

MyADHD.com
Childhood Disorders Checklist #6172

Child's name: _____ Age: _____ Grade: _____

Completed by: _____ Date: _____ Sex: _____

Below are lists of behaviors or reactions that describe disorders that may be seen in children and adolescents. Read each list and indicate whether your child has displayed any of these behaviors or reactions during the period noted for each list.

A	Oppositional Defiant Disorder List Indicate if your child has displayed any of the behaviors listed below within the past six months.
<input type="checkbox"/>	Often loses temper
<input type="checkbox"/>	Often argues with adults
<input type="checkbox"/>	Often defies or refuses to do what you tell him
<input type="checkbox"/>	Often does things to deliberately annoy others
<input type="checkbox"/>	Often blames others for his/her own mistakes or misbehavior
<input type="checkbox"/>	Is often touchy or is easily annoyed by others
<input type="checkbox"/>	Is often angry or resentful
<input type="checkbox"/>	Often takes anger out on others or tries to get even
	Does your child show four or more of these behaviors?-
	Have these behaviors been exhibited for at least the past six months?
	At what age did these behaviors first cause problems for your child? -(yrs)
	Have these behaviors been the cause of problems for your child in any of the following areas? <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Community
B	Conduct Disorder List Indicate if your child has displayed any of the behaviors listed below within the past six months.
<input type="checkbox"/>	Often bullies, threatens, or intimidates others
<input type="checkbox"/>	Often starts physical fights
<input type="checkbox"/>	Has used a weapon when fighting (bat, brick, bottle, etc.)
<input type="checkbox"/>	Has been physically cruel to people
<input type="checkbox"/>	Has stolen things from others using physical force
<input type="checkbox"/>	Has stolen things when others were not looking
<input type="checkbox"/>	Has forced someone into sexual activity
<input type="checkbox"/>	Has destroyed others' property (other than by fire setting)
<input type="checkbox"/>	Has broken into someone else's house, building, or car
<input type="checkbox"/>	Has not come home overnight at least twice while living in parent's home, foster care, or group home? If so, how many times?
<input type="checkbox"/>	Is often truant from school. Did this occur before age 13? If so, at what age? (yrs)
	Does your child show three or more of the above behaviors?
	Have three of these behaviors occurred during the past 12 months?
	Has at least one of these behaviors occurred during the past six months?
	Did any of these behaviors occur prior to age ten years?
	Have these characteristics been the cause of problems for your child in any of the following areas? <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Community

C	Attention-Deficit/Hyperactivity Disorder List Indicate if your child has displayed any of the behaviors listed below within the past six months.
	Inattention List
<input type="checkbox"/>	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
<input type="checkbox"/>	Often has difficulty sustaining attention in tasks or play activities
<input type="checkbox"/>	Often does not seem to listen when spoken to directly
<input type="checkbox"/>	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
<input type="checkbox"/>	Often has difficulty organizing tasks and activities
<input type="checkbox"/>	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
<input type="checkbox"/>	Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
<input type="checkbox"/>	Is often easily distracted by extraneous stimuli
<input type="checkbox"/>	Is forgetful in daily activities
	Hyperactivity-Impulsivity List
<input type="checkbox"/>	Often fidgets with hands or feet or squirms in seat
<input type="checkbox"/>	Often leaves seat in classroom or in other situations in which remaining seated is expected
<input type="checkbox"/>	Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
<input type="checkbox"/>	Often has difficulty playing or engaging in leisure activities quietly
<input type="checkbox"/>	Is often "on the go" or often acts as if "driven by a motor"
<input type="checkbox"/>	Often talks excessively
<input type="checkbox"/>	Often blurts out answers before questions have been completed
<input type="checkbox"/>	Often has difficulty awaiting turn
<input type="checkbox"/>	Often interrupts or intrudes on others (e.g., butts into conversations or games)
	Does your child show six or more of the behaviors on the inattention list?
	Does your child show six or more of the behaviors on the hyperactive list?
	At what age did these behaviors first cause problems for this child?
	Have these behaviors existed for at least the past six months?
	Have these behaviors been the cause of problems for your child in any of the following areas?
D	Learning Problems List or Academic Skills Disorder Indicate if your child has displayed any of the following problems in learning or academic performance compared to other children of his or her age or grade level.
<input type="checkbox"/>	Recognizing unfamiliar words when reading
<input type="checkbox"/>	Comprehending the meaning of what he/she read
<input type="checkbox"/>	Spelling
<input type="checkbox"/>	Expressing ideas in writing
<input type="checkbox"/>	Expressing ideas orally
<input type="checkbox"/>	Memory
<input type="checkbox"/>	Handwriting
<input type="checkbox"/>	Arithmetic computation
<input type="checkbox"/>	Arithmetic problem solving (word problems)
<input type="checkbox"/>	Organizing work and homework

