



ADVANCED PEDIATRIC ASSOCIATES

Hand in Hand for Healthy Kids

Greetings from the Providers at Advanced Pediatric Associates:

Attention Deficit Hyperactivity Disorder (ADHD) / Attention Deficit Disorder (ADD) is challenging for children, families, schools, and providers. ADHD is one of the most common chronic childhood disorders in the United States with more than 16 million (9.4%) children diagnosed.

When managed appropriately, medication and regularly scheduled follow-up appointments for ADHD can control symptoms of hyperactivity, impulsiveness, and lack of focus and concentration. To ensure that your child's medication is prescribed and managed correctly, it is important that children be monitored closely by a healthcare provider.

To ensure we are following American Academy of Pediatrics (AAP) guidelines, some of our processes and procedures are:

- Follow-up appointments are required every three months.
- Follow-up paperwork is required every six months.
- Medication refills will be managed at follow-up appointments.
- It is important to complete the needed paperwork and make your follow-up appointments before your child is out of medication.
- Our ADHD coordinator will be contacting you to aid in scheduling follow-up appointments.
- Telehealth **may** be offered for these follow-up appointments up to two times a year and at the discretion of the provider.
- Your child's annual well care **may** be combined with a follow-up visit. Your child must be stable on their current dosage of ADHD medication, and a combined visit must be approved by your child's provider.

Enclosed please find forms for you, your child, and your child's teacher to complete. Please return the questionnaires to us by fax, email, or drop them off at a clinical office.

- Fax: 720-974-7189
- Email: apa.ref@advanced-pediatrics.com
- Clinical office locations:
 - 5657 S. Himalaya St., #100, Centennial, CO 80015
 - 1300 S. Potomac St., #156, Aurora, CO 80012
 - 9397 Crown Crest Blvd., #330, Alpine Building, Parker, CO 80138

After the forms have been received and reviewed by the provider, we will contact you to schedule an appointment for a medication evaluation.

Additional charges will be added to the next office visit for the provider's time to score and evaluate the questionnaires.

We look forward to working with you and your child under these new guidelines. Please contact our ADHD coordinators at 720-974-7188 with any questions.

Enclosures

APA ADD064 11/2023

Aurora Office
1300 S. Potomac Street, Suite 156 | Aurora, CO 80012

Centennial Office
5657 S. Himalaya Street, Suite 100 | Centennial, CO 80015

Parker Office
9397 Crown Crest Boulevard, Suite 330 | Parker, CO 80138

Administrative Office
3300 S. Parker Road, Suite 404 | Aurora, CO 80014



ADHD INITIAL PARENT QUESTIONNAIRE

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

Name of Person completing this form: _____ Relationship: _____

1. Do you have a preferred provider? No Preference Yes _____
2. In your own words, what is the reason for this evaluation? _____

3. When did you first notice these concerns? _____
4. Does your child have a history of developmental delays or concerns? If so, have they received speech, occupational, or physical therapy? _____

5. Does your child receive special services at school? (Examples: educational plan (IEP, 504), support from a learning specialist or tutor) _____

6. Has your child met with a professional to support their behavioral or emotional health? (Example: therapist, psychologist, psychiatrist, or social worker) _____

MEDICAL HISTORY

1. Is your child currently or have they previously taken medications or supplements regularly?

Medication/Supplement	Dosage	Medication/Supplement	Dosage

2. Does your child have a history of significant or chronic medical problems? (Example: history of heart problems, palpitations, fainting, or seizures.) _____

SLEEP HISTORY

	Yes	No		Yes	No
Snores	<input type="checkbox"/>	<input type="checkbox"/>	Falls asleep easily	<input type="checkbox"/>	<input type="checkbox"/>
Restless while asleep	<input type="checkbox"/>	<input type="checkbox"/>	Gets out of bed frequently	<input type="checkbox"/>	<input type="checkbox"/>
Regular bedtime	<input type="checkbox"/>	<input type="checkbox"/>	Sleeps in own bed	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any additional concerns about your child's sleep? _____



ADHD INITIAL PARENT QUESTIONNAIRE

SCHOOL & SOCIAL SKILLS

1. How does your child feel about school? _____
2. Are there any subjects that your child likes or dislikes? _____
3. Do you or your child's teacher have concerns about your child's behavior at school? _____
4. Does your child struggle with making and keeping friends? _____

FAMILY

1. Who does your child live with? If your child spends time in multiple households, please describe.

2. Has your family recently or previously faced stressful circumstances that may be affecting your child?
(Example: divorce, financial hardship, death, illness, abuse, or changes at home)

3. Indicate **relatives of the child** with any of the following:

	Sisters/ Brothers	Natural Mother	Mother's Relatives	Natural Father	Father's Relatives
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder, fussy habits, picky, rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics or other nervous habits, Tourette syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression for more than 2 weeks, medications for mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis or schizophrenia, hospitalized for mental or emotional issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal problems, arrests, jail/prison time, court probations, "always in trouble"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious or chronic medical conditions: heart problems, seizures, diabetes, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling, shopping, or other compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism spectrum disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Is there anything else we should know about your child or family? _____

PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

Filled out by: _____ Record #: _____

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

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	0	1	2
*	Feels sad, unhappy	0	1	2
◆	Daydreams too much	0	1	2
□	Refuses to share	0	1	2
□	Does not understand other people's feelings	0	1	2
*	Feels hopeless	0	1	2
◆	Has trouble concentrating	0	1	2
□	Fights with other children	0	1	2
*	Is down on him or herself	0	1	2
□	Blames others for his or her trouble	0	1	2
*	Seems to be having less fun	0	1	2
□	Does not listen to rules	0	1	2
◆	Acts as if driven by a motor	0	1	2
□	Teases others	0	1	2
*	Worries a lot	0	1	2
□	Takes things that do not belong to him or her	0	1	2
◆	Distracted easily	0	1	2

OFFICE USE ONLY							
Total ◆	_____	Total □	_____	Total *	_____	Grand Total ◆+□+*	_____



NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Name: _____

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 (0)	Occasionally (1)	Often (2)	Very Often (3)	
1 Does not pay attention to details or makes careless mistakes with, for example, homework	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2 Has difficulty keeping attention to what needs to be done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3 Does not seem to listen when spoken to directly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4 Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
5 Has difficulty organizing tasks and activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
6 Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
7 Loses things necessary for tasks or activities (toys, assignments, pencils, books)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
8 Is easily distracted by noises or other stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
9 Is forgetful in daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /9
10 Fidgets with hands or feet or squirms in seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
11 Leaves seat when remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
12 Runs about or climbs too much when remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
13 Has difficulty playing or beginning quiet play activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14 Is "on the go" or often acts as if "driven by a motor"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15 Talks too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16 Blurts out answers before questions have been completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
17 Has difficulty waiting his or her turn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
18 Interrupts or intrudes in on others' conversations and/or activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /9
19 Argues with adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
20 Loses temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
21 actively defies or refuses to go along with adults' requests or rules	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
22 Deliberately annoys people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
23 Blames others for his or her mistakes or misbehaviors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
24 Is touchy or easily annoyed by others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
25 Is angry or resentful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
26 Is spiteful and wants to get even	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /8



Symptoms (cont.)	Never (0)	Occasionally (1)	Often (2)	Very Often (3)	
27 Bullies, threatens, or intimidates others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
28 Starts physical fights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
29 Lies to get out of trouble or to avoid obligations (ie. "cons" others)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
30 Is truant from school (skips school) without permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
31 Is physically cruel to people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
32 Has stolen things that have value	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
33 Deliberately destroys others' property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
34 Has used a weapon that can cause serious harm (bat, knife, brick, gun)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
35 Is physically cruel to animals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
36 Has deliberately set fires to cause damage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
37 Has broken into someone's home, business, or car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
38 Has stayed out at night without permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
39 Has run away from home overnight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
40 Has forced someone into sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /14
41 Is fearful, anxious, or worried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
42 Is afraid to try new things for fear of making mistakes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
43 Feels worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
44 Blames self for problems, feels guilty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
45 Feels lonely, unwanted, or unloved; complains "no one loves him/her"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
46 Is sad, unhappy, or depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
47 Is self-conscious or easily embarrassed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /7

Performance	Excellent (1)	Above Average (2)	Average (3)	Somewhat of a Problem (4)	Problematic (5)	
48 Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
49 Writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 4s: /3
50 Mathematics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 5s: /3
51 Relationship with parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
52 Relationship with siblings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
53 Relationship with peers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 4s: /4
54 Participation in organized activities (eg. teams)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 5s: /4

Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

- Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.
 No tics present Yes, they occur nearly every day but go unnoticed Yes, noticeable tics occur nearly every day
- Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking grunting, or repetition of words or short phrases.
 No tics present Yes, they occur nearly every day but go unnoticed Yes, noticeable tics occur nearly every day
- If YES to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? No Yes

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

- Has your child been diagnosed with a tic disorder or Tourette syndrome? No Yes
- Is your child on medication for a tic disorder or Tourette syndrome? No Yes
- Has your child been diagnosed with depression? No Yes
- Is your child on medication for depression? No Yes
- Has your child been diagnosed with any anxiety disorder? No Yes
- Has your child been diagnosed with a learning or language disorder? No Yes

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	0	1	2
*	Feel sad, unhappy	0	1	2
◆	Daydream too much	0	1	2
□	Refuse to share	0	1	2
□	Do not understand other people's feelings	0	1	2
*	Feel hopeless	0	1	2
◆	Have trouble concentrating	0	1	2
□	Fight with other children	0	1	2
*	Down on yourself	0	1	2
□	Blame others for your troubles	0	1	2
*	Seem to be having less fun	0	1	2
□	Do not listen to rules	0	1	2
◆	Act as if driven by a motor	0	1	2
□	Tease others	0	1	2
*	Worry a lot	0	1	2
□	Take things that do not belong to you	0	1	2
◆	Distract easily	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total □ _____ Total * _____ Grand Total ◆+□+* _____



ADVANCED PEDIATRIC ASSOCIATES

Hand in Hand for Healthy Kids

Date: _____

Student's Name: _____

Date of Birth: _____

Phone Number: _____

Dear Teacher:

The parent or guardian of the above student have requested an evaluation by our office for a health concern. As part of the evaluation process, we ask that both the student's parent or guardian, and teacher(s) complete a set of behavioral rating scales.

Please complete the enclosed teacher rating scales and questionnaires:

- Initial Teacher Questionnaire
- NICHQ Vanderbilt Teacher Assessment Scale

Generally, the teacher who spends the most time with the child should complete these forms. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of forms from each teacher. If this is the case, please feel welcome to make the necessary copies.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write "Don't know," so that we can be sure the item was not overlooked. After the forms are completed, please return them to the student's parent or guardian.

Thank you for your time. If you have any questions, please do not hesitate to contact our office.

Sincerely,

ADHD Coordinator
720-974-7188

Enclosures

APA ADD068 09/2023

Aurora Office
1300 S. Potomac Street, Suite 156 | Aurora, CO 80012

Centennial Office
5657 S.Himalaya Street, Suite 100 | Centennial, CO 80015

Parker Office
9397 Crown Crest Boulevard, Suite 330 | Parker, CO 80138

Administrative Office
3300 S. Parker Road, Suite 404 | Aurora, CO 80014

Phone | 303-699-6200 Fax | 303-766-6903



ADHD Initial Teacher Questionnaire

Hand in Hand for Healthy Kids

Student's Name _____ Date Completed _____

School _____ Student's Grade _____

Teacher's Name _____ Subject(s) Taught _____

Hours with student (daily average) _____ Number of students in class _____

1. How long have you known this student? _____

2. Please describe any concerns you have about this student's academic performance and/or behavior at school.

3. Number of school days absent/tardy: _____

4. Record the results of any IQ or other educational tests this student has taken:

5. Please list consultations previously obtained from school psychologists, developmental specialists, or other school staff.

6. Please list or describe any special help or services this student is receiving inside/outside your class.



NICHQ Vanderbilt Assessment Scale: Teacher Informant

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

Teacher's Name: _____ Class Name: _____ Period: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Symptoms	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
1 Fails to give attention to details or makes careless mistakes in schoolwork.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 Has difficulty sustaining attention to tasks or activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 Does not seem to listen when spoken to directly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 Does not follow through when given directions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 Has difficulty organizing tasks and activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 Loses things necessary for tasks or activities (school assignments, pencils, books)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 Is easily distracted by extraneous stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9 Is forgetful in daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 Fidgets with hands or feet or squirms in seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11 Leaves seat in classroom or in other situations in which remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12 Runs about or climbs excessively in situations in which remaining seated is expected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13 Has difficulty playing or engaging in leisure activities quietly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14 Is "on the go" or often acts as if "driven by a motor"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 Talks excessively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16 Blurts out answers before questions have been completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17 Has difficulty waiting in line	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18 Interrupts or intrudes in on others' conversations and/or activities (eg, butts into conversations/games)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 Loses temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 Actively defies or refuses to go along with adults' requests or rules	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21 Is angry or resentful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22 Is spiteful and vindictive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23 Bullies, threatens, or intimidates others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24 Initiates physical fights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25 Lies to obtain goods for favors or to avoid obligations (ie. "cons" others)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26 Is physically cruel to people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27 Has stolen items of nontrivial value	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28 Deliberately destroys others' property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For office use only:
2 & 3s: /9

For office use only:
2 & 3s: /9

For office use only:
2 & 3s: /9



		Never (0)	Occasionally (1)	Often (2)	Very Often (3)	
Symptoms						
29	Is fearful, anxious, or worried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
30	Is self-conscious or easily embarrassed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
31	Is afraid to try new things for fear of making mistakes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
32	Feels worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
33	Blames self for problems; feels guilty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
34	Feels lonely, unwanted, or unloved; complains "no one loves him/her"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
35	Is sad, unhappy, or depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 2 & 3s: /7

		Excellent (1)	Above Average (2)	Average (3)	Somewhat of a Problem (4)	Problematic (5)	
Academic Performance							
36	Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
37	Mathematics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 4s: /3
38	Written expression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 5s: /3

Classroom Behavioral Performance							
39	Relationship with peers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
40	Following directions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
41	Disrupting class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
42	Assignment completion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 4s: /5
43	Organizational skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	For office use only: 5s: /5

Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

- 1 **Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.
 No tics present Yes, they occur nearly every day but go unnoticed Yes, noticeable tics occur nearly every day
- 2 **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking grunting, or repetition of words or short phrases.
 No tics present Yes, they occur nearly every day but go unnoticed Yes, noticeable tics occur nearly every day
- 3 If YES to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? No Yes

Comments