

# PARENT RATING FORMS

**This set of forms will allow me to evaluate your child in a more comprehensive manner. Please complete them and return them today or at your next appointment.**

## 1. FAMILY HISTORY QUESTIONNAIRE

Please inform me if any of this child's biological family members show any of the following types of problems. Place a check in each appropriate box. "Other" family member could include grandparents, aunts, and uncles.

Problem	Father	Mother	Sibling(s)	Other (who?)
Aggressiveness and defiance as a child				
Problems with impulse control and attention				
Learning disability				
Failed to graduate high school				
Mental retardation				
Bipolar Disorder (manic depression)				
Psychosis or Schizophrenia				
Depression lasting more than 2 weeks				
Anxiety problems that impair daily life				
Tics or Tourette's Disorder				
Alcohol abuse				
Drug abuse (other than alcohol)				
Antisocial behavior (theft, assaults, etc.)				
Arrests				
Physical abuse victim				
Sexual abuse victim				
Abuse/Domestic violence perpetrator				
Thyroid disorder				
Tobacco dependence				

Who has this child seen before for mental health evaluation or treatment?

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Please list any medications your child may have been prescribed for attention or behavior.

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## 2. ADHD-RS-IV PARENT REPORT

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Rater's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Rate this child on the following behaviors using the following scale:

- 0 = Not at all
- 1 = Just a little
- 2 = Pretty much true
- 3 = Often or very true

Rate since:     the past several years                       From age \_\_\_\_ to \_\_\_\_  
                    the last few weeks only                       the several weeks before medication  
                    Other \_\_\_\_\_

circle one		Office Use Only
1. 0 1 2 3	Often fails to give close attention to details, making careless errors	IN__ HI__
2. 0 1 2 3	Fidgets with hands or feet or squirms in seat	IN__ HI__
3. 0 1 2 3	Has difficulty sustaining attention to tasks or play activities	IN__ HI__
4. 0 1 2 3	Leaves seat in classroom or in other areas in which remaining seated is expected	IN__ HI__
5. 0 1 2 3	Does not seem to listen when spoken to directly	IN__ HI__
6. 0 1 2 3	Runs about or climbs excessively in situations in which it is inappropriate	IN__ HI__
7. 0 1 2 3	Does not follow through on instructions or fails to finish work	IN__ HI__
8. 0 1 2 3	Has difficulty playing or engaging in leisure activities quietly	IN__ HI__
9. 0 1 2 3	Has difficulty organizing tasks and activities	IN__ HI__
10. 0 1 2 3	Is "on the go" or acts as if "driven by a motor"	IN__ HI__
11. 0 1 2 3	Avoids tasks that require sustained mental effort (i.e., homework)	IN__ HI__
12. 0 1 2 3	Talks excessively	IN__ HI__
13. 0 1 2 3	Loses things necessary for tasks and activities	IN__ HI__
14. 0 1 2 3	Blurts out answers before questions have been completed	IN__ HI__
15. 0 1 2 3	Is easily distracted	IN__ HI__
16. 0 1 2 3	Has difficulty awaiting turn	IN__ HI__
17. 0 1 2 3	Is forgetful in daily activities	IN__ HI__
18. 0 1 2 3	Interrupts or intrudes on others	IN__ HI__

circle one

Yes No Not sure These problems were evident before age 7

Yes No Not sure These problems are evident in two or more settings (i.e., home, school, sports)

Yes No Not sure These have caused **clear and consistent** problems how the child relates socially, and to his/her progress in school

Office Use:    ADHD-RS \_\_\_\_    SS \_\_\_\_    DSM IA \_\_\_\_    DSM HI \_\_\_\_  
                   ADHD-RS Inattention \_\_\_\_ SS \_\_\_\_ ADHD-RS Impulsivity \_\_\_\_ SS \_\_\_\_

