
 If yes, please explain \_\_\_\_\_  
 Length of hospital stay? Mother \_\_\_\_\_ Infant \_\_\_\_\_

Birth weight: \_\_\_\_\_ Length: \_\_\_\_\_ Head Circumference: \_\_\_\_\_  
 APGAR Scores: 1 minute \_\_\_\_\_, 5 minutes \_\_\_\_\_, 10 minutes \_\_\_\_\_

At birth, did your child...?  

Breathe/Cry immediately	YES	NO	Require resuscitation	YES	NO
Appear blue	YES	NO	Appear jaundiced/yellow	YES	NO
Have low blood sugars	YES	NO	Have an infection	YES	NO
Have convulsions	YES	NO	Have a rash	YES	NO

Please check any procedures or treatments your child may have had:  
 \_\_\_ oxygen \_\_\_ fluids by IV \_\_\_ blood transfusions \_\_\_ breathing machine  
 \_\_\_ tube feeding \_\_\_ chest tube \_\_\_ antibiotics \_\_\_ medicines by breathing tube  
 \_\_\_ special lights for jaundice \_\_\_ incubator warming (more than 4 hours)  
 \_\_\_ other (please explain) \_\_\_\_\_

### INFANCY (First year of life)

Was your child breast fed?	YES	NO	How long? _____
Was your child formula fed?	YES	NO	How long? _____
If yes, which formula(s)? _____			When did you start cow's milk? ____ months
Have colic?	YES	NO	When/How long? _____
Food allergies?	YES	NO	To what? _____
Problems chewing/swallowing/feeding?	YES	NO	Describe: _____
Growth problems ?	YES	NO	Child's Weight at 12 months: _____
If yes, what was the concern? _____			
Child attached primarily to:	Mother	Father	Other (Who?) _____
Changes in care takers before age 3?	YES	NO	If yes, describe: _____

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### EARLY CHILDHOOD PROFILE (First three years of life)

Please note the age at which your child first demonstrated each developmental milestone:

	Age (Wk/Mo.)	Early <i>(CHECK appropriate line)</i>	Average	Late
Smiled responsively	_____	_____	_____	_____
Babbled	_____	_____	_____	_____
Sat up without help	_____	_____	_____	_____
Crawled	_____	_____	_____	_____
Pulled to a stand	_____	_____	_____	_____
Walked alone (10-15 steps)	_____	_____	_____	_____
Used fingers to feed self	_____	_____	_____	_____
Drank from a cup	_____	_____	_____	_____
Combined two words	_____	_____	_____	_____
Began eating solid foods	_____	_____	_____	_____
Bowel trained	_____	_____	_____	_____
Bladder trained	_____	_____	_____	_____
Bladder trained (during Night)	_____	_____	_____	_____
Used spoon to feed self	_____	_____	_____	_____
Could scribble	_____	_____	_____	_____
Could wash and dry hands	_____	_____	_____	_____
Could dress self	_____	_____	_____	_____
Could separate from mother easily	_____	_____	_____	_____
Spoke clearly	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____
Spoke in 2 or 3 word sentences	_____	_____	_____	_____
Could recognize 3 or 4 colors	_____	_____	_____	_____
Rode tricycle	_____	_____	_____	_____

Compared with children of the same age, does/did your child have any trouble with:

Having his / her speech understood?	YES	NO
Understanding others' speech?	YES	NO
Responding to his / her name?	YES	NO
Hearing?	YES	NO
Please explain any "YES" answers _____		
_____		
_____		



**MEDICAL HISTORY OF CHILD (cont'd)**

Has your child had a medical exam recently? YES NO When? \_\_\_\_\_ Where? \_\_\_\_\_

Has your child had psychological / psychiatric / social work treatment / counseling? \_\_\_\_\_

YES NO When? \_\_\_\_\_ Where? \_\_\_\_\_

If YES, why? \_\_\_\_\_

Please indicate any serious or significant medical illnesses or problems below by circling the appropriate condition(s), writing in the age of child at occurrence of condition:

<u>Condition</u>	<u>- Age</u>	<u>Condition</u>	<u>- Age</u>	<u>Condition</u>	<u>- Age</u>
frequent ear infections		Frequent colds		Pneumonia	
frequent ear fluids		Recurrent sore throats		Bronchitis	
Arthritis		Low blood count/anemia		Asthma/wheezing	
joint problems		Fevers		Chronic cough	
muscle problems		Headaches		Frequent vomiting	
seizures/convulsions		Head trauma / concussion		Chronic diarrhea	
tremors		Loss of consciousness		Constipation	
tingling in hands/feet		Dizziness		Eating non-food items	
paralysis		Fainting		Slow weight gain	
weakness		Encephalitis		Chronic skin problems	
awkwardness		Meningitis		bad reaction to medicine	
unusual walk		Eye problems		Allergies	
limp		Hearing problems		Poisonings	
drooling		Dental problems		Accidents	
heart disease		Frequent nosebleeds		Excessive bleeding	
kidney disease		German measles (3 day)		Whooping cough	
thyroid disease		Regular measles (7 day)		Scarlet fever	
lymph gland problems		Baby measles (roseola)		Chicken pox	
genital problems				Mumps	

