Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Life Incidence of Traumatic Events - Parent Form

Your Name_____ Child's Name_____ Date_____

Please circle **No** or **Yes** to show which things have happened **to your child**. **If Yes**, also fill in the rest of the line.

Did this ever happen to him/her?			how many times	how old s/he was (first time)	how much it upset him/her **then**	how much it bothers him/her **now**
No	Yes	been in a car accident	_____	_____	none some lots	none some lots
No	Yes	been hurt in another kind of accident or sick in the hospital	_____	_____	none some lots	none some lots
No	Yes	seen someone else get hurt	_____	_____	none some lots	none some lots
No	Yes	someone in the family in the hospital (hurt or sick)	_____	_____	none some lots	none some lots
No	Yes	someone in the family died	_____	_____	none some lots	none some lots
No	Yes	friend very sick, hurt or died	_____	_____	none some lots	none some lots
No	Yes	been in a fire	_____	_____	none some lots	none some lots
No	Yes	been in a hurricane, tornado, flood, or mudslide (circle which)	_____	_____	none some lots	none some lots
No	Yes	parents (or grown-ups) broke things or hurt each other	_____	_____	none some lots	none some lots
No	Yes	parents separated or divorced	_____	_____	none some lots	none some lots
No	Yes	been taken away from family	_____	_____	none some lots	none some lots
No	Yes	been hit, whipped, beaten, or hurt by someone	_____	_____	none some lots	none some lots
No	Yes	been tied up, or locked in a small space	_____	_____	none some lots	none some lots
No	Yes	been made to do sex things	_____	_____	none some lots	none some lots
No	Yes	been threatened (someone said they would do something bad)	_____	_____	none some lots	none some lots
No	Yes	been robbed (or house robbed)	_____	_____	none some lots	none some lots
No	Yes	other scary or upsetting event (what was it?_____)	_____	_____	none some lots	none some lots

Child's grade in school: _____ Participant #: _____

Date: _____

RCADS-P

Please put a circle around the word that shows how often each of these things happen for your child.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child feels sad or empty	Never	Sometimes	Often	Always
3. When my child has a problem, he/she gets a funny feeling in his/her my stomach	Never	Sometimes	Often	Always
4. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5. My child feels afraid of being on his/her own at home	Never	Sometimes	Often	Always
6. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7. My child feels scared when taking a test	Never	Sometimes	Often	Always
8. My child worries when he/she thinks someone is angry with him/her	Never	Sometimes	Often	Always
9. My child worries about being away from me	Never	Sometimes	Often	Always
10. My child gets bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11. My child has trouble sleeping	Never	Sometimes	Often	Always
12. My child worries about doing badly at school work	Never	Sometimes	Often	Always
13. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14. My child suddenly feel as if he/she can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15. My child has problems with his/her appetite	Never	Sometimes	Often	Always
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18. My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
19. My child has no energy for things	Never	Sometimes	Often	Always
20. My child worries about looking foolish	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23. My child can't seem to get bad or silly thoughts out of his/her head	Never	Sometimes	Often	Always
24. When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always

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Child's grade in school: _____ Participant #: _____

Date: _____

25. My child cannot think clearly	Never	Sometimes	Often	Always
26. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28. When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29. My child feels worthless	Never	Sometimes	Often	Always
30. My child worries about making mistakes	Never	Sometimes	Often	Always
31. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. My child worries what other people think of him/her	Never	Sometimes	Often	Always
33. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35. My child worries about what is going to happen	Never	Sometimes	Often	Always
36. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. My child thinks about death	Never	Sometimes	Often	Always
38. My child feels afraid if he/she has to talk in front of the class	Never	Sometimes	Often	Always
39. My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. My child worries when in bed at night	Never	Sometimes	Often	Always
46. My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47. My child feels restless	Never	Sometimes	Often	Always

RESIDENT NAME: **DOB:** **DATE:**

Medical History:

Hospital Admissions		
Name/Setting	Dates	Reason

Physical Health Issues/ injuries (historic/ on- going)			
Name	Date/s	Frequency	Reason

Medical Additional Information (Sleep, diet, activity, etc.):

Psychiatric History:

Past Diagnosis

- ☐ Depression
- ☐ ADHD
- ☐ ODD
- ☐ Anxiety Disorder
- ☐ Spectrum / Sensory Disorders
- ☐ Developmental Disorders
- ☐ Disruptive Disorder
- ☐ Reactive Attachment Disorder
- ☐ Other
- ☐ Learning Disabilities
- ☐ Mood Disorders
- ☐ Psychotic Disorders
- ☐ Self-Harm
- ☐ Conduct
- ☐ PTSD

Psych Hospital Admissions		
Name/Setting	Dates	Reason

Previous Treatment (psychiatry, therapy, in home services, day treatment, residential)				
Name/Setting	Dates	Frequency	Reason	Contact Information

Psychiatric Additional Information:

Background/ Developmental History:

Living Arrangements

Has the child ever lived in any of the following settings? ☐Yes* ☐No

** If yes, check all that apply and provide settings, dates, and reasons*

☐Relative's Home ☐Therapeutic Home ☐Residential Facility ☐Group Home
☐Emergency Shelter ☐Homeless Shelter ☐Foster Home ☐Adoptive Home
☐ Detention Facility ☐Correctional Facility ☐Other _____

Living Settings		
Name/Setting	Dates	Reason

Developmental History: Please complete all items below

Prenatal Exposure				
Type	Yes	No	Unknown	Describe
Alcohol	☐	☐	☐	
Drugs	☐	☐	☐	
Tobacco	☐	☐	☐	
Maternal Health Problems	☐	☐	☐	
Gestation Problems	☐	☐	☐	

Accidents	☐	☐	☐	
Abuse	☐	☐	☐	
Stress/ Mental Health concerns	☐	☐	☐	
Other	☐	☐	☐	

Perinatal Exposure				
Type	Yes	No	Unknown	Describe
Delivery Problems	☐	☐	☐	
Maternal Medication	☐	☐	☐	
Infant Medical Problems	☐	☐	☐	
Preterm	☐	☐	☐	# of weeks _____

Development Concerns		
Milestone	Age	Describe
Walked	☐	
Talked	☐	
Toilet Trained	☐	
Sensory sensitivities (sound, light, textures, smells, etc.)	☐	
Other	☐	

Infant Temperament: ☐Quiet/Aloof ☐Easy to comfort ☐Overactive ☐Excessive irritability

Description Narrative:

Attachment: ☐Secure ☐Avoidant ☐Ambivalent ☐Disorganized/Disoriented

Description Narrative:

Discipline Techniques used in Childhood:

_____

_____

_____

Major losses/ transitions in Childhood:

_____

_____

_____

Atypical Development:

- ☐ aloof (e.g., "in own world")
- ☐ facial expressions don't fit situations
- ☐ produces unusual noises
- ☐ frequent gibberish
- ☐ difficulty understanding basic things (e.g., "just can't get it")

- ☐ difficulty expressing needs or desires
- ☐ repetitive language
- ☐ no spontaneous initiation of speech or communication
- ☐ head banging
- ☐ hand or finger flapping
- ☐ obsession with objects or topics
- ☐ restricted range of interests
- ☐ clumsy
- ☐ smelling, banging, licking or other inappropriate use of toys
- ☐ resists change
- ☐ Comments:

History of Trauma

Emotional	Ever been emotionally abused	☐Yes	☐No
	Ever been accused of being emotionally abusive	☐Yes	☐No
Sexual	Ever been sexually abused	☐Yes	☐No
	Ever been accused of sexually abusing another	☐Yes	☐No
Physical	Ever been physically abused	☐Yes	☐No
	Ever been accused of physically abusing another	☐Yes	☐No
Violence	Been a witness to Domestic violence	☐Yes	☐No
	Community violence	☐Yes	☐No
Neglect	History of neglect	☐Yes	☐No
Other	Other trauma history	☐Yes	☐No

Is further trauma assessments indicated? (UCLA) ☐Yes ☐No

Background Additional Information:

Family History:

Biological Parents and Adoptive Parents

☐Married ☐Divorced ☐Separated ☐Never Married ☐Deceased ☐Unknown

Primary Household				
Household Member Name	Relationship to child	Age	Quality of relationship (close, neutral conflicted)	Occupation/ School

Secondary Household				
Household Member Name	Relationship to child	Age	Quality of relationship (close, neutral conflicted)	Occupation/ School

Street address if different from above:_____

Custody and Parenting

☐Lives with both parents
☐Single parent – whom _____
☐Shared custody
☐Other

Family Strengths and Challenges

Primary Language at home _____
Family/Race/Ethnicity _____
Family/Spiritual Background _____
Spiritual advisor involved/Name _____
Family Activities _____
Community Activities _____
Hobbies/Recreation _____
Family Strengths _____
Family's favorite thing to do _____
Housing Concerns _____
Moving History _____

Family member disabilities

Source of Income for Family

☐Employed ☐Unemployed ☐Disability/SSI ☐Child Support ☐

Family Psychiatric History (include relationship to child)

☐ADHD ☐Bulimia/Anorexia ☐Personality Disorder ☐Unknown
☐Anxiety ☐Depression ☐Schizophrenia
☐Bipolar ☐OCD ☐Other _____

Family History of Chemical Abuse/Dependency (current/ historic)

☐Father ☐Mother ☐Brother ☐Grandparent
☐Uncle ☐Aunt ☐Unknown ☐Other _____

Family History of experiencing Abuse/ neglect (current/ historic)

☐Father ☐Mother ☐Brother ☐Grandparent
☐Uncle ☐Aunt ☐Unknown ☐Other _____

Family History Additional Information: