CHILD AND ADOLESCENT BEHAVIORAL HEALTH CENTER
BACKGROUND QUESTIONNAIRE C# _____

Child's name: _____Child's preferred name: _____

Today's date: _____ Birthdate: _____ Age: _____

Sex assigned at birth: □ Male □ Female □ Intersex Social Security #: _____

Gender Identity: □ Male □ Female □ Non Binary □ Other: _____

Child's preferred pronouns: □ he/him □ she/her □ they/them □ Other: _____

Primary Guardian Name:_____ Relationship to child: _____

Primary home address: _____

_____

Guardian home phone: _____

Guardian cell: _____

Guardian E-Mail: _____

Secondary Guardian Name:_____ Relationship to child: _____

Secondary home address: _____

_____

Secondary Guardian home phone: _____

Secondary Guardian cell: _____

Secondary Guardian E-Mail: _____

Person filling out this form: □ Mother □ Father □ Stepmother □ Stepfather □ Both together
□ Caregiver □ Other (please explain): _____

Please return to: 425 Robinson Street Binghamton NY 13904 Or email to: OMH.365.GBHC.Open-Access-Referral@omh.ny.gov Or fax to: 607-773-4527 Questions? Please call: 607-773-4520	**Must be present for initial screening appointment:** -Legal Guardian -Child -Custody paperwork – if appropriate

HISTORY OF SERVICES/CURRENT SERVICES

Who referred you to this clinic? _____

Why did they refer you to this clinic? _____

Primary Care Physician:_____Phone:_____

Address:_____City:_____Zip Code:_____

Are you **currently** receiving mental health services? □ Yes □ No
If yes, name:_____

Are you currently **applying** for mental health services elsewhere? □ Yes □ No
If yes, name: _____

Has the child received evaluation or treatment for the current problem or similar problems? □ Yes □ No

If yes, please provide the following information (Please use a separate sheet of paper if there are more services):

Type of Service	Dates of Services	Reason/Frequency	Name of Agency and Provider/Phone
Mental Health – Private or Clinic			
Mental Health – Private or Clinic			
Mental Health – Private or Clinic			
Drug and Alcohol			
DSS/CPS Involvement			
SPOA			
CPEP visits			
Assessments/Evaluations			
School Counselor/Social Worker			
PINS/Probation			
Community Providers (Catholic Charities, Elmcrest, Children's Home, etc.)			
Medical Specialist			

LEGAL INVOLVEMENT AND HISTORY

Type of Legal Involvement	**Reason for Involvement/Charges**	**Status/Outcome**	**Comment (**Term, if known; Contact Person and Number)
□ None □ Criminal Court □ Family Court □Treatment/Specialty Court □ Other:		□ PINS Diversion □ PINS Probation Supervision (has been to court) □ Adjudicated Juvenile Delinquent or Offender □ DSS Custody/Placement □ OCFS Custody/Placement □ Jail □ Family Court Order □ Other:	
□ Child Protective Services (CPS)		□ Past □ Current If current: □ Investigation □ Indicated/Founded	

PRESENTING PROBLEM/MENTAL HEALTH HISTORY

Please check all that apply to your child:

□ Feelings of sadness
□ Tearfulness
□ Feelings of emptiness
□ Feelings of hopelessness
□ Angry outbursts/often and easily loses temper
□ Irritability
□ Frustration, even over small matters
□ Loss of interest or pleasure in most or all normal activities
□ Trouble falling asleep
□ Waking up frequently and not being able to fall back asleep easily
□ Sleeping too much
□ Tiredness and lack of energy, so even small tasks take extra effort
□ Reduced appetite and weight loss
□ Increased cravings for food and weight gain
□ Agitation
□ Restlessness
□ Slowed thinking
□ Slowed speaking
□ Slowed body movements
□ Feelings of worthlessness or guilt
□ Fixating on past failures or self-blame
□ Trouble thinking, concentrating, making decisions
□ Difficulty remembering things
□ Frequent or recurrent thoughts of death/suicidal thoughts
□ Suicide attempt(s) * see section below
□ Self-harm behavior(s) * see section below
□ Unexplained physical problems, such as back pain or headaches, stomach aches
□ Feeling nervous, restless, or tense
□ Sense of impending danger, panic, or doom
□ Increased heart rate
□ Breathing rapidly (hyperventilation)
□ Sweating
□ Trembling
□ Feeling weak or tired
□ Trouble concentrating or thinking about anything other than the present worry
□ Decreased participation in liked/preferred activities
□ Experiencing gastrointestinal (GI) problems
□ Difficulty controlling worry
□ Urge to avoid things that trigger anxiety/worry

