

Today's Date: _____ Child's Name: _____ DOB: _____

Parent's Name: _____ Phone #: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

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, pencils, assignments, 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
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
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

Child's Name: _____ Date of Birth: _____

Performance	Above		Average	Problem	Problematic
	Excellent	Average			
27. Reading	1	2	3	4	5
28. Writing	1	2	3	4	5
29. Mathematics	1	2	3	4	5
30. Relationships with parents	1	2	3	4	5
23. Relationships with siblings	1	2	3	4	5
24. Relationships with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?

- Headache
- Stomachache
- Change of appetite – explain below
- Trouble sleeping
- Irritability in the late morning, late afternoon or evening – explain below
- Socially withdrawn – decreased interaction with others
- Extreme sadness or unusual crying
- Dull, tired, listless behavior
- Tremors/feeling shaky
- Repetitive movements, tics, jerking, twitching, eye blinking – explain below
- Pocking at skin or fingers, nail biting, lip or cheek chewing – explain below
- Sees or hears things that aren't there

Are these side effects currently a problem?

None	Mild	Moderate	Severe
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

Explain/Comments:
