



# SWANSON, CONTI & ASSOCIATES

A PSYCHOLOGICAL CORPORATION

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ENCINO MEDICAL PLAZA

5400 BALBOA BOULEVARD, SUITE 311

ENCINO, CALIFORNIA, 91316

## CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE

Today's Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

### Background Information

#### Child / Patient

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Chronological Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

#### Mother

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Single  Married  Partnered  Divorced  Remarried  Widowed

Current Spouse/Partner:  Father  Other : \_\_\_\_\_

#### Father

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Single  Married  Partnered  Divorced  Remarried  Widowed

Current Spouse/Partner:  Mother  Other : \_\_\_\_\_

# Referral Information

Referred by: \_\_\_\_\_

Describe the reasons you are requesting therapy for your child.  
If possible, list specific questions for which answers are sought.

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Language spoken in the home if not English: \_\_\_\_\_

List all people now living in the household, then draw a line and list others who have lived with the child (please note dates):

	(1)	(2)	(3)
Name:	_____	_____	_____

Relationship:	_____	_____	_____
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Name to child:	_____	_____	_____
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Age:	_____	_____	_____
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With child now?	_____	_____	_____
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Occupation:	_____	_____	_____
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	(4)	(5)	(6)
Name:	_____	_____	_____

Relationship:	_____	_____	_____
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Name to child:	_____	_____	_____
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Age:	_____	_____	_____
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With child now?	_____	_____	_____
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Occupation:	_____	_____	_____
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Please indicate if any children in the household were adopted and dates of any previous marriages, divorces, remarriages of parents. Describe custody arrangements. Describe any deaths in the immediate family. Note any unusual family circumstances.

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## Current Care Providers

### Current Pediatric Care

Child's Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Permission to talk to pediatrician?  Yes \_\_\_\_ (Please initial if yes)  No

### Current Psychiatric Care

Child's Psychiatrist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Permission to talk to psychiatrist?  Yes \_\_\_\_ (Please initial if yes)  No

Other Current Care Provider  None

Name and Type of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Permission to talk to provider?  Yes \_\_\_\_ (Please initial if yes)  No

Other Current Care Provider  None

Name and Type of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Permission to talk to provider?  Yes \_\_\_\_ (Please initial if yes)  No

## Pregnancy and Birth History

Describe any complications that occurred during pregnancy:

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Describe any complications that occurred during delivery (e.g., prematurity, postmaturity, length of labor, special procedures, etc.).

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Birth Length: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

How long after birth did you take your baby home? \_\_\_\_\_

# Early Childhood

## Early Temperament

Describe your child's temperament during the first six months (i.e., sleep patterns, colic, eating patterns).

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## Developmental History

Note the approximate ages of the following:

Toileting:

Sitting unsupported \_\_\_\_\_

Urine daytime \_\_\_\_\_

Urine nighttime \_\_\_\_\_

Bowel daytime \_\_\_\_\_

Bowel nighttime \_\_\_\_\_

Walking alone \_\_\_\_\_

Using single words \_\_\_\_\_

Using two to three words together \_\_\_\_\_

Which hand does your child prefer?

Right \_\_\_\_\_ Left \_\_\_\_\_ Mixed \_\_\_\_\_

Approximate age established \_\_\_\_\_

# Medical History

List sicknesses operations and injuries. Note history of frequent ear infections, ruptured eardrums, tubes. Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

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Is there anyone in your immediate family or biologically related to your child that currently experiences or has previously experienced the following?

Nervous tics:            Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Seizures (epilepsy):    Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Depression:            Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Bipolar Disorder:      Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Thyroid problems:      Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Emotional problems:    Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

ADHD:                    Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Learning problems:     Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Language problems:    Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Mental retardation:    Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Left-handedness:        Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Similar problems  
as child:                Yes \_\_\_ No \_\_\_            Who? \_\_\_\_\_

Does any disease run in the family?      Yes \_\_\_ No \_\_\_

If so, what? \_\_\_\_\_

## Current Medication

Indicate any medications your child is *currently* taking and prescribing physician. (Include dosage and the reason for taking it.)

Medication	Dose (mg./ml.)	Time Administered
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Indicate any medication your child has taken in the past *for more than a month* and the prescribing physician. (Include dosage and the reason for taking it.)

Medication	Prescribing Physician	Why Stopped
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Vision and Hearing Care

Has your child's vision been examined? \_\_\_\_\_ Date last examined: \_\_\_\_\_

If so, by whom? \_\_\_\_\_

Results: \_\_\_\_\_

Has your child's hearing been examined? \_\_\_\_\_ Date last examined: \_\_\_\_\_

If so, by whom? \_\_\_\_\_

Results: \_\_\_\_\_

## Other Relevant Psychological / Medical History

### Medical

Other special medical tests (EEG, CAT scan, MRI):

Name of Test: \_\_\_\_\_ Date tested: \_\_\_\_\_

Results: \_\_\_\_\_

Name of Test: \_\_\_\_\_ Date tested: \_\_\_\_\_

Results: \_\_\_\_\_

Name of Test: \_\_\_\_\_ Date tested: \_\_\_\_\_

Results: \_\_\_\_\_

### Psychological

Have there been any previous psychological, psychiatric or neurological evaluations? If so, please list names, addresses and dates of contact.

Please attach any pertinent reports.

Date(s)	Name of Assessor	Phone	Address
_____	_____	_____	_____

Diagnoses Given: \_\_\_\_\_

Date(s)	Name of Assessor	Phone	Address
_____	_____	_____	_____

Diagnoses Given: \_\_\_\_\_

Date(s)	Name of Assessor	Phone	Address
_____	_____	_____	_____

Diagnoses Given: \_\_\_\_\_



## Social/Emotional/Behavioral History

List your child's personality characteristics, both positive and negative:

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Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, difficulties paying attention, destructiveness, unusual habits, fears, tenseness, etc.).

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Describe your current discipline techniques:

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Effective?     Yes    No If 'No,' please explain why \_\_\_\_\_

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Who disciplines? \_\_\_\_\_

Do parents agree on how to discipline? \_\_\_\_\_

Please explain any parenting challenges: \_\_\_\_\_

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How does your child respond to discipline? \_\_\_\_\_

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## School History

List previous schools attended with dates or years (include nursery school and preschool):

School	Grades / Dates Attended
_____	_____
_____	_____
_____	_____
_____	_____

List current teachers and subjects taught:  
(Please bring copies of prior report card to the first meeting)

Teacher's Name	Subject Taught	Current Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Permission to talk to teachers and other school personnel?

Yes \_\_\_\_ (Please initial if yes)     No

Describe any learning/behavioral/social difficulties at school:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child received any special services in school (resource room, tutors, remedial reading, speech therapy, etc.)?  Yes  No

If so, Date placed: \_\_\_\_\_ How often? \_\_\_\_\_

Does your child currently have an IEP or 504 in place?  Yes  No  
If so, please provide a copy

Has your child received any special services privately?  Yes  No

(1)

(2)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of Service: \_\_\_\_\_

Date begun \_\_\_\_\_

(3)

(4)

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of Service: \_\_\_\_\_

Date begun \_\_\_\_\_

Describe services, how often seen, length of time, effectiveness:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

Has your child ever repeated a grade?  Yes  No When? \_\_\_\_\_

Reason? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Addition Comments

I very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments below or on a separate sheet of paper as needed. When you come for your first appointment, please bring copies of any reports or report cards previously received. The more you can bring the better. Please also bring copies of any prior standardized achievement testing the school may have done.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Symptom Checklists

Following, you will find two copies of a symptoms checklist. It is requested that both mother and father complete the checklists independently and bring them to the first meeting.

# MOTHER'S CHECKLIST

Child's name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Answer *Yes* only if the behavior is *considerably more frequent* than that of most people the same age as your child and has persisted for at least six months.

