

## PARENT QUESTIONNAIRE

### A. General Information

Child's name: \_\_\_\_\_  Male  Female

Name at birth if different from above: \_\_\_\_\_

Resident Address: \_\_\_\_\_ City/Town/Village: \_\_\_\_\_

Province/Territory: \_\_\_\_\_ Postal code: \_\_\_\_\_

Child's date of birth (yy/mm/dd): \_\_\_\_\_ Age: \_\_\_\_\_

Provincial health care insurance number: \_\_\_\_\_

Alternate health care plan name: \_\_\_\_\_ Number: \_\_\_\_\_

Is the child a Registered or Treaty Indian?  Yes  No

Please attach a recent photograph of your child.

### Parents/Legal Guardians:

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

Address:  Same as child; or:

No./street: \_\_\_\_\_

City: \_\_\_\_\_ Prov/Terr: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Biological  Adoptive  Foster

Step-parent  Grandparent

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

Address:  Same as child; or:

No./street: \_\_\_\_\_

City: \_\_\_\_\_ Prov/Terr: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Biological  Adoptive  Foster

Step-parent  Grandparent

Language(s) spoken at home: 1. \_\_\_\_\_ 2. \_\_\_\_\_

If English is not spoken at home, indicate the name of an English-speaking contact person:

\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

List everyone living in the home: \_\_\_\_\_

\_\_\_\_\_



Child's guardianship status (if applicable): \_\_\_\_\_

Social worker/legal guardian (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Who suggested this referral? \_\_\_\_\_

Family physician: \_\_\_\_\_ Paediatrician: \_\_\_\_\_

Please list your main concerns:

\_\_\_\_\_

\_\_\_\_\_

Do you have any specific questions you would like answered?

\_\_\_\_\_

\_\_\_\_\_

Current daycare/preschool/school: \_\_\_\_\_ Grade/level: \_\_\_\_\_

Contact name and title/role: \_\_\_\_\_ Phone: \_\_\_\_\_

List the preschools, daycare centres, and schools your child has attended. Use a separate sheet if necessary:

Name of program/school	Years attended	Grade/level	Problems noted	Special programs

Previous assessments:

	Date	Consultant or agency	Is your child currently involved?
Psychology			
Speech-language pathology			
Occupational/physiotherapy			
Audiology (hearing)			
Vision			
Other:			

**PLEASE ATTACH ANY AVAILABLE REPORTS OF PREVIOUS ASSESSMENTS TO THIS QUESTIONNAIRE.**

Are you aware of any assessments planned in the next six to twelve months? Yes  No

If yes, when, where, and by whom? \_\_\_\_\_

### B. Prenatal/Birth History

Total number of pregnancies: \_\_\_\_\_ Any miscarriage(s)/stillbirth(s)/abortion(s): \_\_\_\_\_

Duration of this pregnancy (weeks): \_\_\_\_\_

Did you have any of the following during this pregnancy?

Check all that apply:

- |                                                        |                                                       |                                                       |
|--------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Excessive vomiting            | <input type="checkbox"/> Operation(s)                 | <input type="checkbox"/> Excessive vaginal bleeding   |
| <input type="checkbox"/> Infection with fever or rash  | <input type="checkbox"/> Injuries/accidents           | <input type="checkbox"/> Other health problems: _____ |
| <input type="checkbox"/> Toxemia (high blood pressure) | <input type="checkbox"/> Unusual emotional stress     | _____                                                 |
| <input type="checkbox"/> Convulsions/seizures          | <input type="checkbox"/> Prolonged hospitalization(s) | _____                                                 |

During your pregnancy, did you:

Smoke cigarettes?  No  Less than 1/2 pack per day  1/2 to 1 pack per day  
 More than 1 pack per day

Drink alcoholic beverages?  No  First three months only  Throughout most of pregnancy

Amount each time (1 drink = 1 beer, 1 glass of wine, or 1 mixed drink):

1-2 drinks  3-5 drinks  6 drinks or more

Frequency:  Once per week  Two or more times per week

Use prescription or nonprescription medications?  No  Yes

Use any drugs (marijuana, cocaine, heroin, etc.)?  No  Yes

Name of birth hospital: \_\_\_\_\_ City/Province: \_\_\_\_\_

How long was labour? \_\_\_\_\_ hours Was labour:  Spontaneous?  Induced?