Please explain any condition circled above, or any not mentioned: \_\_\_\_\_

**SCHOOL DATA**

Child's age entering kindergarten? \_\_\_\_\_ Child's age entering first grade? \_\_\_\_\_

What was your child's first reaction to school? \_\_\_\_\_

Complete School History (reflecting any grade readjustment / changes of school):

<u>GRADE(S)</u>	<u>DATE(S) ATTENDED</u>	<u>SCHOOL NAME / LOCATION</u>
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

What's your child's reaction to school now? \_\_\_\_\_

**SCHOOL DATA (cont'd)**

Has your child repeated any grades? YES NO: Grade(s) repeated: \_\_\_\_\_  
What kind of grades is your child currently getting? \_\_\_\_\_  
Name of child's teacher \_\_\_\_\_ Name of school counselor \_\_\_\_\_

Does your child have difficulty in school? *(Circle any that apply)*  
Reading Spelling Math Speech / Language Handwriting  
Attention Difficulties Fighting Relating to adults /other children

Ages of children your child enjoys playing with? \_\_\_ younger \_\_\_ same \_\_\_ older  
What activity(ies) does your child enjoy the most? \_\_\_\_\_  
What activity(ies) does your child dislike the most? \_\_\_\_\_

Has your child suffered emotional / physical trauma? YES NO  
If YES, explain: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever been on an Individualized Family Service Plan (IFSP)? YES NO (yes, provide copy)  
Has your child ever been on an Individual Education Plan (IEP)? YES NO (yes, provide copy)  
Is your child currently on an IEP? YES NO  
Does he /she attend any special education? YES NO  
Does he /she receive any type of school therapy? YES NO  
If yes, explain, which subject(s)? \_\_\_\_\_  
Special educator/teacher's name \_\_\_\_\_  
Please describe any problems your child is having or has had at school with subjects, teachers, and peers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT CONCERNS**

**BEHAVIOR (Please circle answer which describes your child)**

Angers easily	YES	NO
Has difficulties falling asleep	YES	NO
Has difficulties staying asleep	YES	NO
Frequently sad	YES	NO
Frequently soils underwear	YES	NO
Frequently wets bed/pants	YES	NO
Sucks thumb or objects	YES	NO
Has frequent physical complaints	YES	NO
Shy	YES	NO
Has temper tantrums	YES	NO
Can't tolerate changes in routine	YES	NO
Has difficulty making or keeping friends	YES	NO
Moody	YES	NO
Uses peculiar or bizarre speech	YES	NO
Cries easily	YES	NO
Has unusual fears or nightmares	YES	NO
Is destructive	YES	NO
Lacks self confidence	YES	NO
Often disliked by other children	YES	NO
Often gets into trouble	YES	NO

### **CURRENT CONCERNS (cont'd)**

Has difficulties sitting through a meal	YES	NO
Is easily distracted	YES	NO
Stares and daydreams often	YES	NO
Is easily frustrated	YES	NO
Is difficult to discipline	YES	NO
Has nervous habits or tics	YES	NO
Is a "loner"	YES	NO
Reacts strangely to affection	YES	NO
Is cruel to animals	YES	NO
Awakens before everyone in the morning	YES	NO

### **MOTOR**

Trips or falls frequently	YES	NO
Has difficulties climbing	YES	NO
Walks/runs slowly	YES	NO
Has difficulties with coordination	YES	NO
Dislikes physical activity	YES	NO
Switches hands when playing ball or writing	YES	NO
Fatigues easily	YES	NO
Has fear of movement (afraid on playground)	YES	NO

### **SPEECH AND LANGUAGE**

Has difficulty pronouncing words	YES	NO
Cannot follow spoken instructions well	YES	NO
Speaks in incomplete sentences or thoughts	YES	NO
Speech is difficult to understand	YES	NO
Stutters	YES	NO

### **SELF-HELP**

Needs help dressing or undressing	YES	NO
Unable to tie shoes	YES	NO
Dislikes certain clothing or tags	YES	NO
Is a messy eater	YES	NO
Is disorganized	YES	NO

### **EDUCATION**

Has difficulties with reading	YES	NO
Has difficulties in math	YES	NO
Has difficulties spelling	YES	NO
Has a poor memory	YES	NO
Has difficulties with writing	YES	NO
Has repeated a grade	YES	NO
Has received special education	YES	NO



**SUMMARY (cont'd)**

4. Please list anything not covered in this questionnaire pertinent to your child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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The following questions relate to the parent's social / family / medical history and upbringing. Your input will assist providers in planning appropriate, comprehensive, medical and/or educational interventions for your child. It is well known that family support issues are vital to the development of a child's care plan. If you find any of the questions irrelevant, confusing, or an invasion of privacy, leave them blank and discuss with your provider. Thank you for taking the time to help us help your child.