## Section A

**Yes**   **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often has difficulty sustaining attention in tasks or play activities   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often does not seem to listen when spoken to directly   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Often has difficulty organizing tasks and activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is often easily distracted by extraneous stimuli (sights or sounds or objects unrelated to the task at hand)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Is often forgetful in daily activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Some of the behaviors listed under Section A have been present before age 7  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. The behaviors listed under Section A cause problems at home, school and/or elsewhere   |

## Section B

**Yes**   **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often fidgets with hands or feet or squirms in seat   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often leaves seat in classroom or in other situations in which remaining seated is expected   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often has difficulty playing or engaging in leisure activities quietly  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is often "on the go" or often acts as if "driven by a motor"  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Often talks excessively   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Often blurts out answers before questions have been completed   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Often has difficulty awaiting turns   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Often interrupts or intrudes on others (e.g., butts into conversations or games)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Some behaviors listed under Section B have been present before age 7   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. The behaviors listed under Section B cause problems at home, school and/or elsewhere   |

### Section C

Yes No

#### *Aggression towards people and animals*

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often bullies, threatens, or intimidates others  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often initiates physical fights  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has been physically cruel to people  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has been physically cruel to animals   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)               |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has forced someone into sexual activity  |

#### *Destruction of property*

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has deliberately engaged in fire setting with the intention of causing serious damage |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has deliberately destroyed others' property (other than by fire setting)              |

#### *Deceitfulness or theft*

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Has broken into someone else's house, building or car   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "con" others)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Has stolen items of nontrivial value without confronting a victim (shoplifting, but without breaking and entering; forgery) |

#### *Serious violations of rules*

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Often stays out at night despite parental prohibitions, beginning before age 13  |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period) |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Is often truant from school, beginning before age 13 (for older person, absent from work)  |

### Section D

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often loses temper   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often argues with adults   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often deliberately does things that annoy other people, e.g., grabs other children's hats    |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Often blames others for his or her own mistakes or misbehavior                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is often touchy or easily annoyed by others  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Is often angry and resentful   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is often spiteful or vindictive  |

## Section E

Answer “Yes” only if the response is clearly not due to a general medical condition.

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Seems to experience a depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., “I feel sad or empty”) or observation made by others (e.g., appears tearful). <b>Note:</b> In children and adolescents, this can include irritable mood. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Appears to have experienced a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has experienced a significant weight loss not related to dieting or has experienced a significant weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has been sleeping too much or too little nearly every day.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has displayed an increase or decrease in motor activity nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has experienced fatigue or loss of energy nearly every day.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has experienced feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has experienced a diminished ability to think or concentrate, or seems more indecisive, nearly every day (either by subjective account or as observed by others).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has experienced recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. The symptoms listed in Section E cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. To the best of your knowledge, are the symptoms listed in Section E related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).   |

If so, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 12. To the best of your knowledge, are the symptoms listed in section E related to bereavement (i.e., after the loss of a loved one). |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have the symptoms listed in Section E persisted for longer than 2 months.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Does your child possess a preoccupation with suicidal ideation.   |

**Section F**

**Yes    No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Experienced excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has difficulty controlling the worry.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Feels restlessness or feeling keyed up or on edge.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is easily fatigued.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Experiences difficulty concentrating or mind going blank.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is often irritable.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Reports muscle tension.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has experienced a disturbance in sleep (difficulty falling or staying asleep, or restless unsatisfying sleep).   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Experiences panic attacks.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Has unusual obsessive rituals, interests or thoughts.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Has multiple physical complaints.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Has intense fears   |

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Avoids public places                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Is afraid to separate from parents or primary care givers |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Has experiences a major or traumatic life event           |

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 16. The symptoms listed in Section F cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. To the best of your knowledge, are the symptoms listed in Section F related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism). |



# FATHER'S CHECKLIST

Child's name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Answer *Yes* only if the behavior is *considerably more frequent* than that of most people the same age as your child and has persisted for at least six months.