□ Fail to pay close attention to details or make careless mistakes in schoolwork
□ Trouble staying focused in tasks or play
□ Appear not to listen, even when spoken to directly
□ Difficulty following through on instructions and fail to finish schoolwork or chores
□ Trouble organizing tasks and activities
□ Avoid or dislike tasks that require focused mental effort, such as homework
□ Lose items needed for tasks or activities, for example, toys, school assignments, pencils
□ Be easily distracted
□ Forget to do some daily activities, such as forgetting to do chores
□ Fidget with or tap hands or feet, or squirm in the seat
□ Difficulty staying seated in the classroom or in other situations
□ Be on the go, in constant motion
□ Run around or climb in situations when it's not appropriate
□ Trouble playing or doing an activity quietly
□ Talk too much
□ Blurt out answers, interrupting the questioner
□ Difficulty waiting/taking turns
□ Interrupt or intrude on others' conversations, games, or activities
□ Is frequently touchy and easily annoyed by others
□ Often argues with adults or people in authority
□ Often actively defies or refuses to follow adults' requests or rules
□ Often annoys or upsets people on purpose
□ Often blames others for their own mistakes or misbehavior
□ Says mean and hateful things when upset
□ Tries to hurt the feelings of others and seeks revenge, also called being vindictive
□ Shown vindictive behavior at least twice in the past six months
□ Bullying or threatening behavior
□ Physical aggression
□ Cruelty toward people
□ Cruelty towards animals
□ Fire-setting
□ Breaking curfew
□ Truancy from home or school
□ Trespassing
□ Lying
□ Cheating
□ Stealing
□ Vandalism
□ Emotionally or physically abusive behaviors (such as wielding a deadly weapon or forcing sex)
□ Enuresis (peeing) (daytime or nighttime)
□ Encopresis (pooping) (daytime or nighttime)
□ Sensory issues: food, clothes, textures, sounds, tastes (circle those that apply)
□ Auditory Hallucinations
□ Visual Hallucinations
□ Sexually acting out behaviors
□ Running away for more than 24 hours
□ Issues with personal hygiene
□ Other: _____

How long has this problem been of concern to you? □ Couple weeks □ One month
□ 2-3 months □ 4-5 months □ 6-7 months □ 8-9 months □ 10-11 months
□ 1 year □ Greater than 1 year.

SUICIDE/SELF-HARM HISTORY

Has the child ever talked about having thoughts of suicide? □ Yes □ No If yes, please describe, include time frames/when: _____

_____

Has the child ever talked about a suicide plan? □ Yes □ No If yes, please describe plan and include time frames/when: _____

_____

Has the child ever tried to kill themself? □ Yes □ No If yes, please describe and include time frames/when: _____

_____

Does the child have a history of self-injurious behavior (i.e. cutting/burning)? □ Yes □ No If yes, please describe methods and include time frames/when: _____

_____

VIOLENCE HISTORY

Has the child had recent thoughts/intentions or an actual plan to hurt others? □ Yes □ No If yes, please describe plan and include time frames/when: _____

_____

Does the child have a history of threatening/attempting or actually hurting others? □ Yes □ No If yes, please describe plan and include time frames/when: _____

_____

Does the child have any current and/or recent thoughts or behaviors that appear to be threatening? □ Yes □ No If yes, please describe: _____

