Instructions for the

CHILD OR ADOLESCENT COMPREHENSIVE HISTORY AND QUESTIONNAIRE FORMS

The packet you have received contains the Child/Adolescent Comprehensive History and the Child/Adolescent Questionnaire. The information collected in these documents is very important in order to give you a complete and accurate assessment.

That is why we require that they be completed and returned
<u>Before</u> an evaluation appointment is made.

While this process may seem like a lot of work, your participation gives us the information necessary to provide your child with the best diagnostic assessment possible.

The process will require an hour or more of your time. Please be as accurate and complete as possible. If you need more space, you can use the back of the assessment forms.

Some of the questions will seem quite personal; but it is important that you answer them completely. **The information is strictly confidential and will follow the guidelines in the Privacy Statement.**

We do encourage you to allow us to share it with other health care professionals who are treating you. They also may not release any information about you without your written permission.

We recognize that no one has a perfect memory; but please do the best you can in answering the questions accurately. **It is especially important to have approximate dates for any previous treatment.**

For any psychiatric medication your child has taken, start and stop dates as well as dosages are needed. Month and year will do in most cases.

We realize that some questions may not apply to very young children, but please answer as completely as possible.

Try your best; we don't expect perfection.

You will notice that the instructions on the questionnaire ask **<u>if your child has ever had any of the symptoms listed</u>**. Psychiatric symptoms will come and go, so it is important to try to remember if your child has ever had symptoms.

After you have completely filled the questionnaire out, we ask that you **<u>go back through the symptoms and circle the number that corresponds to symptoms your child is presently experiencing</u>**.

The same would be true for children and adolescents who can answer the child/adolescent questionnaire themselves.

For example on Page 1 #1 of the Parent Questionnaire "My child feels discouraged a lot."
Child/Adolescent Questionnaire "I feel discouraged a lot."

If your child/adolescent has ever felt discouraged in the past, you would mark the appropriate box for the degree of difficulty she/he has ever had:

— Never, Not at all
— Sometimes, Just a little
— Often, Pretty much
— Frequently, Very much.

If your child/adolescent is feeling discouraged **at this time**, you would indicate this by **Circling the number 1.** The same is true for each question on every page of both the parent and child/adolescent forms.

Example with the Child/Adolescent Questionnaire:

*Please **check the appropriate box** if you have **ever experienced** any of the following symptoms.* *Please **circle the number** by any symptoms you **have now**.*	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
(1.) I feel discouraged a lot.			X	
(2.) I feel down, low, or sad most of the time.				X
3. I cry easily.		X		
(4.) I get mad easily ☑ feel cranky.☐			X	
5. I feel people are irritating me.☑ I often feel frustrated.☐			X	
6. I blow up over little things.			X	
7. I have lost interest in activities. (sports, going out, shopping)		X		
8. I spend less time with family.	X			
9. I spend less time with friends.	X			
10. I get into fights with friends.	X			
(11.) I often don't feel like eating.		X		
12. I have lost weight. (_____ pounds)	X			
(13.) I skip meals.		X		

In this way, we get a clearer picture of what your child has experienced and what he/she is experiencing at this time. Then we can make the appropriate diagnosis and develop the best treatment plan to fit your child's needs.

This information is essential for establishing a good understanding of your child's problems.

Please enter the child's name on every page.

Thank you for your cooperation.

We look forward to working with you and your child in the treatment process.

CHILD OR ADOLESCENT COMPREHENSIVE HISTORY – Page 1 Date _____

Child's Name _____ Birth Date_____ Age _____

Referred By _____ Form Filled Out By _____ Phone _____

Child's Address _____

Child's School_____ Grade _____

Reason for Seeking Treatment _____

_____

Family

Father's Name _____ Occupation _____ Age __

Mother's Name _____ Occupation _____ Age __

Stepfather's Name _____ Occupation _____ Age __

Stepmother's Name _____ Occupation _____ Age __

Brothers and Sisters Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

If parents are separated or divorced, address and phone numbers of other parent

Name _____ Phone _____ Work Phone _____

Address _____

Other persons residing in the home

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Healthcare

Company Health Benefits _____ Private Insurance _____ Medicaid _____ Medicare _____ Self-Pay _____

DEVELOPMENTAL HISTORY

Was the pregnancy planned? Yes __ No ___ If there were any complications during the pregnancy, please explain.

_____

Were you under emotional stress during the pregnancy? Yes__ No __ If yes, what was stressful? _____

_____

Did you use: Drugs _____ Alcohol _____ Tobacco _____ Medications _____

If yes to any of the above, please give the type, amounts used, and frequency during the pregnancy _____

_____

Were you involved in prenatal care? Yes _____ No _____ Birth weight of child _____

Any difficulties with the birth? Please explain _____

Did your baby have to stay in the hospital after the birth? Yes ___ No ___ If yes, why? _____

_____

For the next questions if you do not remember an approximate time, please check *Before or After*?

When did your child walk? _____ Before ___ After ___ one year?
Say his/her first word? _____ Before ___ After ___ one year?
Talk in sentences? _____ Before ___ After ___ three years?
Complete toilet training? _____ Before ___ After ___ three years?
Were there any speech problems? _____Has your child had speech therapy? _____

EARLY CHILDHOOD PROBLEMS

Were there early difficulties during infancy with Feeding ☐ Sleeping ☐ Colic ☐ Head banging ☐ Excessive Rocking? ☐

Were there any early problems (before age 5) with the following? Poor eye contact ☐ Disliked being touched ☐ or held ☐ Not cuddly ☐ Would stare into space ☐ Look through you ☐Lack of expression ☐ Seemed in a shell ☐ Seemed distant ☐ Avoids adults ☐ other children ☐ Little interest in sharing ☐ Need for sameness ☐ Hard to know what he/she wants ☐ Hard time talking to people ☐ Unusual speech ☐ Lines up toys ☐ Spins toys ☐ Echoes words ☐ Flaps hands ☐ Upset with change in routine ☐ Attachment to things not people ☐ Bites or hurts self ☐ Unusual food likes and dislikes ☐ Sensitive to light ☐ sound ☐ touch ☐ Little reaction to pain ☐ Lack of pretend play ☐

Nightmares ☐ Night terrors ☐ Bed wetting ☐ Messing pants ☐ Unusual fears ☐ Aggression ☐ Temper tantrums ☐ Hyperactive ☐ Difficulties with impulse control ☐ Inability to pay attention ☐ Problems with other children ☐ Being a dare devil ☐ Having no fear ☐ Being bold ☐ Being demanding ☐ Being overly sensitive ☐

If yes to any of the above early childhood problems, please explain _____

_____

_____

_____

_____

For the following questions, please indicate dates and how long the abuse lasted.

Has your child ever been physically abused? _____

Sexually abused? _____

Psychologically abused? _____

SCHOOL

Has your child experienced any difficulties in school? Academic _____ Behavioral _____

Has your child been suspended from school? _____ How many times _____ When _____

Has your child been expelled from school? _____ When _____ For how long _____

Does your child have a learning disability? Please explain._____

_____

SCHOOL PERFORMANCE

***Extremely Important*:**

1. **Please fill in the ESTIMATED average grades for each school year.**
   - **Average Grades by Year (S = Satisfactory, U = Unsatisfactory, Letter Grades = A, B, C, D, F)**

2. **Please Explain Any Behavioral or Academic Problems For Each Year**
   - **Example of problems (Would not sit down, could not follow directions, cut class, etc.)**

Example ↓		**My Child's Averages** ↓	**Problems during the year** ↓
S	**K**	Average_____	Problems_____
S	**1st Grade**	Average_____	Problems_____
U	**2nd Grade**	Average_____	Problems_____
S	**3rd Grade**	Average_____	Problems_____
B	**4th Grade**	Average_____	Problems_____
C	**5th Grade**	Average_____	Problems_____
C	**6th Grade**	Average_____	Problems_____
D	**7th Grade**	Average_____	Problems_____
F	**8th Grade**	Average_____	Problems_____
D	**9th Grade**	Average_____	Problems_____
C	**10th Grade**	Average_____	Problems_____
D	**11th Grade**	Average_____	Problems_____
F	**12th Grade**	Average_____	Problems_____

POSITIVES ABOUT YOUR CHILD

Please list positives about your child (for example, good with children, athletic, musical, etc.) _____

CHILD'S ACTIVITIES

What does your child like to do for fun? _____

TREATMENT EXPECTATIONS

Please list your expectations concerning the outcome of treatment for your child. _____

CONCERNS, IF ANY, ABOUT MENTAL HEALTH TREATMENT

ENVIRONMENTAL STRESSORS

Have there been major changes or events in your child or family's life? Please explain.

Death of friend or family member _____

Moves _____

Significant medical problems for child _____

Ill health of family member _____

Financial problems _____

Abuse in family _____

Addiction in family _____

Violence in family _____

Other Stressors _____

LOCAL SUPPORT SYSTEMS

Friends / Relatives _____

Religious Affiliation _____

Other _____

CHILD'S PAST MENTAL HEALTH OR PSYCHIATRIC HISTORY

Please write in counselor, reason for counseling, and dates of counseling.

Counselor (Past and Present)	Reason for Counseling	Dates of Counseling

Please list the condition or diagnosis and any medications prescribed with dates, dosages, and who prescribed them.

***Example**: ADHD* *Ritalin 5 mg* *Dr. Jones 2001-2002*

Condition or Diagnosis (Past)	Medications and Dosages	Prescribed by and Date

Reason treatment (counseling/medication) was not successful _____

FAMILY HEALTH HISTORY

Have any of your child's <u>biological</u> relatives (brothers, sisters, mother, father, aunts, uncles, and grandparents) suffered from any of the following conditions? Please specify family member and whether it is paternal (father's relative) or maternal (mother's relative). (**Example**: Maternal Grandmother, Paternal Uncle)

Depression _____
Attention problems, Hyperactivity - ADD _____
Bed-wetting _____
Bipolar Disorder (Mood swings) _____
Anger outbursts _____
Attempted suicide _____
Completed suicide _____
Sexual abuse _____
Panic attacks _____
Anxiety _____
Tic Disorder _____
Diabetes _____
Heart disease _____
Overweight _____

Alcohol problems _____
Drug problems _____
Schizophrenia _____
Big mood changes _____
Seizures _____
Obsessive-Compulsive Disorder behavior _____
Physical abuse _____
Problems with the law _____
Learning disability _____
Autism/Asperger's _____
Thyroid disorder _____
Cancer _____
High Blood Pressure _____
Other Hereditary Disorders _____

CHILD'S MEDICAL HISTORY

Has your child ever experienced any of the following? Please explain.

Major medical problems _____

Seizures _____

Medical Hospitalization _____

Psychiatric Hospitalization _____

Attempted suicide _____

Head injuries _____

Prolonged fevers _____

Serious infections _____

Surgeries _____

Broken bones _____

Asthma _____

Allergies _____

Medication allergies _____

If female, last menstrual period _____ Has your child ever been pregnant? _____ If yes, age _____

Immunizations current? Yes ___ No ___ If not, which are lacking? _____

Child's overall health ___ Excellent ____ Good _____ Fair____ Poor

Please list below all medications your child is presently taking and the condition for which they are prescribed.

Condition	Medication	Dosage	Times per Day	Prescribing Doctor

LEGAL HISTORY

Please list all present and past legal charges your child has experienced giving dates of offenses _____