**YOU AND YOUR UPBRINGING:**

(Spouse - see second page)

Where do you work? \_\_\_\_\_  
What do you do for fun? \_\_\_\_\_  
Describe how your relationship/marriage is going? \_\_\_\_\_  
How do you discipline your children? \_\_\_\_\_

How well do the adults in your household function as a parenting team? \_\_\_\_\_  
How would you describe your childhood? \_\_\_\_\_

Did you have problems similar to what your child is experiencing? \_\_\_\_\_

Circle all that apply to you:

- |                     |                        |                   |
|---------------------|------------------------|-------------------|
| Friendship problems | Disliked school        | Loss of parent(s) |
| Verbal abuse        | Inadequate supervision | Harsh discipline  |
| Sexual abuse        | Physical abuse         | Emotional abuse   |
| Family conflict     | Poverty                | OTHER:            |

Explain circled items: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your parents' relationship (i.e., warm, distant, affectionate, conflicted, other):  
\_\_\_\_\_  
\_\_\_\_\_

How were you disciplined when you were growing up? \_\_\_\_\_  
Do you have any emotional problems? \_\_\_\_\_  
Have you ever been treated for these problems? \_\_\_\_\_  
Do you have a history of drug or alcohol abuse?      YES NO      If YES, describe: \_\_\_\_\_

Describe any family history of mental illness, emotional problems, drug / alcohol abuse, criminal behavior, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SPOUSE/PARTNER’S UPBRINGING:**

Where do you work? \_\_\_\_\_

What do you do for fun? \_\_\_\_\_

Describe how your relationship/marraige is going? \_\_\_\_\_

How do you discipline your children? \_\_\_\_\_

How well do the adults in your household function as a parenting team? \_\_\_\_\_

How would you describe your childhood? \_\_\_\_\_

Did you have problems similar to what your child is experiencing? \_\_\_\_\_

Circle all that apply to you:

Friendship problems

Disliked school

Loss of parent(s)

Verbal abuse

Inadequate supervision

Harsh discipline

Sexual abuse

Physical abuse

Emotional abuse

Family conflict

Poverty

OTHER:

Explain circled items: \_\_\_\_\_

Describe your parents’ relationship (i.e., warm, distant, affectionate, conflicted, other):

How were you disciplined when you were growing up? \_\_\_\_\_

Do you have any emotional problems? \_\_\_\_\_

If so, have you ever been treated for these problems? \_\_\_\_\_

Do you have a history of drug or alcohol abuse? YES NO Describe: \_\_\_\_\_

Describe any family history of mental illness, emotional problems, and drug / alcohol abuse, criminal behavior, etc.: \_\_\_\_\_

Thank you for your help in evaluating your child by filling out this form.

We advise you keep a copy for future use so it doesn’t have to be done again!

Today's date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Parent's Phone Number: \_\_\_\_\_

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

**Is this evaluation based on a time when the child**  **was on medication**  **was not on medication**  **not sure?**

**SYMPTOMS**

	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 1-9:</b> _____				
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his/her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 10-18:</b> _____				
<b>Total Symptom Score for question #'s 1-18:</b> _____				
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 19-26:</b> _____				
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3

**-Please Turn Over-**

Today's date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

	Never	Occasionally	Often	Very Often
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 27-40: \_\_\_\_\_

41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 41-47: \_\_\_\_\_

<b>PERFORMANCE</b>	<b>Excellent</b>	<b>Above Average</b>	<b>Average</b>	<b>Somewhat of a Problem</b>	<b>Problematic</b>
48. Overall School Performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (e.g., teams)	1	2	3	4	5
Total number of questions scored "4" or "5" in question #'s 48-55: _____					
Average Performance Score: _____					

**COMMENTS:**

Today's date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Parent's Phone Number: \_\_\_\_\_

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past **6 months**.

**Is this evaluation based on a time when the child**  **was on medication**  **was not on medication**  **not sure?**

**SYMPTOMS**

	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 1-9:</b> _____				
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his/her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 10-18:</b> _____				
<b>Total Symptom Score for question #'s 1-18:</b> _____				
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
<b>Total number of questions scored "2" or "3" in question #'s 19-26:</b> _____				
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3

**-Please Turn Over-**

Today's date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

	Never	Occasionally	Often	Very Often
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 27-40: \_\_\_\_\_

41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 41-47: \_\_\_\_\_

<b>PERFORMANCE</b>	<b>Excellent</b>	<b>Above Average</b>	<b>Average</b>	<b>Somewhat of a Problem</b>	<b>Problematic</b>
48. Overall School Performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (e.g., teams)	1	2	3	4	5
Total number of questions scored "4" or "5" in question #'s 48-55: _____					
Average Performance Score: _____					

**COMMENTS:**