_____

Has the child had recent/historical thoughts/intentions or an actual plan to hurt animals? □ Yes □ No If yes, please describe plan and include time frames/when: _____

_____

Has the child had recent/historical thoughts/intentions or an actual plan to start fires? □ Yes □ No If yes, please describe plan and include time frames/when: _____

_____

Are there guns/weapons present in the home? □ Yes □ No If yes, please describe how they are stored/accessed: _____

_____

ALCOHOL/SUBSTANCE USE/ABUSE

The child has used the following substances (check all that apply):

□ None
□ Alcohol
□ Alprazolam (Xanax)
□ Barbiturate
□ Benzodiazepine (Klonopin)
□ Buprenorphine
□ Catapres (Clonidine)
□ Cocaine
□ Crack
□ Ecstasy
□ Ephedrine
□ Elavil
□ GHB
□ Heroin
□ Inhalant
□ Ketamine
□ Khat
□ Marijuana/Hashish
□ Methamphetamine
□ Methadone (non-prescription- i.e., suboxone)
□ Over the Counter Drugs
□ OxyContin
□ PCP
□ Rohypnol (Roofies)
□ Tobacco/Nicotine
□ Other Amphetamines
□ Other Hallucinogen
□ Other Sedative/Hypnotic
□ Other Stimulant
□ Other Tranquilizer
□ Other: _____

If anything other than none is checked for alcohol/substances used:

Child's Age at First Use: _____
Child's Frequency of Substance Use:
□ No use in last 30 days □ 1-3 times last 30 days □ 1-2 times per week □ 3-6 times per week □ daily

Date last used: Month: _____ /Year: _____
Primary Route of Administration: □ Inhalation □ Oral □ Smoking □ Injection
□ Other: _____

Negative impact of substance use on life areas (check all that apply and explain how):

□ School/Work
□ Interpersonal/Family Relationships
□ Usual Peer Group/Friends and/or Environments
□ Mental Health (include emotional/behavioral factors)
□ Legal
□ Medical/Physical
□ Housing
□ Other: _____

If yes, how have these areas been affected?

_____

DEVELOPMENTAL/MEDICAL HISTORY

During pregnancy, did/was the mother

Receive prenatal care? □ Yes □ No

Smoke? □ Yes □ No

Drink alcoholic beverages? □ Yes □ No

Use drugs (including prescription, over-the-counter, and recreational)? □ Yes □ No

Exposed to any x-rays or chemicals? □ Yes □ No

Exposed to any infectious disease? □ Yes □ No

If yes to any of the above, please specify:

_____

Was delivery induced? □ Yes □ No

Were forceps used during delivery? □ Yes □ No

Was a Caesarean section performed? □ Yes □ No If yes, □ scheduled □ emergency

Was the child premature? □ Yes □ No If yes, by how many weeks? _____

What was the child's birth weight? _____ Were there any birth defects or complications? □ Yes □ No

Did the child meet developmental milestones (i.e., rolling, crawling, walking, talking, potty training) within the normal time frames? □ Yes □ No
If not, please specify: _____

Did the child ever receive services from the Early Intervention Program (birth to three years old)?
□ Yes □ No If yes, which services did they receive? □ OT □ PT □ Speech □ Education

Did the child ever receive services from OPWDD? □ Yes □ No
If yes, which services did they receive? _____

Has the child ever been evaluated for an Autism Spectrum Disorder? □ Yes □ No
If yes, who did the evaluation and what were the results of the evaluation? _____
_____

Does the child have any medical diagnoses (i.e., diabetes, epilepsy, etc.)? _____
_____

Has the child had any surgeries (i.e., tubes, appendix, dental, etc.)? _____
_____

Does the child see any specialists (i.e., GI, neurology, etc.) If yes, who and for what: _____
_____

Has the child ever had a concussion, TBI, head injury? If yes, how and when: _____
_____

Has the child been diagnosed with a genetic condition? If yes, how and when: _____
_____

Current medications (prescribed and over the counter):

Medication Name	Dosage/Frequency	Reason for Taking	Prescribed by:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:

Allergies/Adverse Reaction to or Non-effective Medications:

Medication Name	Response to Medication	Reason for Taking	Prescribed by:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:
			□ OTC □ Prescriber:

Other Allergies (i.e., seasonal, insects, food, etc.):

Allergy to:	Response/Reaction	Other (i.e., treatment, etc.)