Type of anaesthetics:  General  Spinal  Local  None  Other

Method of delivery:  Spontaneous  Assisted (forceps used)  Vacuum extraction  
 Vaginal  Caesarean (elective)  Caesarean (emergency)

Position of baby:  Head first  Breech  Other

Were there any concerns about your baby (such as fetal distress) immediately before the birth?

No  Yes Please explain: \_\_\_\_\_

Did your baby need any help to breathe right after birth?

No  Yes Please explain: \_\_\_\_\_

How was your baby fed? Were there any feeding problems? \_\_\_\_\_

Did your baby have any of these problems at birth or during the first month of life? Check all that apply?

- |                                                     |                                                                |                                                   |
|-----------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Poor sucking               | <input type="checkbox"/> Injured at birth                      | <input type="checkbox"/> Birth defects            |
| <input type="checkbox"/> Unusual rash               | <input type="checkbox"/> Trouble breathing                     | <input type="checkbox"/> Was given medications    |
| <input type="checkbox"/> Turned yellow              | <input type="checkbox"/> Turned blue                           | <input type="checkbox"/> Infection (specify)_____ |
| <input type="checkbox"/> Received blood transfusion | <input type="checkbox"/> Kept in incubator (how long?_____)    | <input type="checkbox"/> Seizures/convulsions     |
| <input type="checkbox"/> Needed surgery             | <input type="checkbox"/> Transferred to intensive care nursery | <input type="checkbox"/> Was very jittery         |
| <input type="checkbox"/> Other problems: _____      |                                                                |                                                   |

### C. Child's Developmental and Medical History

**Early development:** When (specify age in years and months, if possible) did your child first accomplish the following:

Age	Milestone	Age	Milestone	Age	Milestone
	Sat without help		Crawled		Walked alone for 10 to 15 steps
	Toilet trained (day)		Toilet trained (night)		Walked upstairs
	Rode a bike without training wheels		Used sentences		Used a spoon
	Spoke first words ("mama," "dada")		Rode a tricycle using pedals		Named 3 or more colours
	Ate independently		Counted from 1 to 10		Named 3 or more body parts
	Used fingers to feed		Put 2 or 3 words together		

When did you first become concerned about your child's development? \_\_\_\_\_

Do you have any concerns now? \_\_\_\_\_

Has your child lost any skills he or she used to be able to do? \_\_\_\_\_

**Functional problems:** Please check which, if any, of the following concerns you have:

- |                                                    |                                                            |                                                           |
|----------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Feeding difficulties      | <input type="checkbox"/> Withdrawn/In own world            | <input type="checkbox"/> Unusual/Odd mannerisms           |
| <input type="checkbox"/> Avoiding eye contact      | <input type="checkbox"/> Clumsy/Awkward/Poorly coordinated | <input type="checkbox"/> Constipation/Diarrhea            |
| <input type="checkbox"/> Limited food choices      | <input type="checkbox"/> Recurrent stomach ache            | <input type="checkbox"/> Unusual fears/Anxiety            |
| <input type="checkbox"/> Social skill difficulties | <input type="checkbox"/> Resistance to change of routine   | <input type="checkbox"/> Trouble falling asleep           |
| <input type="checkbox"/> Soiling                   | <input type="checkbox"/> Night crying/Nightmares           | <input type="checkbox"/> Bedwetting                       |
| <input type="checkbox"/> Shy with strangers        | <input type="checkbox"/> Snoring                           | <input type="checkbox"/> Rocking/Head banging             |
| <input type="checkbox"/> Recurrent headaches       | <input type="checkbox"/> Hyperactive/Impulsive             | <input type="checkbox"/> Aggression toward self or others |
| <input type="checkbox"/> Short attention span      | <input type="checkbox"/> Defiant/Negativistic              | <input type="checkbox"/> Cruelty to animals               |
| <input type="checkbox"/> Destructive to property   | <input type="checkbox"/> Stealing                          | <input type="checkbox"/> Setting fires                    |
| <input type="checkbox"/> Mood swings               | <input type="checkbox"/> Inappropriate sexual behaviour    | <input type="checkbox"/> Thumb-sucking/Nail-biting        |
| <input type="checkbox"/> Frequent temper tantrums  | <input type="checkbox"/> Resistance to going to school     | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Trouble with police       |                                                            |                                                           |

