Last Name: _____

First Name: _____

Date of Birth: _____

Today's Date: _____

Doctor: _____

Please mark under the heading that best fits you or check yes or no	Never (0)	Sometimes (1)	Often (2)
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
✪ 29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
✪ 32. Tease others			
33. Blame others for your trouble			
✪ 34. Take things that do not belong to you			
✪ 35. Refuse to share			
36. During the past three months, have you thought of killing yourself?		❑ Yes	❑ No
37. Have you ever tried to kill yourself?		❑ Yes	❑ No

For Office Use Only: ■ 5 or more: Int ✪ 7 or more: Ext ❖ 7 or more: Attn TS 30 or more 36 or 37 = Y Total Score _____