### 3. ODD-RS-IV PARENT REPORT

**Instructions:** Rate this child on the following behaviors using the following scale:

- 0 = Not at all
- 1 = Just a little
- 2 = Pretty much true
- 3 = Often or very true

circle one

Office Use Only

- |            |                                    |        |
|------------|------------------------------------|--------|
| 1. 0 1 2 3 | Loses temper easily                | ODD___ |
| 2. 0 1 2 3 | Argues with adults                 | ODD___ |
| 3. 0 1 2 3 | Actively defies rules and requests | ODD___ |
| 4. 0 1 2 3 | Blames others for his/her mistakes | ODD___ |
| 5. 0 1 2 3 | Deliberately annoys other people   | ODD___ |
| 6. 0 1 2 3 | Is touchy or easily annoyed        | ODD___ |
| 7. 0 1 2 3 | Is angry and resentful             | ODD___ |
| 8. 0 1 2 3 | Is spiteful or vindictive          | ODD___ |

circle one

- |                 |   |
|-----------------|---|
| Yes No Not Sure | For more than 6 months, this child has shown a consistent pattern of unusually stubborn, disobedient, and angry behavior toward adults. |
| Yes No Not Sure | These problems are evident in two or more settings (i.e., home, school, church, sports, etc.).  |
| Yes No Not Sure | These have caused <b>clear and consistent</b> problems how the child relates socially with parents, teachers, friends, etc.             |
| Yes No Not Sure | These have caused <b>clear and consistent</b> problems how the child performs at school (or daycare).                                   |
| Yes No Not Sure | These behaviors tend to occur more often with people the child knows well (i.e., parents and close relatives).                          |
| Yes No Not Sure | These problems seem to be more intense and frequent than other children the same age.   |

How much impairment do the behaviors cause in the child's ability to interact socially with others and meet the demands placed on them at home, school, etc.? (Circle one number)

No problem at all 1 2 3 4 5 6 7 8 9 10 Totally Devastating

Office Use Only: DSM-IV Symptoms \_\_\_/8 Total ODD \_\_\_\_\_

## 4. PHYSICAL SYMPTOMS RATING SCALE

**Instructions:** Does this child have problems with any of these symptoms or behaviors? If so, please indicate the severity of these problems.

Circle only one number beside each item. A 0 (zero) means you have not seen this problem during the past week, and a 9 (nine) means that you believe it to be *either* very serious or to occur very frequently.

If you circle "No" to a symptom, you do not need to rate it on the 0-9 scale.

	<b>Behavior/Symptom</b>	<b>A Problem?</b>		<b>If Yes, how severe?</b>									
		circle	one	mild	-----	serious							
1.	Insomnia or trouble sleeping	Yes	No	0	1	2	3	4	5	6	7	8	9
2.	Nightmares	Yes	No	0	1	2	3	4	5	6	7	8	9
3.	Stares a lot or daydreams	Yes	No	0	1	2	3	4	5	6	7	8	9
4.	Talks less than others	Yes	No	0	1	2	3	4	5	6	7	8	9
5.	Uninterested in others	Yes	No	0	1	2	3	4	5	6	7	8	9
6.	Unusual or strong body odor	Yes	No	0	1	2	3	4	5	6	7	8	9*
7.	Decreased appetite	Yes	No	0	1	2	3	4	5	6	7	8	9
8.	Irritability	Yes	No	0	1	2	3	4	5	6	7	8	9
9.	Stomachaches	Yes	No	0	1	2	3	4	5	6	7	8	9
10.	Headaches	Yes	No	0	1	2	3	4	5	6	7	8	9
11.	Drowsiness	Yes	No	0	1	2	3	4	5	6	7	8	9
12.	Overeating	Yes	No	0	1	2	3	4	5	6	7	8	9*
13.	Sad/unhappy	Yes	No	0	1	2	3	4	5	6	7	8	9
14.	Prone to crying	Yes	No	0	1	2	3	4	5	6	7	8	9
15.	Anxious	Yes	No	0	1	2	3	4	5	6	7	8	9
16.	Bites fingernails	Yes	No	0	1	2	3	4	5	6	7	8	9
17.	Euphoric/unusually happy	Yes	No	0	1	2	3	4	5	6	7	8	9
18.	Constipation	Yes	No	0	1	2	3	4	5	6	7	8	9*
19.	Dizziness	Yes	No	0	1	2	3	4	5	6	7	8	9
20.	Nervous tics or twitches	Yes	No	0	1	2	3	4	5	6	7	8	9

Office Use: Total: \_\_\_\_\_ Mean: \_\_\_\_\_