CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

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

CADDRA Child Assessment Instructions

Name of the child: _____ Date: _____

Parent(s): _____

_____

Time period for which the form was filled out: _____

If the child was on medication when this was completed, what medication was s/he on? _____

_____

_____

Your child is presently being evaluated for Attention Deficit Hyperactivity Disorder. Your doctor will require you to complete the following questionnaires as part of this process. (All these documents can be downloaded and printed from the Guidelines section on the CADDRA website: 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 your child functions 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 the child is living in two households, each household should complete these forms.

Questionnaires

- ☐ Weiss Symptom Record: To be completed by both parents
- ☐ WFIRS-P: To be completed by parents
- ☐ ADHD Checklist
- ☐ CADDRA Teacher Assessment Form
- ☐ SNAP-IV 26

If your child is on medication, it would be helpful if you could fill in the forms twice in order to assess the child on and off medication. Please fill in the forms in two different colours to demonstrate the differences.

If your child has already started using ADHD medication, please also complete the CADDRA Patient ADHD Medication Form. If not, please keep this form on hand for possible future use.

- ☐ CADDRA Patient ADHD Medication Form

Information Sheets

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

- ☐ CADDRA ADHD Information and Resources

Points to discuss at the next medical appointment:

_____
_____
_____
_____
_____

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:

❑ Excessive vomiting ❑ Operation(s) ❑ Excessive vaginal bleeding

❑ Infection with fever or rash ❑ Injuries/accidents ❑ Other health problems:

❑ Toxemia (high blood pressure) ❑ Unusual emotional stress _____

❑ Convulsions/seizures ❑ Prolonged hospitalization(s) _____

During your pregnancy, did you:

Smoke cigarettes? ❑ No ❑ Less than ½ pack per day ❑ ½ 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?

❑ Poor sucking ❑ Injured at birth ❑ Birth defects

❑ Unusual rash ❑ Trouble breathing ❑ Was given medications

❑ Turned yellow ❑ Turned blue ❑ Infection (specify)_____

❑ Received blood transfusion ❑ Kept in incubator (how long?_____) ❑ Seizures/convulsions

❑ Needed surgery ❑ Transferred to intensive care nursery ❑ Was very jittery

❑ 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:

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

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

_____

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

- ❑ Ear infections
- ❑ Hearing problem
- ❑ Tics or muscle twitches
- ❑ Rash/Skin problems
- ❑ Eye problem
- ❑ Casts/Braces
- ❑ Head injury
- ❑ Recurrent infections
- ❑ Surgery (operations)
- ❑ Meningitis
- ❑ Allergies
- ❑ Admissions to hospital
- ❑ Seizures
- ❑ Asthma
- ❑ 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)?

_____

_____

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

_____

_____

Name of person filling out this form: _____

Signature: _____ Date: _____

Please fully complete

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Physician Name: Date:

Person completing form:_____

Weiss Symptom Record (WSR)

Instructions to Informant: *Check the box that best describes typical behavior* ***Instructions to Physician:*** *Symptoms rated 2 or 3 are positive and total count completed below*	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	# items scored 2 or 3 (DSM Criteria)
ADHD COMBINED TYPE 314.01						**≥6/9 IA & HI**
ATTENTION 314.00						
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						
Difficulting organizing tasks and activities						
Avoids tasks that require sustained mental effort (boring)						
Losing things						
Easily distracted						
Forgetful in daily activities						/9 (≥6/9)
HYPERACTIVE/IMPULSIVE 314.01						
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)
OPPOSITIONAL DEFIANT DISORDER 313.81						
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
TIC DISORDERS 307.2						**SEVERITY**
Repetitive involuntary movements (blinking, twitching)						
Repetitive involuntary noises (throat clearing, sniffing)						
CONDUCT DISORDER 312.8						
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)
ANXIETY						
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
DEPRESSION 296.2 (single) .3 (recurrent)						
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
DEPRESSION (CONT'D)						**SEVERITY**
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			
MANIA 296.0(manic) .6(mixes) .5(depressed)						
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)
SOCIAL SKILLS 299						
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)						
PSYCHOSIS 295						
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
SUBSTANCE ABUSE						**SEVERITY**
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						
SLEEP DISORDERS 307.4						
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						
ELIMINATION DISORDERS 307						
Wets the bed at night						
Wets during the day						
Soils self						
EATING DISORDERS 307						
Vomits after meals or binging						
Underweight and refuses to eat						307.1
Distorted body image						
Picky eater						
High junk food diet						
LEARNING DISABILITIES 315						
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
DEVELOPMENTAL COORDINATION DISORDER						
Difficulty with gross motor skills (i.e. gym, sports, biking)						
Clumsy						
Difficulty with fine motor (buttons, shoe laces, cutting)						
PERSONALITY 301						**SEVERITY**
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
COMMENTS:						

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:
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Physician Name: 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
A	**FAMILY**					
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	**SCHOOL**					
	Learning					
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
	Behaviour					
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
C	**LIFE SKILLS**					
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
D	**CHILD'S SELF-CONCEPT**					
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
E	**SOCIAL ACTIVITIES**					
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
F	**RISKY ACTIVITIES**					
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	
Total	