FAMILY HISTORY/COMPOSITION

Mother's name: _____ Age: ____ Education: _____

Occupation: _____ Home Phone: _____ Cell: _____

Father's name: _____ Age: ____ Education: _____

Occupation: _____ Home Phone: _____ Cell: _____

Stepparent's name: _____ Age: ____ Education: _____

Occupation: _____ Home Phone: _____ Cell: _____

Stepparent's name: _____ Age: _____ Education: _____

Occupation: _____ Home Phone: _____ Cell: _____

Marital status of parents: □ Married □ Separated □ Divorced
□ Never Married, Together □ Never Married, Not Together □ Other: _____

If separated or divorced, how old was the child when the separation occurred? _____
Disagreements over Custody or Visitation: □Yes □ No If yes, describe: _____

Who has legal custody of the child? _____
How often does the child see their other parent? _____

If remarried, how old was the child when the stepparent entered into the family? _____

List all the people living in the household(s) – identify which household if there is more than one (also add any other siblings living out of the household that have a relationship with the child):

Name	Relationship to Child	Age	Occupation

(cont.) **Name**	**Relationship to Child**	**Age**	**Occupation**

Does the child have difficulty getting along with the following:
Siblings □ Yes □ No If yes, explain: _____

Parents □ Yes □ No If yes, explain: _____

Was the child adopted? □ Yes □ No If yes, at what age? _____
Does the child know? □ Yes □ No

Is there any family history of the following? (If yes, please specify who/relation to child)

Serious Medical/Physical problems:
□ Diabetes □ Heart Problems □ Cancer □ Seizures □ Thyroid
□ HIV/AIDS □ High Blood Pressure □ Tuberculosis □ Blood disease □ Other: _____

Mental Illness/Psychiatric problems:
□ Depression □ Anxiety □ Schizophrenia □ ADHD
□ Personality Disorders □ Problems with Alcohol □ Problems with Drug Abuse
□ Bipolar □ Other: _____

TRAUMA HISTORY

Has your child experienced any of the following:

□ **Serious Accidental Injury**: Have you ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed? Have you ever seen a bad accident where someone was badly hurt or killed?
□ **Illness/Medical Trauma**: Have you even been so sick that you and your parents (or people taking care of you) were scared that you might die? Did you have a medical treatment that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared that they might die?
□ **Community Violence**: Did you ever see a bad fight or shooting in your neighborhood, like between gangs? Were you afraid of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?
□ **Domestic Violence**: Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?
□ **School Violence/Emergency**: Were you ever at school when something really scary happened, like a shooting, a stabbing, a fire, where you or someone got badly beaten up or someone attempted or committed suicide?
□ **Physical Assault**: Have you ever been badly physically hurt (punched, kicked, stabbed, shaken) by someone outside of your family or who has not taken care of you? Have you ever been badly hurt (punched, kicked, stabbed) by someone outside of your family, like someone in your neighborhood or a stranger?
□ **Disaster**: Have you even been in a natural disaster, like a hurricane, tornado, earthquake, flood or wildfire where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed? Have you been in a place where there was a chemical spill or explosion?
□ **Sexual Abuse**: Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?
□ **Physical Abuse**: Have you ever been badly hurt (punched, kicked, stabbed, shaken) by someone who is in your family or was taking care of you? Have you seen another child in your family being badly physically hurt by a parent, caregiver or legal guardian?
□ **Neglect**: Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?
□ **Psychological Maltreatment/Emotional Abuse**: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to leave you or send you away? Were you often punished at home in ways that felt very unfair?
□ **Interference with Caregiving**: Was there ever a time when someone who was supposed to take care of you couldn't, like they were too sick, they were so sad they stayed in bed, or they had a drinking or drug problem?
□ **Sexual Assault**: Did someone outside your family ever force you to do something sexual? Did you ever see someone else being forced to do something sexual?
□ **Kidnapping/Abduction**: Have you ever been stolen or kidnapped (taken somewhere against your will) by someone without the permission of your parent or legal guardian?
□ **Terrorism**: Were you ever there when a terrorist attack happened, like a bombing, chemical attack or where people were taken hostage?
□ **Bereavement**: Has someone really close to you ever died?