Please list times in detention and for what offenses _____

Please give name of your child's present probation officer _____

Please list legal difficulties family members have experienced _____

CHILD OR ADOLESCENT QUESTIONNAIRE – Page 1

Name _____ Date _____

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I feel discouraged a lot.				
2. I feel down, low, or sad most of the time.				
3. I cry easily.				
4. I get mad easily ☐ feel cranky.☐				
5. I feel people are irritating me.☐ I often feel frustrated.☐				
6. I blow up over little things.				
7. I have lost interest in usual activities (sports, going out, shopping).				
8. I spend less time with family.				
9. I spend less time with friends.				
10. I get into fights with friends.				
11. I often don't feel like eating.				
12. I have lost weight. How many pounds? _____				
13. I skip meals.				
14. I have gained weight recently. How many pounds? _____				
15. I eat or crave foods (sweets) when I feel sad.				
16. I have a hard time going to sleep. How many hours? _____				
17. I like to stay up late regularly.				
18. I wake up in the middle of the night ☐ early in the morning.☐				
19. I like to sleep a lot ☐ take naps during the day.☐				
20. I feel bored or blah a lot.				
21. I feel restless or can't sit still.				
22. I feel tired.				
23. I don't have much energy.				
24. I don't like myself. (feel ugly ☐ fat ☐ stupid ☐)				
25. I feel worthless.				
26. I feel bad or guilty about things I have done or said.				
27. I feel like there is not much future.☐ I feel hopeless.☐				
28. I am easily distracted by things around me.				
29. I have problems paying attention ☐ concentrating.☐				
30. I have a hard time making decisions.				
31. I don't care about life.				
32. I think about people dying.				
33. I think about suicide.				
34. I think about ways to commit suicide.				
35. I have attempted suicide.				
36. My grades have dropped.				
37. I have frequent headaches ☐ stomachaches ☐ other pains.☐				
38. I hear my name called when no one is around.☐ I hear voices.☐				
39. I hear voices that seem to come from nowhere.				
40. My mood changes quickly.☐ I have mood swings.☐				
41. I have problems learning at school.				
42. I have used alcohol ☐ or drugs ☐ to feel better.				
43. I feel my parents are unfair. ☐ I lied to them. ☐ stole from them.☐				
44. I have run away from home ☐ skipped school. ☐				
45. I have hit someone ☐ threatened to hit someone.☐				
46. At times I feel very confident ☐ or very good.☐				
47. I get moody in the fall, happy in the spring.				
48. I get depressed every fall or winter.				

EDM 1 – 48

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I feel I came close to dying (in a severe accident/abuse etc.)				
2. I felt severely threatened or fearful at one time.				
3. I was severely injured or thought I would be.				
4. I saw someone be severely injured or hurt.				
5. I have been abused physically.				
6. I have been abused psychologically.				
7. I have been abused sexually.				
8. I have experienced upsetting memories of events. (abuse, accident,)				
9. I feel upset thinking about things that happened. (abuse, accident, etc.)				
10. I have dreams of things that have happened. (abuse, accident, etc.)				
11. I experience flashbacks of things that have happened. (abuse/accident,)				
12. I feel like I'm reliving what happened. (abuse, accident, etc.)				
13. I feel bad when reminded of an event (abuse, accident, etc.)				
14. I feel upset when experiencing something similar.				
15. I try to avoid thinking of the event. (abuse, accident, etc.)				
16. I avoid things that remind me of the event. (abuse, accident, etc.)				
17. I can't remember parts of the event. (abuse, accident, etc.)				
18. I have problems with my memory.				
19. I have lost interest in normal activities. (sports, friends)				
20. I can't enjoy participating in activities.				
21. I feel different from others.				
22. I feel numb inside.				
23. I try to avoid feelings.				
24. I feel alone.				
25. I feel helpless.				
26. I feel there is no future.				
27. I have a hard time falling asleep.				
28. I wake up in the middle of the night.				
29. I get angry easily.				
30. I feel irritable.				
31. I daydream in school.				
32. I have problems concentrating in school.				
33. I seem on edge all the time.				
34. I startle very easily.				
35. I sweat at times for no reason.				
36. I sweat when reminded of the event (abuse, accident, etc.)				
37. I fight with parents or teachers.				
38. I feel people are trying to control me.				
39. I have problems with brothers or sisters.				
40. I have problems with friends.				
41. I feel like it's happening all over again (abuse, accident, etc.)				
42. I feel certain my negative thoughts will come true.				
43. I feel I will be hurt if I talk about abuse.				
44. I feel if I let go, my feelings will be out of control.				

DSTP 1-44

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often make careless mistakes ☐ have problems with details.☐				
2. I often have problems keeping attention. ☐ keeping focused. ☐				
3. I often have had a hard time listening.				
4. I often have had a hard time following through on instructions.				
5. I often have had a hard time organizing things.				
6. I often haven't liked activities that require a lot of thinking.				
7. I have often lost school things (pencils, books, assignments).				
8. I have often been easily distracted by activities around me.				
9. I have forgotten things quite often.				
10. People often say I'm fidgety ☐ that I was fidgety when younger. ☐				
11. I often have had difficulty staying seated at school. ☐ home. ☐				
12. I would often run around or climb on things when I wasn't supposed to				
13. I have a hard time playing or doing things quietly.				
14. I feel like the Energizer Bunny. ☐ I have to be on the go. ☐				
15. I have often gotten into trouble for talking too much.				
16. I have often answered questions before they are completed.				
17. I have often had difficulty waiting my turn.				
18. I have/have had problems with interrupting others when they are talking.				
19. I avoid doing homework.				
20. I have a difficult time with homework.				
21. I have a difficult time finishing schoolwork or chores.				
22. I have to move my hands and feet all the time.				
23. I have to move around the room.				
24. I pay attention to unimportant things.				
25. I needed to be in the front of the line when I was younger.				
26. I talked out in class when I was younger.				
27. I have to be told several times to do things.				
28. My parents bug me about not paying attention.				
29. I can't complete tasks.				
30. People have said I'm loud or excitable.				
31. I can't keep my mouth shut.				
32. I butt into conversations.				
33. I space things off.				
34. I can't get homework home from school.				
35. I like to take risks or am a daredevil.				
36. I would run away from my parents when I was younger.				
37. I don't think about the consequences of my actions.				
38. I do dumb things and don't know why.				
39. I am or have been hyper.				
40. I am or have been impulsive.				