## Section A

**Yes**   **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often has difficulty sustaining attention in tasks or play activities   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often does not seem to listen when spoken to directly   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Often has difficulty organizing tasks and activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is often easily distracted by extraneous stimuli (sights or sounds or objects unrelated to the task at hand)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Is often forgetful in daily activities  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Some of the behaviors listed under Section A have been present before age 7  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. The behaviors listed under Section A cause problems at home, school and/or elsewhere   |

## Section B

**Yes**   **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often fidgets with hands or feet or squirms in seat   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often leaves seat in classroom or in other situations in which remaining seated is expected   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often has difficulty playing or engaging in leisure activities quietly  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is often "on the go" or often acts as if "driven by a motor"  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Often talks excessively   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Often blurts out answers before questions have been completed   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Often has difficulty awaiting turns   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Often interrupts or intrudes on others (e.g., butts into conversations or games)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Some behaviors listed under Section B have been present before age 7   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. The behaviors listed under Section B cause problems at home, school and/or elsewhere   |

### Section C

Yes No

#### *Aggression towards people and animals*

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often bullies, threatens, or intimidates others  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often initiates physical fights  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has been physically cruel to people  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has been physically cruel to animals   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)               |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has forced someone into sexual activity  |

#### *Destruction of property*

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has deliberately engaged in fire setting with the intention of causing serious damage |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has deliberately destroyed others' property (other than by fire setting)              |

#### *Deceitfulness or theft*

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Has broken into someone else's house, building or car   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "con" others)   |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Has stolen items of nontrivial value without confronting a victim (shoplifting, but without breaking and entering; forgery) |

#### *Serious violations of rules*

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Often stays out at night despite parental prohibitions, beginning before age 13  |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period) |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Is often truant from school, beginning before age 13 (for older person, absent from work)  |

### Section D

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Often loses temper   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Often argues with adults   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Often deliberately does things that annoy other people, e.g., grabs other children's hats    |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Often blames others for his or her own mistakes or misbehavior                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is often touchy or easily annoyed by others  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Is often angry and resentful   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is often spiteful or vindictive  |

## Section E

Answer “Yes” only if the response is clearly not due to a general medical condition.

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Seems to experience a depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., “I feel sad or empty”) or observation made by others (e.g., appears tearful). <b>Note:</b> In children and adolescents, this can include irritable mood. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Appears to have experienced a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has experienced a significant weight loss not related to dieting or has experienced a significant weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has been sleeping too much or too little nearly every day.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has displayed an increase or decrease in motor activity nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has experienced fatigue or loss of energy nearly every day.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has experienced feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has experienced a diminished ability to think or concentrate, or seems more indecisive, nearly every day (either by subjective account or as observed by others).  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has experienced recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. The symptoms listed in Section E cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. To the best of your knowledge, are the symptoms listed in Section E related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).   |

If so, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 12. To the best of your knowledge, are the symptoms listed in section E related to bereavement (i.e., after the loss of a loved one). |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have the symptoms listed in Section E persisted for longer than 2 months.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Does your child possess a preoccupation with suicidal ideation.   |

**Section F**

**Yes    No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Experienced excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has difficulty controlling the worry.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Feels restlessness or feeling keyed up or on edge.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is easily fatigued.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Experiences difficulty concentrating or mind going blank.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is often irritable.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Reports muscle tension.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has experienced a disturbance in sleep (difficulty falling or staying asleep, or restless unsatisfying sleep).   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Experiences panic attacks.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Has unusual obsessive rituals, interests or thoughts.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Has multiple physical complaints.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Has intense fears   |

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Avoids public places                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Is afraid to separate from parents or primary care givers |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Has experiences a major or traumatic life event           |

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 16. The symptoms listed in Section F cause significant distress or impairment in social, academic, occupational, or other important areas of functioning.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. To the best of your knowledge, are the symptoms listed in Section F related to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism). |