□ **Separation:** Were you ever separated for a long time from someone you depend on, like a parent went to jail or was hospitalized, or you were placed in foster care?
□ **War/Political Violence**: Have you lived in a country where a war or armed conflict was happening (like soldiers or armed groups were fighting)? Did you see people who had been badly hurt or killed in a war or armed conflict?
□ **Forced Displacement**: Have you ever been forced to move out of your house due to war, armed conflict or disaster, like having to move to a trailer or refugee camp?
□ **Trafficking/Sexual Exploitation**: Have you ever done sexual things for money, food, clothes or protection? Were you ever sold to someone to work for them? Have you been forced into prostitution or pornography?
□ **Bullying**: Has someone your age or a student at your school ever bullied you, like kept calling you dirty names, making sexual comments, threatening to beat you up or spreading mean rumors around school or online?
□ **Attempted Suicide**: Have you ever tried to kill yourself?
□ **Witnessed Suicide**: Have you ever seen someone after they attempted or committed suicide?

ETHNIC/CULTURAL BACKGROUND

Primary language spoken in the home: _____
Preferred language for discussing healthcare: _____

Race: (Select all that apply)
□ Alaska Native
□ American Indian
□ Asian
□ Black or African American
□ Hawaiian or other Pacific Islander
□ White
□ Other
*(Specify):*_____
_____

Hispanic Origin (Select one):
□ Not of Hispanic Origin
□ Hispanic, Not specified
□ Cuban
□ Mexican
□ Puerto Rican
□ Other Hispanic

Was the child born in the United States? □ Yes □ No
If no, where were they born? _____
When did the child come to the United States? _____

Were both parents born in the United States? □ Yes □ No
If no, where were they born? _____
When did the parents come to the United States? _____

Please describe any specific ethnic/cultural practices observed in your family, including customs, traditions, food preferences, etc.

_____
_____
_____

EDUCATIONAL HISTORY

At what age did the child begin kindergarten? _____What is their current grade? _____

Is the child in a special education class? □ Yes □ No
If yes, what type of class? □ 6:1:1 □ 8:1:1 □ 12:1:1

Did the child receive services from the Committee of Preschool Special Education? □ Yes □ No

Does the child currently have and IEP or a 504 Plan (circle one)? □ Yes □ No
If yes, what is their Classification?
□ Emotionally Disturbed □ Learning Disabled □ Multiply Disabled
□ Other Health Impaired □ Other: _____

Has the child been held back in a grade? □ Yes □ No If yes, what grade and why? _____
_____

Has the child ever received special tutoring or therapy (Speech, OT, PT, RTI, AIS, etc.) in school?
□ Yes □ No If yes, please describe: _____

Has the child missed a lot of school? □ Yes □ No If yes, please indicate reason(s): _____
_____

Has the child been suspended or expelled from school? □ Yes □ No If yes, please indicate reason(s):
_____

Where has the child attended school?