**Discipline:** When your child is misbehaving, what do you usually do?

\_\_\_\_\_

**Past health problems:** Please give age of occurrence and details.

- |                                             |                                               |                                                  |
|---------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Ear infections     | <input type="checkbox"/> Hearing problem      | <input type="checkbox"/> Tics or muscle twitches |
| <input type="checkbox"/> Rash/Skin problems | <input type="checkbox"/> Eye problem          | <input type="checkbox"/> Casts/Braces            |
| <input type="checkbox"/> Head injury        | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Surgery (operations)    |
| <input type="checkbox"/> Meningitis         | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Admissions to hospital  |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Other (specify): _____  |

Details: \_\_\_\_\_  
\_\_\_\_\_

List any long-term medication, special diets, or large doses of vitamins (taken for longer than two weeks at a time)?

Name/dose: \_\_\_\_\_ When: \_\_\_\_\_

Name/dose: \_\_\_\_\_ When: \_\_\_\_\_

Name/dose: \_\_\_\_\_ When: \_\_\_\_\_

Name/dose: \_\_\_\_\_ When: \_\_\_\_\_

**Birth parent information/Family history:**

**Birth mother**

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

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Present occupation: \_\_\_\_\_

Education (highest grade completed): \_\_\_\_\_

Any learning/behaviour/  
emotional problems? \_\_\_\_\_

Any health problems? \_\_\_\_\_  
\_\_\_\_\_

**Birth father**

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

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

Present occupation: \_\_\_\_\_

Education (highest grade completed): \_\_\_\_\_

Any learning/behaviour/  
emotional problems: \_\_\_\_\_

Any health problems? \_\_\_\_\_  
\_\_\_\_\_

Marital status: \_\_\_\_\_ Are the birth mother and father related?  Yes  No

Describe special circumstance (e.g., other parental relationships involved): \_\_\_\_\_  
\_\_\_\_\_

**Siblings:**

Full Name	Date of birth	Gender (M/F)	Grade	Relationship (full, step, half)	Health, learning or behaviour problems

**Health conditions in the family:**

Check conditions that apply and indicate relationship to your child.

	Problem/Condition	Relationship to child		Problem/Condition	Relationship to child
	ADHD			Migraine headaches	
	Behaviour problems in childhood			Epilepsy	
	Learning, reading problems			Autism spectrum disorder	
	Speech problems			Thyroid problems	
	Developmental delay			Depression	
	Repeated a grade			Anxiety disorder	
	Genetic syndrome/birth defect			Drinking problems	
	Vision problems			Drug abuse	
	Hearing problems			Other mental health issues	
	Cerebral palsy			Other: _____	

Have there been any major events that may have been stressful to the family (e.g., moving home, physical/mental illness, death, separation/divorce, unemployment, legal or financial problem)?

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Additional information that you feel may help us better understand your child (e.g., additional school history):

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Name of person filling out this form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## CADDRA Adolescent Assessment Instructions

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent(s): \_\_\_\_\_  
 \_\_\_\_\_

Time period for which the form was filled out: \_\_\_\_\_

If you were on medication when this was completed, what medication were you on? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

You are presently being evaluated for Attention Deficit Hyperactivity Disorder. During this process, your doctor will require you and those who know you best (your parents and a teacher) to complete some questionnaires. (These questionnaires can also be downloaded and printed from the Guidelines section on the CADDRA website: [www.caddra.ca](http://www.caddra.ca)). Your input is very important, but please do not worry about answering the questions incorrectly. There are no right or wrong answers. You will be asked questions about how you function in a variety of different ways. If you are unsure of an answer, go with your first instinct. Individual questions are less important than the scale as a whole. If you are living in two households, each household should complete these forms.

### Questionnaires

- Weiss Symptom Record: To be completed by both parents, (you can also try to complete it by yourself if you wish).
- WFIRS-S: To be completed by yourself **These ones to be completed by parents and**
- WFIRS-P: To be completed by both parents **adolescent as specified on forms.**
- ADHD Checklist
- SNAP-IV 26 **May have other teachers, tutor, coach, etc. complete this**

If you are taking medication, you can also complete the forms both on medication and off medication. In this case, it would be helpful if you use two different colours to demonstrate the difference.

If you have already started ADHD medication, please also complete the CADDRA Patient ADHD Medication Form. If not, keep the form on hand for possible future use.

- CADDRA Patient ADHD Medication Form

### Information Sheets

Please read the information provided and note any questions to discuss at your next appointment.

- CADDRA ADHD Information and Resources

### Points to discuss at the next medical appointment:

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## Weiss Symptom Record (WSR)

<i>Instructions to Informant: Check the box that best describes typical behavior</i> <i>Instructions to Physician: Symptoms rated 2 or 3 are positive and total count completed below</i>	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	# items scored 2 or 3 (DSM Criteria)
<b>ADHD COMBINED TYPE 314.01</b>						<b>≥6/9 IA &amp; HI</b>
<b>ATTENTION 314.00</b>						
Fails to give close attention to details, careless mistakes						
Difficulty sustaining attention in tasks or fun activities						
Does not seem to listen when spoken to directly						
Does not follow through on instructions and fails to finish work						
Difficult organizing tasks and activities						
Avoids tasks that require sustained mental effort (boring)						
Losing things						
Easily distracted						
Forgetful in daily activities						/9 (≥6/9)
<b>HYPERACTIVE/IMPULSIVE 314.01</b>						
Fidgety or squirms in seat						
Leaves seat when sitting is expected						
Feels restless						
Difficulty in doing fun things quietly						
Always on the go or acts as if "driven by a motor"						
Talks excessively						
Blurts answers before questions have been completed						
Difficulty awaiting turn						
Interrupting or intruding on others						/9 (≥6/9)
<b>OPPOSITIONAL DEFIANT DISORDER 313.81</b>						
Loses temper						
Argues with adults						
Actively defies or refuses to comply with requests or rules						
Deliberately annoys people						
Blames others for his or her mistakes or misbehaviour						
Touchy or easily annoyed by others						
Angry or resentful						
Spiteful or vindictive						/8 (≥4/8)

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>TIC DISORDERS 307.2</b>						<b>SEVERITY</b>
Repetitive involuntary movements (blinking, twitching)						
Repetitive involuntary noises (throat clearing, sniffing)						
<b>CONDUCT DISORDER 312.8</b>						
Bullies, threatens, or intimidates others						
Initiates physical fights						
Has used a weapon (bat, brick, bottle, knife, gun)						
Physically cruel to people						
Physically cruel to animals						
Stolen while confronting a victim						
Forced someone into sexual activity						
Fire setting with the intent of damage						
Deliberately destroyed others' property						
Broken into a house, building, or car						
Often lies to obtain goods or benefits or avoid obligations						
Stealing items of nontrivial value without confronting victim						
Stays out at night despite prohibitions						
Run away from home overnight at least twice						
Truant from school						/15(≥3/15)
<b>ANXIETY</b>						
Worries about health, loved ones, catastrophe						300.02
Unable to relax; nervous						300.81
Chronic unexplained aches and pains						300.30
Repetitive thoughts that make no sense						
Repetitive rituals						300.01
Sudden panic attacks with intense anxiety						300.23
Excessively shy						
Refusal to do things in front of others						309.21
Refusal to go to school, work or separate from others						300.29
Unreasonable fears that interfere with activities						312.39
Pulls out hair, eyebrows						
Nail biting, picking						
Refusal to talk in public, but talks at home						mutism
<b>DEPRESSION 296.2 (single) .3 (recurrent)</b>						
Has been feeling sad, unhappy or depressed		Yes	No			Must be present
No interest or pleasure in life		Yes	No			Must be present
Feels worthless						
Has decreased energy and less productive						
Hopeless and pessimistic about the future						
Excessive feelings of guilt or self blame						
Self-injurious or suicidal thoughts						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>DEPRESSION (CONT'D)</b>						<b>SEVERITY</b>
Social withdrawal						
Weight loss or weight gain						
Change in sleep patterns						≥5/9>2wks
Agitated or sluggish, slowed down						
Decreased concentration or indecisiveness						
Past suicide attempts	#	Serious				
<b>MANIA 296.0(manic) .6(mixes) .5(depressed)</b>						
Distinct period of consistent elevated or irritable mood	Yes		No		Must be present	
Grandiose, sudden increase in self esteem						
Decreased need for sleep						
Racing thoughts						
Too talkative and speech seems pressured						
Sudden increase in goal directed activity, agitated						≥3 >1wk
High risk activities (spending money, promiscuity)						/3 (≥3)
<b>SOCIAL SKILLS 299</b>						
Makes poor eye contact or unusual body language						
Failure to make peer relationships						
Lack of spontaneous sharing of enjoyment						
Lacks reciprocity or sensitivity to emotional needs of others						
Language delay or lack of language communication						
Difficulty communicating, conversing with others						
Speaks in an odd, idiosyncratic or monotonous speech						
Lack of creative, imaginative play or social imitation						
Intensely fixated on one particular interest						
Rigid sticking to nonfunctional routines or rituals						
Preoccupied with objects and parts of objects						
Repetitive motor mannerisms (hand flapping, spinning)						
<b>PSYCHOSIS 295</b>						
Has disorganized, illogical thoughts						
Hears voices or sees things						
Conviction that others are against or will hurt them						
People can read their thoughts, or vice versa						
Belief that the television is talking specifically to them						
A fixed belief that is out of touch with reality						
Thought sequence does not make sense						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>SUBSTANCE ABUSE</b>						<b>SEVERITY</b>
Excessive alcohol (> 2 drinks/day, > 4 drinks at once)						305
Smokes cigarettes						
Daily marijuana use						
Use of any other street drugs						
Abuse of prescription drugs						
<b>SLEEP DISORDERS 307.4</b>						
Agitated or sluggish, slowed down						
Has difficulty falling asleep						
Has difficulty staying asleep						
Has abnormal sleep patterns during the day						347
Unanticipated falling asleep during the day						307.4
Sleep walking						307.4
Has nightmares						307.45
Falls asleep late and sleeps in late						3.27
Sleep schedule changes from day to day						
Excessive snoring						
A feeling of restless legs while trying to sleep						
Observed to have sudden kicking while asleep						780.57
Observed to have difficulty breathing at night						
<b>ELIMINATION DISORDERS 307</b>						
Wets the bed at night						
Wets during the day						
Soils self						
<b>EATING DISORDERS 307</b>						
Vomits after meals or bingeing						
Underweight and refuses to eat						307.1
Distorted body image						
Picky eater						
High junk food diet						
<b>LEARNING DISABILITIES 315</b>						
Delayed expressive language						
Stuttering						
Problems articulating words						315
Below grade level in reading						315.1
Below grade level in math						315.2
Trouble with writing (messy, tiring, avoids writing)						
Variable performance in school						
Underachieves at school relative to potential						315.4

