NARRATIVE DESCRIPTION OF CHILD – PARENT FORM

Child's name: _____

Parent/ Caregiver's name: _____

Date Completed: _____

Instructions: In the space below, please describe what you see as your child's primary problem(s) and describe how your child's problems have affected the following areas. Then, complete the rating at the end of each section by marking an 'X' on the lines at the points that you believe reflect the impact of your child's problems on this area and whether he or she may need treatment or special services for the problem. Please continue on the back of this sheet if necessary.

Primary problem(s): _____

_____

1. How your child's problems affect his or her relationships with peers or friends.

   Does your child seem to have a close or "best" friend they have kept for more than a few months?

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

2. How your child's problems affect his or her relationship with their brothers or sisters.

   (If the child has no brothers or sisters, check here to skip this question _____)

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

3. How your child's problems affect his or her relationship with you (and your spouse, if present)

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

4. How your child's problems affect his or her academic progress at school.

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

5. How your child's problems affect his or her self-esteem.

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

6. How your child's problems affect your family in general.

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

7. Please mark 'X' on the following line at the point you believe reflects the OVERALL severity of this child's problem in functioning and OVERALL need for treatment.

No Problem (_____) Extreme Problem

Definitely does not need treatment - - - - - - - - - - - - - - - - - Definitely needs treatment or special services

Additional Comments:

_____

_____

_____

_____

Child Attention Profile

Directions: Below is a list of items that describes children. For each item that describes your child now or within the past few weeks, check whether the item is Not True, Somewhat or Sometimes True, or Very or Often True. Please check all items as well as you can, even if some do not seem to apply to your child.

	Not True	Somewhat or Sometimes True	Very or Often True
1. Fails to finish things he/she starts	[ ]	[ ]	[ ]
2. Can't concentrate, can't pay attention for long	[ ]	[ ]	[ ]
3. Can't sit still, restless, or hyperactive	[ ]	[ ]	[ ]
4. Fidgets	[ ]	[ ]	[ ]
5. Daydreams or gets lost in thoughts	[ ]	[ ]	[ ]
6. Impulsive or acts without thinking	[ ]	[ ]	[ ]
7. Difficulty following directions	[ ]	[ ]	[ ]
8. Talks out of turn	[ ]	[ ]	[ ]
9. Messy work	[ ]	[ ]	[ ]
10. Inattentive, easily distracted	[ ]	[ ]	[ ]
11. Talks too much	[ ]	[ ]	[ ]
12. Fails to carry out assigned tasks	[ ]	[ ]	[ ]

Please feel free to write any comments about your child's recent behaviors.