	School District	**School Building**	**Program (Regular or Special Education)**
Preschool/Headstart			
K – 5			
6 – 8			
9 – 12			

What does your child want to do or be when they are older?
_____

Does the child have a job? □ Yes □ No
If yes, □ Full Time: _____ □ Part Time: _____

INTERPERSONAL RELATIONSHIPS/SOCIAL FUNCTIONING

Does the child have **difficulty** getting along with the following: (if yes, please explain)
Other children their own age □ Yes □ No If yes, explain: _____
Other Adults □ Yes □ No If yes, explain: _____
Pets □ Yes □ No If yes, explain: _____

Approximately how many friends does the child have? _____
Do they spend time with them outside of school? □ Yes □ No
Are their friends □ the same age □ tend to be younger □ tend to be older
Are their friends □ a positive support for them □ a negative influence

Has the child expressed any concerns or questions related to their sexual identity or orientation?
□ Yes □ No If yes, explain:_____

Has your child been involved in dating relationships? □ Yes □ No

To your knowledge, has the child engaged in sexual activity? □ Yes □ No

LEISURE INTERESTS/ SUPPORTS

Please list any **Meaningful/Extracurricular Activities** that the child participates in (e.g., Community Involvement, Volunteer work, Clubs, Scouts, Sports, Music, Art, Recreation, reading, games, crafts, etc.):

_____
_____

What are the child's favorite activities?

1. _____ 2. _____ 3. _____

What activities would your child like to engage in more often than they do at present?

1. _____ 2. _____ 3. _____

What activities do they like least?

1. _____ 2. _____ 3. _____

What chores does the child do around the house? _____

What time does the child usually go to bed on weekdays? _____ On weekends? _____

Which disciplinary techniques are usually **effective**? □ Yelling □ Talking □ Time Out □ Take electronics □ Grounding □ Extra chores/work □ Take toys □ Redirection □ Help Problem Solve □ Spanking □ Other: _____

Which disciplinary techniques **do not** work for your child? □ Yelling □ Talking □ Time Out □ Take electronics □ Grounding □ Extra chores/work □ Take toys □ Redirection □ Help Problem Solve □ Spanking □ Other: _____

Who usually administers discipline? _____

What do you enjoy doing with the child? _____

_____

RELIGIOUS/SPIRITUAL BELIEFS AND PRACTICES

Do you belong to a church or religious organization? □ Yes □ No
Do you attend religious services regularly? □ Yes □ No If yes, where: _____
Does the child attend religious services? □ Yes □ No

What, if any, religious holidays/practices does your family observe?_____

_____

GOALS/PROBLEMS/STRENGTHS

Please list up to 3 treatment goals/outcomes that you and your child would like:

1. _____
2. _____
3. _____

Child's willingness to engage in therapy?

1	2	3	4	5	6	7
Not at all						100% wants to come

What are your child's assets or strengths? _____

What are your child's needs/problems? _____

Is there any other information that you think may help us in working with your child? _____

_____

_____

_____

_____

_____

_____ _____
Signature of Person Completing Form Date/Time

_____ _____
Print Name of Person Completing Form Relationship to Child

***Legal Guardian must be present for initial screening and intake appointments with the therapist and medication provider.**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Please have the child complete this:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Neary every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING: *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Please have the child complete this:

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Neary every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: **Total Score T____** = ____ + ____ + ____)

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**

	Symptoms	Never	Occasionally	Often	Very Often
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 or her turn	**0**	**1**	**2**	**3**
18	Interrupts or intrudes in on others' conversations and/or activities	**0**	**1**	**2**	**3**

	Symptoms	Never	Occasionally	Often	Very Often
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**

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

Today's Date: _____ Child's Name: _____
Date of Birth: _____

	Symptoms	Never	Occasionally	Often	Very Often
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**
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**

	Symptoms	Never	Occasionally	Often	Very Often
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 or 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**

	Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
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**

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9:
_____

Total number of questions scored 2 or 3 in questions 10–18:_____

Total Symptom Score for questions 1–18:
_____

Total number of questions scored 2 or 3 in questions 19–26:_____

Total number of questions scored 2 or 3 in questions 27–40:_____

Total number of questions scored 2 or 3 in questions 41–47:_____

Total number of questions scored 4 or 5 in questions 48–55:
_____

Average Performance Score:
_____