<input type="checkbox"/>	Completing homework on his/her own and in a timely manner
<input type="checkbox"/>	Excessive absences from school
<input type="checkbox"/>	Little effort made to achieve up to his/her potential
E	Asperger's Disorder List Indicate if your child has exhibited any of the following patterns of behavior:
	Problems in social interaction as manifested by at least two of the following
<input type="checkbox"/>	Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, gestures to regulate social interaction
<input type="checkbox"/>	Failure to develop peer relationships appropriate to developmental level
<input type="checkbox"/>	Marked impairment in the ability to express pleasure at other people's happiness
<input type="checkbox"/>	Lack of social or emotional reciprocity
	In addition, which of the following patterns of behavior are exhibited?
<input type="checkbox"/>	Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities
<input type="checkbox"/>	Lack of any significant delay in language
<input type="checkbox"/>	Lack of any significant delay in cognitive development. Has age-appropriate self-help skills, adaptive behavior and curiosity about the environment.
F	Tourette's Disorder List Indicate whether your child has exhibited the following tics. A tic is an involuntary, sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.
<input type="checkbox"/>	Both multiple motor and one or more vocal tics (not necessarily at the same time)
<input type="checkbox"/>	The tics occur many times a day (usually in bouts), nearly every day or intermittently throughout a period of more than one year and never stop for more than two months at a time.
	Describe the tic(s).
G	Chronic Motor or Vocal Tic Disorder List Indicate whether your child has exhibited the following tics.
	Either vocal or motor tics but not both.
	The tics occur many times a day (usually in bouts), nearly every day or intermittently throughout a period of more than one year and never stop for more than two months at a time.
	Describe the tic(s).
H	Transient Tic Disorder List Indicate whether your child has exhibited the following tics.
	Single or multiple motor or vocal tics.
<input type="checkbox"/>	The tics occur many times a day, nearly every day for at least four weeks, for no longer than 12 consecutive months.
	Describe the tic(s).
I	Specific Phobia List Indicate whether your child has exhibited each of the behaviors in this list within the past six months.
<input type="checkbox"/>	Persistent, excessive and unreasonable fear triggered by the presence of, or the anticipation of, a specific object or situation. For example, in response to, or anticipation of, certain animals, heights, being in the dark, receiving an injection, seeing blood, etc.
<input type="checkbox"/>	Exposure to the feared situation or object almost always produces immediate anxiety. In children this may be expressed by crying, tantrums, freezing, or clinging
<input type="checkbox"/>	The fearful situation or object is avoided or else endured with extreme anxiety or distress
<input type="checkbox"/>	Avoidance or anxious anticipation or distress in the feared situation interferes significantly with the child's normal routine and affects academic functioning, social

	activities, or relationships with others.
	Has this fearful or anxious reaction to a situation or object persisted for at least the past 6 months?
	Describe the specific situation or object that your child exhibits anxiety to.
J	Separation Anxiety List Indicate whether your child has exhibited each of the behaviors in this list.
<input type="checkbox"/>	Persistent and excessive worry about losing a major attachment figure (e.g., parent, grandparent, guardian, etc.) or of possible harm befalling a major attachment figure.
<input type="checkbox"/>	Extreme worry that something will occur that will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
<input type="checkbox"/>	Persistent reluctance or refusal to go to school or elsewhere due to fear of separation
<input type="checkbox"/>	Persistent reluctance to be alone or without major attachment figures at home or in other settings
<input type="checkbox"/>	Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
<input type="checkbox"/>	Re-occurring nightmares having to do with the theme of separation
<input type="checkbox"/>	Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, or vomiting) when separated from a major attachment figure or when separation is anticipated
<input type="checkbox"/>	Re-occurring distress when separation from home or major attachment figures takes place or is anticipated
K	Generalized Anxiety Disorder List Indicate whether your child has exhibited any of the following behaviors or reactions.
<input type="checkbox"/>	Excessive anxiety and worry occurring more often than not for at least six months
<input type="checkbox"/>	Child finds it difficult to control the worry
	Anxiety and worry are associated with at least three of the following six symptoms:
<input type="checkbox"/>	Restlessness or feeling keyed up or on edge
<input type="checkbox"/>	Being easily fatigued
<input type="checkbox"/>	Trouble with concentration
<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Muscle tension
<input type="checkbox"/>	Trouble falling asleep or staying asleep or restless sleep
L	Obsessive Compulsive Disorder List Indicate whether your child has exhibited any of the following obsessions or compulsions.
	Obsessions
<input type="checkbox"/>	Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety and distress
<input type="checkbox"/>	The thoughts, impulses or images are not simply excessive worries about real-life problems
<input type="checkbox"/>	The child attempts to ignore or suppress these thoughts or impulses or to “neutralize” them with some other thought or action
<input type="checkbox"/>	The child recognizes that the obsessional thoughts, impulses or images are a product of his/her own mind
	Compulsions
<input type="checkbox"/>	Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the child feels driven to perform in

	response to an obsession, or according to rules that must be applied rigidly
<input type="checkbox"/>	The behaviors or mental acts have the goal of preventing or reducing distress or preventing some dreaded event or situation; however, these acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive
	Does the child realize that the obsessions or compulsions are excessive or unreasonable?
	Do the obsessions or compulsions cause marked distress; are they time-consuming; or do they significantly interfere with the person's normal routine or social relationships with others?
M	Dysthmic Disorder List Indicate whether your child has exhibited any of the following reactions.
<input type="checkbox"/>	Exhibits depressed mood or irritability for most of the day, for more days than not, for at least one year
	Presence, while depressed, of at least three of the following:
<input type="checkbox"/>	Low self-esteem or self-confidence, or feelings of inadequacy
<input type="checkbox"/>	Feelings of pessimism, hopelessness, or despair
<input type="checkbox"/>	General loss of interest or pleasure in activities that others of his/her age enjoy
<input type="checkbox"/>	Little interest in social activities
<input type="checkbox"/>	Persistent state of fatigue or tiredness
<input type="checkbox"/>	Feelings of guilt, brooding about the past
<input type="checkbox"/>	Subjective feelings of irritability or excessive anger
<input type="checkbox"/>	Decreased activity, drive, or productivity
<input type="checkbox"/>	Difficulty concentrating, poor memory, or indecisiveness
	If your child has exhibited signs of depressed mood, has this created distress for your child or impairment in any of the following areas? <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Community
N	Major Depressive Disorder List Indicate whether your child has exhibited any of the following reactions for at least a two-week period of time.
<input type="checkbox"/>	Depressed or irritable mood most of the day, nearly every day, as indicated by complaints of feeling sad or appears to be sad or irritable.
<input type="checkbox"/>	Diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
<input type="checkbox"/>	Significant weight loss or weight gain when not dieting
<input type="checkbox"/>	Trouble falling asleep or staying asleep, or excessive sleeping
<input type="checkbox"/>	Agitated or lethargic (slow moving) nearly every day
<input type="checkbox"/>	Fatigue or loss of energy nearly every day
<input type="checkbox"/>	Feelings of worthlessness or excessive or inappropriate guilt nearly every day
<input type="checkbox"/>	Diminished ability to concentrate or cannot make a decision nearly every day
<input type="checkbox"/>	Repeated thoughts of death (not just fear of dying), repeated suicidal thoughts without a specific plan or with a plan
O	Bipolar Disorder: Manic Episode List Indicate if your child has ever experienced the following reactions for a period of time that lasted at least 1 week.
<input type="checkbox"/>	Mood was abnormally and persistently elevated (he/she felt abnormally happy, giddy, ecstatic)
<input type="checkbox"/>	Mood was abnormally and persistently expansive (he/she felt able to accomplish everything he/she decided to do and had no limits on his/her abilities to accomplish things)

<input type="checkbox"/>	Mood was abnormally and persistently irritable (he/she was very touchy, easily given to outbursts of anger or temper, easily annoyed by minor events or by others, or abnormally cranky)
	If your child exhibited any of the above, indicate if during the week or more that your child showed this abnormal and persistent mood, mark which of the following behaviors exhibited:
<input type="checkbox"/>	Inflated self-esteem or grandiosity
<input type="checkbox"/>	Decreased need for sleep (e.g., feels rested after only three hours of sleep)
<input type="checkbox"/>	More talkative than usual or pressure to keep talking
<input type="checkbox"/>	Thoughts seem to be racing
<input type="checkbox"/>	Easily distracted (i.e. attention drawn away by unimportant external stimuli)
<input type="checkbox"/>	Increased goal-directed activity; he/she became unusually focused and productive towards one or more tasks
<input type="checkbox"/>	Becomes highly involved in pleasurable activities without regard for negative consequences (e.g., spending excessively, taking risks, etc.)
	Were at least three of the behaviors listed above present?
	Was this disturbance in your child's mood significant enough to cause marked impairment in social relationships, academic performance, or other important activities?
	Did your child's abnormal mood result in him/her being hospitalized?
	Did your child have hallucinations or bizarre ideas or feel or act paranoid?
	Explain in more detail.
	Give this completed form to the health care professional who you are consulting.
	From: myADHD.com. Copyright 2003. Health Link Systems, Inc. This form may be reproduced by myADHD.com active members only for their personal use.