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>DEVELOPMENTAL COORDINATION DISORDER</b>						
Difficulty with gross motor skills (i.e. gym, sports, biking)						
Clumsy						
Difficulty with fine motor (buttons, shoe laces, cutting)						
<b>PERSONALITY 301</b>						<b>SEVERITY</b>
Unstable interpersonal relationships						
Frantic efforts to avoid abandonment						
Recurrent suicidal ideation or attempts						
Intense anger						
Major mood swings						BPD 301.83
Impulsive self destructive or self injurious behavior						
Fragile identity or self image						
Chronic feelings of emptiness						
Transient stress related dissociation or paranoia						/9 (≥5/9)
Self centred or entitled						NPD 301.81
Deceitful, aggressive, or lack of remorse						ASP 301.7
<b>COMMENTS:</b>						

ADHD=attention deficit hyperactivity disorder; IA=inattentive subtype; HI=hyperactive impulsive subtype; BPD=borderline personality disorder; NPD=narcissistic personality disorder; ASP=antisocial personality disorder.

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## Weiss Symptom Record (WSR)

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Avoids tasks that require sustained mental effort (boring)						
Losing things						
Easily distracted						
Forgetful in daily activities						/9 (≥6/9)
<b>HYPERACTIVE/IMPULSIVE 314.01</b>						
Fidgety or squirms in seat						
Leaves seat when sitting is expected						
Feels restless						
Difficulty in doing fun things quietly						
Always on the go or acts as if "driven by a motor"						
Talks excessively						
Blurts answers before questions have been completed						
Difficulty awaiting turn						
Interrupting or intruding on others						/9 (≥6/9)
<b>OPPOSITIONAL DEFIANT DISORDER 313.81</b>						
Loses temper						
Argues with adults						
Actively defies or refuses to comply with requests or rules						
Deliberately annoys people						
Blames others for his or her mistakes or misbehaviour						
Touchy or easily annoyed by others						
Angry or resentful						
Spiteful or vindictive						/8 (≥4/8)