DHDA 1-40

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I use drugs or alcohol at school.				
2. I missed school because of use.				
3. I have had problems in school because of use.				
4. I have had problems with my parents because of use.				
5. I have had problems with the law because of use.				
6. I have had consumption tickets. ☐ possession tickets. ☐				
7. I can drink more than most people				
8. I have had money problems because of use.				
9. I have borrowed money from friends to buy drugs or alcohol.				
10. I have blacked out while using.				
11. I have had shakes in the morning after using.				
12. I have drunk more or used more than I wanted to.				
13. I have gotten drunk or high when I did not expect to.				
14. I have tried to cut back on using.				
15. I have had to use more to get the same effect.				
16. I have had an accident while using.				
17. I have driven while drinking.				
18. I have driven while using drugs.				
19. I use regularly.				
20. I quit using and started again.				
21. I have been in treatment for use. ☐ involved in AA or NA. ☐				
22. I rarely have hangovers when I drink.				
23. Most of my friends use.				
24. I use to deal with my feelings.				
25. When I'm using, I get into fights. ☐ argue. ☐				
26. It takes a lot to get me drunk.				
27. I have gone without things to buy drugs or alcohol.				
28. I have skipped meals when I was using.				
29. I have used until everything was gone.				
30. I have had sex when using.				
31. I have a hard time getting up in the morning after using.				
32. I have a constant runny nose.				
33. I have been involved in dealing.				
34. I need to use to have fun.				

AD 1-34

Did you remember to circle your current symptoms?

EXAMPLE OF HOW TO FILL THIS PAGE

Substance Examples	How much I use	How often I use	How long have I used	How old was I when I started	When I last used
Alcohol	1 case a day	Daily	4 years	12	Last night
Marijuana	10 bowls a day	Every weekend	6 years	10	2 weeks ago

YOUR DRUG AND ALCOHOL USE

Substance	How much I use	How often I use	How long have I used	How old was I when I started	When I last used
Cigarettes/Chew					
Caffeine					
Alcohol					
Marijuana (Pot)					
LSD (Acid, Fry)					
PCP (Angel Dust) Ketamine “Special K”					
Cocaine (Coke)					
Crack					
Speed (Crank)					
Crystal Meth					
Heroin					
Gasoline					
Visine eye drops (to hide use of marijuana)					
Abuse of cough syrup, over-the counter drugs					
Mescaline (“Shrooms”)					
Ecstasy					
OxyContin/Narcotic pain medications, Morphine					
Glue, Paint thinner, Spray paint, “Huffing”					
Dramamine					
Abused prescribed medications					
Other Substances Abused _____					

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I bully or threaten others.				
2. I have stolen from someone.				
3. I have often run away overnight.				
4. I stay out all night against my parents' wishes.				
5. I tell lies to my parents regularly to get out of trouble.				
6. I have set fires.				
7. I have skipped school more than once.				
8. I have broken into a house ☐ a car.☐				
9. I have destroyed property.				
10. I have hurt animals.				
11. I have forced someone to have sex.				
12. I have used a weapon in a fight.				
13. I start fights.				
14. I steal from stores ☐ cars ☐ neighbors.☐				
15. I have stolen directly from someone (mugging).				
16. I am cruel to people at times.				
17. I lose my temper often.				
18. I often argue with adults.				
19. I often defy adult rules.				
20. I often refuse to do chores at home.				
21. I often do things to deliberately annoy or bug people.				
22. I often blame other people for my mistakes.				
23. I often feel annoyed by others.				
24. I often feel touchy.				
25. I often feel angry.				
26. I often feel resentful.				
27. I often feel like getting back at people.				
28. I have tried to kill myself but didn't really want to die.				
29. At times I feel I can do almost anything ☐ I have big plans ☐				
30. I sometimes have difficulty paying attention ☐ or am easily distracted ☐				
31. At times I easily get irritated ☐ angry ☐ over little things.				
32. My thoughts go very fast at times.				
33. There are times I get by on little sleep (4-5 hours).				
34. At times I get very silly. ☐ over confident. ☐				
35. I feel like I need to talk a lot ☐ Interrupt conversations ☐				
36. People say I talk fast at times. ☐ ask me to slow down. ☐				
37. At times, even if I do a bad thing, it doesn't bother me that much.				
38. At times I feel like I have to be on the go and get mad if stopped.				
39. I am easily frustrated. ☐ get upset easily. ☐				
40. I have thrown severe temper tantrums ☐ have rage attacks. ☐				
41. I thoughtlessly do risky things or dangerous things ☐ Act impulsively ☐				
42. At times I feel very good. ☐ on top of the world. ☐				
43. I sometimes feel super sexy. ☐ very interested in sexual things. ☐				
44. I become aggressive easily. ☐ hit people. ☐				
45. I get super hyper. ☐ have lots of energy. ☐ have many projects. ☐				
46. I have big mood swings. ☐ rapid mood swings. ☐				

DC 1-16 DDO 17-27 DB 28-46 *28-32

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. My worst fear is looking stupid or being embarrassed.				
2. I don't do things or talk to people for fear of embarrassment.				
3. I avoid activities in which I am the center of attention.				
4. I feel short of breath or like I'm smothering.				
5. When I am anxious, I feel dizzy ☐ lightheaded ☐ unsteady ☐ faint.☐				
6. I feel my heart pounding ☐ beating rapidly.☐				
7. I tremble or shake. ☐ sweat for no reason. ☐				
8. I become anxious quickly (5 – 15 minutes).				
9. I feel like I'm choking. ☐ numb or tingly. ☐				
10. I feel unreal or detached from myself.				
11. I become panicky easily.				
12. I have unexplained chills ☐ hot flashes.☐				
13. I have chest pains ☐ discomfort in my chest.☐				
14. I fear that I might die ☐ might go crazy.☐				
15. I fear being out of control.				
16. When anxious, I often have upset stomach ☐ nausea ☐ diarrhea. ☐				
17. I am afraid of snakes ☐ dogs ☐ spiders ☐ heights ☐ other.☐				
18. I fear social situations.				
19. I fear school.				
20. I fear going outside.				
21. I feel anxious or worried a lot.				
22. I cannot control my worries.				
23. I feel restless, keyed up, or on edge.				
24. I have difficulty with paying attention ☐ my mind going blank.☐				
25. I have a lot of muscle aches ☐ muscle tension ☐				
26. I feel tired a lot.				
27. I have a hard time sleeping.				
28. I sweat for no reason.				
29. I feel really irritable.				
30. My hands get cold and clammy.				
31. My mouth gets dry a lot.				
32. I feel light headed.				
33. I startle easily.				
34. I feel like I have a lump in my throat.				
35. I feel like I'm on the edge.				
36. I have to urinate frequently.				
37. I have disturbing thoughts ☐ impulses ☐ images.☐				
38. I try to push down thoughts ☐ impulses ☐ images.☐				
39. The thoughts ☐ impulses ☐ images.☐ are inside my head.				
34. I have disturbing thoughts ☐ impulses ☐ images ☐ that seem senseless.				
41. I have a hard time ignoring disturbing thoughts ☐ impulses ☐ images.☐.				
42. I feel that I have obsessions ☐ thoughts I can't stop.☐				
43. I do things because of thoughts I can't stop. washing ☐ checking ☐				
44. I do things to prevent feeling bad. washing ☐ counting ☐ checking ☐				
45. I can't stop doing some things. washing ☐ counting ☐ checking ☐				
46. Obsessions or thoughts cause me to feel bad.				
47. Obsessions or thoughts keep me from doing things.				
48. I do things to prevent thoughts. check things ☐ wash my hands ☐				
49. I frequently wash my hands ☐ check things ☐ put things in order.☐				
50. I frequently pray ☐ count ☐ repeat words.☐				

DAS 1-3 DP 4-16 PS 17-20 DAG 21-36 DCO 37-50

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often feel abandoned.				
2. I get very upset when people leave me.				
3. I am unable to be alone.				
4. I am often disappointed by relationships.				
5. I often idealize people.				
6. I need to be close to people too quickly.				
7. I feel I give too much.				
8. I feel people don't give back.				
9. I feel people punish me for no reason.				
10. I often feel bad or evil.				
11. My feelings about myself change quickly.				
12. I feel safer in a structured environment.				
13. I often gamble too much.				
14. I often spend more than I should.				
15. I engage in unsafe sex at times.				
16. I often abuse substances (alcohol or drugs).				
17. I often drive recklessly.				
18. I often threaten suicide.				
19. I have attempted suicide.				
20. I have frequently attempted suicide.				
21. I cut on myself when I'm upset.				
22. I pull out my hair when I'm upset.				
23. I hit myself when I'm upset.				
24. I pick at myself when I am nervous.				
25. I bang my head when I'm upset.				
26. I often burn myself.				
27. I have extreme mood swings.				
28. I am basically unhappy most of the time.				
29. I rarely feel satisfied or feel good.				
30. I have frequent periods of unexplained despair.				
31. I have frequent periods of unexplained panic.				
32. I have frequent periods of unexplained anger.				
33. I feel empty most of the time.				
34. I feel bored a lot.				
35. I have a hard time controlling my anger.				
36. I am often sarcastic.				
37. At times I feel paranoid when stressed.				
38. My doctor tells me I do not weigh enough.				
39. I always think I'm too fat.				
40. I'm afraid of gaining any weight.				
41. Since I lost weight, my periods have stopped.				
42. Parts of my body are always too big.				
43. I lose weight but still feel fat.				
44. When I eat too much, I throw up.				
45. If I feel too heavy, I exercise a lot.				
46. I use diuretics or laxatives to lose weight.				
47. I like to fast or diet a lot.				
48. I often binge eat.				

DPB 1-37 NA 38-48

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often feel people are out to get me.				
2. I think people are watching me.				
3. People want to persecute me.				
4. Songs or books are written about me.				
5. Sometimes shows on TV are about me.				
6. People are trying to steal my thoughts.				
7. I feel that I have been taken over by aliens.				
8. I hear my name called when there is no one around.				
9. At times I hear voices that threaten me.				
10. At times a voice will call me names.				
11. At times I hear conversations in my head.				
12. Sometimes I see things that are not there.				
13. My thoughts often change rapidly.				
14. People tell me I don't make sense.				
15. I have a hard time sticking to a topic.				
16. My thoughts are often disorganized.				
17. I often get off track.				
18. Sometimes I do weird things.				
19. People say I dress funny.				
20. Sometimes I yell and scream for no reason.				
21. Sometimes I do sexual things in public.				
22. Sometimes it feels like I can't move for long periods.				
23. I get so excited other people get scared.				
24. I look flat most of the time.				
25. It's hard to look people in the eye.				
26. People say I am not very expressive.				
27. Most of the time, I don't have much to say.				
28. My answers to questions are usually short.				
29. It is hard to maintain a thought when I talk.				
30. I just don't care about anything.				
31. I have severe problems at school and/or work.				
32. It seems I can't get along with anyone.				
33. It's hard to keep clean.				
34. People say I am very capable.				
35. People say, "If you would only apply yourself."				
36. At times I eat a lot at once.				
37. When I eat a lot, I eat very fast.				
38. I feel guilty when I eat a lot.				
39. I eat when I'm depressed.				
40. I feel out of control when I eat a lot.				
41. When I eat a lot, I throw up.				
42. It is very easy for me to vomit.				
43. Sometimes I stick my fingers down my throat.				
44. I use laxatives and diuretics after I eat a lot.				
45. I am very concerned about my weight.				
46. I eat a lot when I'm angry.				
47. I eat a lot when I feel lonely.				
48. When I eat a lot, for a short while, I feel less depressed.				
49. Whenever I think about what I have eaten, I am self-critical and depressed.				

HCS 1-35 NB 36-49

Did you remember to circle your current symptoms?

PARENT QUESTIONNAIRE – Page 1

Name of Child _____ Form Filled Out by _____ Date: _____

Important – Please Note!

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child feels discouraged a lot.				
2. My child feels sad or depressed.				
3. My child cries easily.				
4. My child is easily: angered ☐ cranky.☐				
5. My child is: irritable ☐ frustrated.☐				
6. My child is not interested in usual activities.(sports, recreation)				
7. My child has withdrawn from: family ☐ friends.☐				
8. My child has problems: making friends ☐ keeping friends.☐				
9. My child is a picky eater.				
10. My child has lost weight.				
11. My child skips meals.				
12. My child has gained weight.				
13. My child eats when depressed. ☐ craves sweets. ☐				
14. My child has a hard time going to sleep.				
15. My child stays up late.				
16. My child wakes up: early in the morning ☐ in the middle of the night.☐				
17. My child: sleeps for long periods of time ☐ takes naps.☐				
18. My child: feels or acts slowed down ☐ complains of being bored.☐				
19. My child feels or acts restless.				
20. My child complains of being tired.				
21. My child doesn't have much energy.				
22. My child makes negative comments about him/herself.				
23. My child feels guilty.				
24. My child feels worthless.				
25. My child feels hopeless about the future.				
26. My child has problems concentrating.				
27. My child has problems paying attention: at school ☐ at home.☐				
28. My child has a hard time making decisions.				
29. My child has an "I don't care" attitude.				
30. My child talks about death.				
31. My child talks about: suicide ☐ wanting to be dead.☐				
32. My child has attempted suicide.				
33. My child complains of hearing voices.				
34. My child's school performance has changed.				
35. My child complains of: headaches ☐ stomachaches ☐ other pains.☐				
36. My child has difficulty learning.				
37. My child pouts and sulks.				
38. My child's mood changes: drastically ☐ quickly.☐				
39. My child at times exaggerates his/her abilities.				
40. My child feels his/her parents are unfair. ☐ steals ☐ tells lies. ☐				
41. My child uses alcohol or drugs.				
42. My child runs away from home.				
43. My child has been aggressive.				
44. My child retreats to his/her room.				
45. My child is inattentive to his/her personal appearance.				
46. My child is sensitive to rejection. ☐ feels that no one understands. ☐				
47. My child is moody in the fall ☐ brightens in the spring. ☐				
48. My child gets depressed every fall – winter.				

EDM 1-48

Did you remember to circle your child's current symptoms?

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child has experienced threat of death.				
2. My child has come close to dying.				
3. My child has been severely injured or hurt.				
4. My child has seen someone severely injured or hurt.				
5. My child has experienced physical abuse.				
6. My child has experienced psychological abuse.				
7. My child has experienced sexual abuse.				
8. My child has continuing distressing memories of the event. (abuse, accident, etc.)				
9. My child feels bad when reminded of the event. (abuse, accident, etc.)				
10. My child feels upset when thinking about the event. (abuse, accident, etc.)				
11. My child dreams of the event. (abuse, accident, etc.)				
12. My child experiences flashbacks of the event (abuse, accident, etc.).				
13. My child thinks he or she is reliving the event (abuse, accident, etc.).				
14. My child feels bad when exposed to similar events (abuse, accident.).				
15. My child has emotional symptoms when reminded of the event. (abuse, accident, etc.)				
16. My child avoids thoughts of the event. (abuse, accident, etc.)				
17. My child avoids similar situations to the event. (abuse, accident, etc.)				
18. My child cannot recall the event or parts of the event. (abuse, accident, etc.)				
19. My child has memory lapses.				
20. My child is not interested in normal activities.				
21. My child has stopped participating in enjoyable activities.				
22. My child feels different from others.				
23. My child feels numb.				
24. My child is unable to have feelings.				
25. My child feels rejected by others.				
26. My child feels helpless.				
27. My child feels there is no future.				
28. My child has difficulty falling asleep.				
29. My child wakes up in the middle of the night.				
30. My child has anger outbursts.				
31. My child is irritable.				
32. My child has difficulty concentrating.				
33. My child has problems in school.				
34. My child appears over alert.				
35. My child startles very easily.				
36. My child has unexplained sweating.				
37. My child sweats when reminded of the event (abuse, accident, etc.).				
38. My child fights with authority figures or parents.				
39. My child feels controlled by others: teachers ☐ parents.☐				
40. My child has difficulties with siblings.				
41. My child has problems with friends.				
42. My child feels the event (abuse, accident, etc.) is happening again.				
43. My child fears being hurt again.				
44. My child fears being out of control.				

DSTP 1-44

Did you remember to circle your child's current symptoms?

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child often makes careless mistakes: at school ☐ at home.☐				
2. My child doesn't pay attention to details.				
3. My child often has a hard time listening.				
4. My child often has a hard time following through on instructions.				
5. My child often has a hard time organizing things.				
6. My child often doesn't like activities or projects that require continuous effort.				
7. My child often loses school materials (pencils, books, assignments).				
8. My child is often easily distracted.				
9. My child often forgets things.				
10. My child seems fidgety most of the time.				
11. My child often has difficulty staying seated at school.				
12. My child often runs or climbs when not supposed to.				
13. My child had a hard time playing quietly when younger. ☐ now. ☐				
14. My child is: often on the go ☐ seems driven.☐				
15. My child often talks excessively.				
16. My child often answers questions before they are completed.				
17. My child often has difficulty waiting his or her turn				
18. My child often interrupts others when they are talking				
19. My child avoids doing homework.				
20. My child has a difficult time with homework.				
21. My child has a difficulty time finishing schoolwork or chores.				
22. My child has to move his/her hands and feet all the time.				
23. My child has to move around the room.				
24. My child pays attention to unimportant things.				
25. My child needed to be in the front of the line when younger.				
26. My child talked out in class when younger.				
27. My child has to be told several times to do things.				
28. My child is often corrected for not paying attention.				
29. My child can't complete tasks.				
30. My child is loud or excitable.				
31. My child talks excessively.				
32. My child butts into conversations.				
33. My child doesn't seem to listen.				
34. My child can't get homework home from school.				
35. My child likes to take risks.				
36. My child: puts him/herself in dangerous situations ☐ is a daredevil.☐				
37. My child went from one activity to another when younger. ☐ now.☐				
38. My child doesn't think about the consequences of his or her actions.				
39. My child is or has been impulsive.				
40. My child is or has been hyperactive.				

DHDA 1-40

Did you remember to circle your child's current symptoms?

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child has used drugs or alcohol at school.				
2. My child has missed school because of use of drugs or alcohol.				
3. My child has problems in school because of use of drugs or alcohol.				
4. My child has problems at home because of use of drugs or alcohol.				
5. My child has legal problems because of use of drugs or alcohol.				
6. My child has had consumption tickets.				
7. My child has had possession tickets.				
8. My child has money problems because of use of drugs or alcohol.				
9. My child has been borrowing money from friends to buy drugs or alcohol.				
10. My child has blackouts.				
11. My child has shakes in the morning.				
12. My child drinks or uses too much.				
13. My child gets high when he or she doesn't expect to.				
14. My child has tried to cut back on use.				
15. My child has to use more to get the same effect.				
16. My child had an accident while using drugs or alcohol.				
17. My child has driven while intoxicated.				
18. My child has driven while using drugs.				
19. My child uses on a regular basis.				
20. My child quit using but started again.				
21. My child has previously been involved in NA/AA.				
22. My child has been in treatment for using drugs or alcohol.				
23. Most of my child's friends use drugs or alcohol.				
24. My child uses drugs or alcohol to deal with feelings.				
25. My child gets into fights when using drugs or alcohol.				
26. My child argues when using.				
27. My child has done without things to buy drugs or alcohol.				
28. My child has skipped meals when using drugs or alcohol.				
29. My child has used until everything was gone.				
30. My child has had sex when using drugs or alcohol.				
31. My child is difficult to wake up after using drugs or alcohol.				
32. My child has a constant runny nose.				

AD 1-32

Did you remember to circle your child's current symptoms?

EXAMPLE OF HOW TO FILL THIS PAGE

Substance **Examples**	How much does your child use?	How often does your child use?	How long has your child used?	Age when he/she first started?	When did your child use last?
Alcohol	1 case a day	Daily	4 years	12	Last night
Marijuana	10 bowls a day	Every weekend	6 years	10	2 weeks ago

YOUR CHILD'S DRUG AND ALCOHOL USE

Substance	How much does your child use?	How often does your child use?	How long has your child used?	Age when he/she first started?	When did your child last use?
Cigarettes/Chew					
Caffeine					
Alcohol					
Marijuana (Pot)					
LSD (Acid, Fry)					
PCP (Angel Dust) Ketamine "Special K"					
Cocaine (Coke)					
Crack					
Speed (Crank)					
Crystal Meth					
Heroin					
Gasoline					
Visine eye drops (to hide use of marijuana)					
Abuse of cough syrup, over-the counter drugs					
Mescaline ("Shrooms")					
Ecstasy					
OxyContin/Narcotic pain medications, Morphine					
Glue, Paint thinner, Spray paint, "Huffing"					
Dramamine					
Abused prescribed medications					
Other Substances Abused					

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child often: bullies others ☐ threatens others.☐				
2. My child has stolen from someone.				
3. My child often runs away overnight.				
4. My child often stays out all night against our wishes.				
5. My child tells lies to obtain things or avoid consequences.				
6. My child has set fires with intention of causing damage.				
7. My child has skipped school more than once.				
8. My child has broken into: a house ☐ a car.☐				
9. My child has destroyed property.				
10. My child has been cruel to animals.				
11. My child has forced someone to have sex.				
12. My child has used a weapon in a fight.				
13. My child has started fights.				
14. My child has stolen from someone without confronting the person.				
15. My child has stolen directly from someone (mugged someone).				
16. My child has been cruel to people at times.				
17. My child often loses his/her temper.				
18. My child often argues with adults.				
19. My child often defies adult rules.				
20. My child often refuses to do chores at home.				
21. My child often deliberately annoys people.				
22. My child often blames other people for his or her mistakes.				
23. My child often feels annoyed by others.				
24. My child often feels touchy.				
25. My child often feels angry.				
26. My child often feels resentful.				
27. My child often feels like getting back at people.				
28. My child has attempted suicide but did not want to die.				
29. My child at times: is grandiose ☐ has big unrealistic plans and ideas.☐				
30. My child has difficulty with: paying attention ☐ being distractible.☐				
31. My child is irritable for little or no reason. ☐ angry for little or no reason. ☐				
32. My child complains of his/her thoughts racing.				
33. My child has times when he/she doesn't need much sleep. (4 – 5 hours)				
34. My child sleeps a lot at times. (12 hours or more)				
35. At times my child feels the need to talk a lot. ☐ interrupts conversations. ☐				
36. My child talks fast at times.				
37. My child does not feel bad about bad behavior. ☐ shows no remorse. ☐				
38. My child has to be on the go ☐ becomes angry when stopped.☐				
39. My child is easily frustrated at times.				
40. My child has had: severe temper tantrums ☐ fits of rage.☐				
41. My child: engages in risky impulsive behavior ☐ is a daredevil.☐				
42. My child is overly confident ☐ overly happy.☐ very silly.☐				
43. My child has excessive sexual: behaviors ☐ interests.☐				
44. My child becomes aggressive easily. ☐ hits people. ☐				
45. My child has periods of extreme activity or hyperactivity.				
46. My child has drastic mood swings. ☐ rapid mood swings. ☐				

DC 1-16 DDO 17-27 DB 28-46 *28-32

Did you remember to circle your child's current symptoms?

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child's worst fear is looking stupid or being embarrassed.				
2. My child doesn't do things or talk because of fear of embarrassment.				
3. My child avoids activities where he/she would be the center of attention.				
4. My child complains of: being short of breath ☐ feeling like he/she is smothering.☐				
5. When anxious, my child feels dizzy. ☐ lightheaded. ☐ unsteady. ☐ faint..☐				
6. My child feels like his or her heart: pounds. ☐ beats rapidly. ☐				
7. My child trembles or shakes. ☐ sweats for no reason. ☐				
8. My child becomes anxious quickly. (5 – 15 minutes)				
9. My child becomes panicky easily.				
10. My child feels unreal or detached from him or herself.				
11. My child feels numb or tingly. ☐ feels like he or she is choking. ☐				
12. My child has unexplained chills ☐ hot flashes.☐				
13. My child has: chest pains ☐ chest discomfort.☐				
14. My child is afraid that he or she might: die ☐ go crazy.☐				
15. My child fears being out of control.				
16. When anxious my child often has an upset stomach ☐ nausea ☐ diarrhea.☐				
17. My child is afraid of dogs ☐ spiders ☐ heights ☐ other.☐_____				
18. My child fears social situations.				
19. My child fears going to school.				
20. My child fears going outside.				
21. My child feels anxious or worried a lot.				
22. My child cannot control his or her worries.				
23. My child feels restless, keyed up, or on edge.				
24. My child has a hard time with: paying attention ☐ mind going blank.☐				
25. My child has muscle aches or muscle tension.				
26. My child often feels tired.				
27. My child has a hard time sleeping.				
28. My child sweats for no reason.				
29. My child feels irritable.				
30. My child's hands become cold and clammy.				
31. My child's mouth becomes dry frequently.				
32. My child feels light-headed.				
33. My child startles easily.				
34. My child feels like he or she has a lump in his or her throat.				
35. My child feels on the edge.				
36. My child has to urinate frequently.				
37. My child has disturbing thoughts ☐ impulses ☐ images.☐				
38. My child tries to push down disturbing thoughts ☐ impulses ☐ images.☐				
39. My child has thoughts ☐ impulses ☐ images.☐ that seem senseless.				
40. The disturbing thoughts ☐ impulses ☐ images☐ are inside my child's head.				
41. My child has a hard time ignoring disturbing thoughts ☐ impulses ☐ images.☐				
42. My child has: obsessions ☐ thoughts he or she can't stop.☐				
43. My child does repetitive activities because of thoughts he or she can't stop.				
44. My child does things to prevent feeling bad. checking ☐ washing ☐ counting.☐				
45. My child can't stop: checking ☐ washing ☐ counting.☐				
46. Obsessions or thoughts cause my child to feel bad.				
47. Obsessions or thoughts keep my child from engaging in normal activities.				
48. My child does things to prevent thoughts. checking ☐ washing ☐ counting.☐				
49. My child frequently: washes his/her hands ☐ checks things ☐ puts things in order.☐				
50. My child frequently: prays ☐ counts ☐ repeats words.☐				
	DAS 1-3	DP 4-16	PS 17-20	DAG 21-36 DCO 37-50

Did you remember to circle your child's current symptoms?

Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child often feels abandoned.				
2. My child feels very upset when people leave him or her.				
3. My child is unable to be alone.				
4. My child is often disappointed by relationships.				
5. My child often idealizes people.				
6. My child needs to be close to people too quickly.				
7. My child feels he or she gives too much.				
8. My child feels people don't give back.				
9. My child feels people punish him or her for no reason.				
10. My child often feels bad or evil.				
11. My child's feelings about him or herself change quickly.				
12. My child feels safer in a structured environment.				
13. My child often gambles too much.				
14. My child often spends more than he or she should.				
15. My child sometimes engages in unsafe sex.				
16. My child often abuses substances (alcohol or drugs).				
17. My child often drives recklessly.				
18. My child often threatens suicide.				
19. My child has attempted suicide.				
20. My child has frequently attempted suicide.				
21. My child cuts on him /herself when upset.				
22. My child pulls out his/her hair when upset.				
23. My child hits him/herself when upset.				
24. My child picks at him/herself when nervous.				
38. My child bangs his/her head when upset.				
39. My child often burns him/herself.				
40. My child has extreme mood swings.				
41. My child is basically unhappy most of the time.				
42. My child rarely feels satisfied or feels good.				
43. My child has frequent periods of unexplained despair.				
44. My child has frequent periods of unexplained panic.				
45. My child has frequent periods of unexplained anger.				
46. My child feels empty most of the time.				
47. My child feels bored a lot.				
48. My child has a hard time controlling his/her anger.				
49. My child is often sarcastic.				
50. My child sometimes feels paranoid when stressed.				

38. My child's doctor tells me he/she does not weigh enough.				
39. My child always thinks he/she is too fat.				
40. My child is afraid of gaining any weight.				
41. Since my child lost weight, her periods have stopped.				
42. My child feels parts of his/her body are always too big.				
43. My child loses weight but still feels fat.				
44. When my child eats too much, he/she throws up.				
45. If my child feels too heavy, he/she exercises a lot.				
46. My child uses diuretics or laxatives to lose weight.				
47. My child likes to fast or diet a lot.				
48. My child often binge eats.				

DPB 1-37 NA 38-48

Did you remember to circle your child's current symptoms?

***Please check the appropriate box if your child has ever experienced any of the following symptoms. Please circle the question number of symptoms your child has now.*.**	Never Not at all	Sometimes Just a little	Often Pretty much	Frequently Very much
1. My child often feels people are out to get him/her.				
2. My child thinks people are watching him/her.				
3. My child thinks people want to persecute him/her.				
4. My child thinks songs or books are written about him/her.				
5. My child sometimes thinks shows on TV are about him/her.				
6. My child thinks people are trying to steal his/her thoughts.				
7. My child feels that he/she has been taken over by aliens.				
8. My child hears his/her name called when there is no one around.				
9. My child sometimes hears voices that threatening him/her.				
10. My child sometimes hears a voice calling his/her name.				
11. My child sometimes I hears conversations in his/her head.				
12. My child sometimes sees things that are not there.				
13. My child's thoughts often change rapidly.				
14. People tell my child he/she doesn't make sense.				
15. My child has a hard time sticking to a topic.				
16. My child's thoughts are often disorganized.				
17. My child often gets off track.				
18. My child sometimes does weird things.				
19. People say my child dresses funny.				
20. My child sometimes yells and screams for no reason.				
21. My child sometimes I does sexual things in public.				
22. My child sometimes feels he/she can't move for long periods of time.				
23. My child gets so excited other people get scared.				
24. My child looks flat most of the time.				
25. My child has difficulty looking people in the eye.				
26. People say my child is not very expressive.				
27. Most of the time, my child doesn't have much to say.				
28. My child's answers to questions are usually short.				
29. My child has difficulty maintaining a thought when he/she talks.				
30. My child just doesn't care about anything.				
31. My child has severe problems at school and/or work.				
32. My child seems unable to get along with anyone.				
33. It's hard for my child to keep clean.				
34. People say my child does not live up to his/her potential.				
35. I tell my child, "If you would only apply yourself."				
36. At times my child eats a lot at once.				
37. When my child eats a lot, he/she eats very fast.				
38. My child feels guilty when he/she eats a lot.				
39. My child eats when he/she is depressed.				
40. My child feels out of control when he/she eats a lot.				
41. When my child eats a lot, he/she throws up.				
42. My child vomits very easily.				
43. My child sometimes sticks his/her fingers down his/her throat.				
44. After he/she eats a lot, my child uses: laxatives ☐ diuretics.☐				
45. My child is very concerned about his/her weight.				
46. My child eats a lot when he/she is angry.				
47. My child eats a lot when he/she feels lonely.				
48. When my child eats a lot, initially he/she feels less depressed.				
49. When my child eats a lot, he/she is self-critical or depressed.				

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Did you remember to circle your child's current symptoms?

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