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
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Forced someone into sexual activity						
Fire setting with the intent of damage						
Deliberately destroyed others' property						
Broken into a house, building, or car						
Often lies to obtain goods or benefits or avoid obligations						
Stealing items of nontrivial value without confronting victim						
Stays out at night despite prohibitions						
Run away from home overnight at least twice						
Truant from school						/15(≥3/15)
<b>ANXIETY</b>						
Worries about health, loved ones, catastrophe						300.02
Unable to relax; nervous						300.81
Chronic unexplained aches and pains						300.30
Repetitive thoughts that make no sense						
Repetitive rituals						300.01
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Belief that the television is talking specifically to them						
A fixed belief that is out of touch with reality						
Thought sequence does not make sense						



	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>SUBSTANCE ABUSE</b>						<b>SEVERITY</b>
Excessive alcohol (> 2 drinks/day, > 4 drinks at once)						305
Smokes cigarettes						
Daily marijuana use						
Use of any other street drugs						
Abuse of prescription drugs						
<b>SLEEP DISORDERS 307.4</b>						
Agitated or sluggish, slowed down						
Has difficulty falling asleep						
Has difficulty staying asleep						
Has abnormal sleep patterns during the day						347
Unanticipated falling asleep during the day						307.4
Sleep walking						307.4
Has nightmares						307.45
Falls asleep late and sleeps in late						3.27
Sleep schedule changes from day to day						
Excessive snoring						
A feeling of restless legs while trying to sleep						
Observed to have sudden kicking while asleep						780.57
Observed to have difficulty breathing at night						
<b>ELIMINATION DISORDERS 307</b>						
Wets the bed at night						
Wets during the day						
Soils self						
<b>EATING DISORDERS 307</b>						
Vomits after meals or bingeing						
Underweight and refuses to eat						307.1
Distorted body image						
Picky eater						
High junk food diet						
<b>LEARNING DISABILITIES 315</b>						
Delayed expressive language						
Stuttering						
Problems articulating words						315
Below grade level in reading						315.1
Below grade level in math						315.2
Trouble with writing (messy, tiring, avoids writing)						
Variable performance in school						
Underachieves at school relative to potential						315.4

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>DEVELOPMENTAL COORDINATION DISORDER</b>						
Difficulty with gross motor skills (i.e. gym, sports, biking)						
Clumsy						
Difficulty with fine motor (buttons, shoe laces, cutting)						
<b>PERSONALITY 301</b>						<b>SEVERITY</b>
Unstable interpersonal relationships						
Frantic efforts to avoid abandonment						
Recurrent suicidal ideation or attempts						
Intense anger						
Major mood swings						BPD 301.83
Impulsive self destructive or self injurious behavior						
Fragile identity or self image						
Chronic feelings of emptiness						
Transient stress related dissociation or paranoia						/9 (≥5/9)
Self centred or entitled						NPD 301.81
Deceitful, aggressive, or lack of remorse						ASP 301.7
<b>COMMENTS:</b>						

ADHD=attention deficit hyperactivity disorder; IA=inattentive subtype; HI=hyperactive impulsive subtype; BPD=borderline personality disorder; NPD=narcissistic personality disorder; ASP=antisocial personality disorder.

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Name: \_\_\_\_\_ Date:      DD MM YY

Date of birth:      DD MM YY Sex:  Male  Female

Work:  Full time  Part time  Other \_\_\_\_\_

School:  Full time  Part time

*Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.*

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>A</b>	<b>FAMILY</b>					
1	Having problems with family	0	1	2	3	n/a
2	Having problems with spouse/partner	0	1	2	3	n/a
3	Relying on others to do things for you	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Makes it hard for the family to have fun together	0	1	2	3	n/a
6	Problems taking care of your family	0	1	2	3	n/a
7	Problems balancing your needs against those of your family	0	1	2	3	n/
8	Problems losing control with family	0	1	2	3	n/a
<b>B</b>	<b>WORK</b>					
1	Problems performing required duties	0	1	2	3	n/a
2	Problems with getting your work done efficiently	0	1	2	3	n/a
3	Problems with your supervisor	0	1	2	3	n/a
4	Problems keeping a job	0	1	2	3	n/a
5	Getting fired from work	0	1	2	3	n/a
6	Problems working in a team	0	1	2	3	n/a
7	Problems with your attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems taking on new tasks	0	1	2	3	n/a
10	Problems working to your potential	0	1	2	3	n/a
11	Poor performance evaluations	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>C</b>	<b>SCHOOL</b>					
1	Problems taking notes	0	1	2	3	n/a
2	Problems completing assignments	0	1	2	3	n/a
3	Problems getting your work done efficiently	0	1	2	3	n/a
4	Problems with teachers	0	1	2	3	n/a
5	Problems with school administrators	0	1	2	3	n/a
6	Problems meeting minimum requirements to stay in school	0	1	2	3	n/a
7	Problems with attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems with working to your potential	0	1	2	3	n/a
10	Problems with inconsistent grades	0	1	2	3	n/a
<b>D</b>	<b>LIFE SKILLS</b>					
1	Excessive or inappropriate use of internet, video games or TV	0	1	2	3	n/a
2	Problems keeping an acceptable appearance	0	1	2	3	n/a
3	Problems getting ready to leave the house	0	1	2	3	n/a
4	Problems getting to bed	0	1	2	3	n/a
5	Problems with nutrition	0	1	2	3	n/a
6	Problems with sex	0	1	2	3	n/a
7	Problems with sleeping	0	1	2	3	n/a
8	Getting hurt or injured	0	1	2	3	n/a
9	Avoiding exercise	0	1	2	3	n/a
10	Problems keeping regular appointments with doctor/dentist	0	1	2	3	n/a
11	Problems keeping up with household chores	0	1	2	3	n/a
12	Problems managing money	0	1	2	3	n/a
<b>E</b>	<b>SELF-CONCEPT</b>					
1	Feeling bad about yourself	0	1	2	3	n/a
2	Feeling frustrated with yourself	0	1	2	3	n/a
3	Feeling discouraged	0	1	2	3	n/a
4	Not feeling happy with your life	0	1	2	3	n/a
5	Feeling incompetent	0	1	2	3	n/a
<b>F</b>	<b>SOCIAL</b>					
1	Getting into arguments	0	1	2	3	n/a
2	Trouble cooperating	0	1	2	3	n/a
3	Trouble getting along with people	0	1	2	3	n/a
4	Problems having fun with other people	0	1	2	3	n/a
5	Problems participating in hobbies	0	1	2	3	n/a
6	Problems making friends	0	1	2	3	n/a
7	Problems keeping friends	0	1	2	3	n/a
8	Saying inappropriate things	0	1	2	3	n/a
9	Complaints from neighbours	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>G</b>	<b>RISK</b>					
1	Aggressive driving	0	1	2	3	n/a
2	Doing other things while driving	0	1	2	3	n/a
3	Road rage	0	1	2	3	n/a
4	Breaking or damaging things	0	1	2	3	n/a
5	Doing things that are illegal	0	1	2	3	n/a
6	Being involved with the police	0	1	2	3	n/a
7	Smoking cigarettes	0	1	2	3	n/a
8	Smoking marijuana	0	1	2	3	n/a
9	Drinking alcohol	0	1	2	3	n/a
10	Taking "street" drugs	0	1	2	3	n/a
11	Sex without protection (birth control, condom)	0	1	2	3	n/a
12	Sexually inappropriate behaviour	0	1	2	3	n/a
13	Being physically aggressive	0	1	2	3	n/a
14	Being verbally aggressive	0	1	2	3	n/a

**SCORING:**

1. Number of items scored 2 or 3  
*or*
2. Total score  
*or*
3. Mean score

<b>DO NOT WRITE IN THIS AREA</b>	
A. Family	
B. Work	
C. School	
D. Life skills	
E. Self-concept	
F. Social	
G. Risk	
<b>Total</b>	

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – PARENT REPORT (WFIRS-P)

Your name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

*Circle the number for the rating that best describes how your child's emotional or behavioural problems have affected each item in the last month.*

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>A</b>	<b>FAMILY</b>					
1	Having problems with brothers & sisters	0	1	2	3	n/a
2	Causing problems between parents	0	1	2	3	n/a
3	Takes time away from family members' work or activities	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Isolating the family from friends and social activities	0	1	2	3	n/a
6	Makes it hard for the family to have fun together	0	1	2	3	n/a
7	Makes parenting difficult	0	1	2	3	n/a
8	Makes it hard to give fair attention to all family members	0	1	2	3	n/a
9	Provokes others to hit or scream at him/her	0	1	2	3	n/a
10	Costs the family more money	0	1	2	3	n/a
<b>B</b>	<b>SCHOOL</b>					
	<b>Learning</b>					
1	Makes it difficult to keep up with schoolwork	0	1	2	3	n/a
2	Needs extra help at school	0	1	2	3	n/a
3	Needs tutoring	0	1	2	3	n/a
4	Receives grades that are not as good as his/her ability	0	1	2	3	n/a
	<b>Behaviour</b>					
1	Causes problems for the teacher in the classroom	0	1	2	3	n/a
2	Receives "time-out" or removal from the classroom	0	1	2	3	n/a
3	Having problems in the school yard	0	1	2	3	n/a
4	Receives detentions (during or after school)	0	1	2	3	n/a
5	Suspended or expelled from school	0	1	2	3	n/a
6	Misses classes or is late for school	0	1	2	3	n/a
<b>C</b>	<b>LIFE SKILLS</b>					
1	Excessive use of TV, computer, or video games	0	1	2	3	n/a
2	Keeping clean, brushing teeth, brushing hair, bathing, etc.	0	1	2	3	n/a
3	Problems getting ready for school	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
4	Problems getting ready for bed	0	1	2	3	n/a
5	Problems with eating (picky eater, junk food)	0	1	2	3	n/a
6	Problems with sleeping	0	1	2	3	n/a
7	Gets hurt or injured	0	1	2	3	n/a
8	Avoids exercise	0	1	2	3	n/a
9	Needs more medical care	0	1	2	3	n/a
10	Has trouble taking medication, getting needles or visiting the doctor/dentist	0	1	2	3	n/a
<b>D</b>	<b>CHILD'S SELF-CONCEPT</b>					
1	My child feels bad about himself/herself	0	1	2	3	n/a
2	My child does not have enough fun	0	1	2	3	n/a
3	My child is not happy with his/her life	0	1	2	3	n/a
<b>E</b>	<b>SOCIAL ACTIVITIES</b>					
1	Being teased or bullied by other children	0	1	2	3	n/a
2	Teases or bullies other children	0	1	2	3	n/a
3	Problems getting along with other children	0	1	2	3	n/a
4	Problems participating in after-school activities (sports, music, clubs)	0	1	2	3	n/a
5	Problems making new friends	0	1	2	3	n/a
6	Problems keeping friends	0	1	2	3	n/a
7	Difficulty with parties (not invited, avoids them, misbehaves)	0	1	2	3	n/a
<b>F</b>	<b>RISKY ACTIVITIES</b>					
1	Easily led by other children (peer pressure)	0	1	2	3	n/a
2	Breaking or damaging things	0	1	2	3	n/a
3	Doing things that are illegal	0	1	2	3	n/a
4	Being involved with the police	0	1	2	3	n/a
5	Smoking cigarettes	0	1	2	3	n/a
6	Taking illegal drugs	0	1	2	3	n/a
7	Doing dangerous things	0	1	2	3	n/a
8	Causes injury to others	0	1	2	3	n/a
9	Says mean or inappropriate things	0	1	2	3	n/a
10	Sexually inappropriate behaviour	0	1	2	3	n/a

**SCORING:**

1. Number of items scored 2 or 3  
*or*
2. Total score  
*or*
3. Mean score

**DO NOT WRITE IN THIS AREA**

A. Family	
B. School Learning Behaviour	
C. Life skills	
D. Child's self-concept	
E. Social activities	
F. Risky activities	
<b>Total</b>	

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

Date of Birth: \_\_\_\_\_

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

MRN/File No: \_\_\_\_\_

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

## SNAP-IV 26 – Teacher and Parent Rating Scale

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_ Ethnicity:  African-American  Asian  Caucasian  Hispanic Other: \_\_\_\_\_

Completed by: \_\_\_\_\_ Type of Class: \_\_\_\_\_ Class size: \_\_\_\_\_

<i>For each item, check the column which best describes this child:</i>	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is "on the go" or often acts as if "driven by a motor"				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				
18. Often has difficulty awaiting turn				
19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Often is angry and resentful				
26. Often is spiteful or vindictive				