**Rating Scales Instructions**

Please complete the seven attached rating scales to help us prepare for your evaluation at the University of Georgia Regents' Center for Learning Disorders.

The student seeking the evaluation should complete the following:

- The **BAARS-IV: Self-Report: Current Symptoms** requires you to rate your behaviors from the past 6 months.
- The **BAARS-IV: Self-Report: Childhood Symptoms** requires you to rate your behaviors from when you were between ages 5 and 12.
- The **SCT: Self-Report: Childhood Symptoms** requires you to rate your behaviors from when you were between ages 5 and 12.
- The **Adult Reading History Questionnaire** has no specified time frame.

A parent of the student should complete the following:

- The **BAARS-IV: Other-Report: Current Symptoms** requires your parent to rate your behaviors from the past 6 months.
- The **BAARS-IV: Other-Report: Childhood Symptoms** requires your parent to rate your behaviors from when you were between ages 5 and 12.
- The **SCT: Other Report: Childhood Symptoms** requires your parent to rate your behaviors from when you were between ages 5 and 12.

The information gathered from the rating scales is very important as it helps the assessment team make preparations for your evaluation. Please note the following when completing the scales:

- Because the scales cannot be used unless they are fully completed, please respond to each item of each scale.
- Provide only one answer for each item.
- If unsure of an answer to an item, please give your best estimate.
- Please complete the scales independently. Whereas it may be tempting to discuss the items with each other as you complete the scales, we are interested in both respondents' independent perceptions. The only exception is the Adult Reading History Questionnaire, which you are encouraged to complete with a parent's assistance.

If a parent is not available to complete the parent versions of the forms, it is acceptable to have someone different complete them. The person should know you well (e.g., sibling, relative), preferably for many years, and have regular contact with you. If a parent is not available, finding someone to complete the "childhood symptoms" versions of the forms can be challenging. Please attempt to find someone who knew you well in childhood (e.g., sibling) that can complete the form.

Please return the completed scales with your referral packet. Your input is essential in order to fully understand your presenting concerns. If you should have any questions, please feel free to call the RCLD at 706-542-4589.

Thank you.

# BAARS-IV: Self-Report: Current Symptoms

**Name: _____ Date: _____**

**Sex: (circle one) Male Female Age: _____**

For the first 27 items, please circle the number next to each item below that best describes your behavior **DURING THE PAST 6 MONTHS**. Then answer the remaining three questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Inattention)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Fail to give close attention to details or make careless mistakes in my work or other activities | 1 | 2 | 3 | 4 |
| 2. Difficulty sustaining my attention in tasks or fun activities | 1 | 2 | 3 | 4 |
| 3. Don't listen when spoken to directly | 1 | 2 | 3 | 4 |
| 4. Don't follow through on instructions and fail to finish work or chores. | 1 | 2 | 3 | 4 |
| 5. Have difficulty organizing tasks and activities | 1 | 2 | 3 | 4 |
| 6. Avoid, dislike, or am reluctant to engage in tasks that require sustained mental effort | 1 | 2 | 3 | 4 |
| 7. Lose things necessary for tasks or activities | 1 | 2 | 3 | 4 |
| 8. Easily distracted by extraneous stimuli or irrelevant thoughts. | 1 | 2 | 3 | 4 |
| 9. Forgetful in daily activities | 1 | 2 | 3 | 4 |
| Office Use Only (Section 1)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 2 (Hyperactivity)** | Never or rarely | Some-times | Often | Very often |
| 10. Fidget with hands or feet or squirm in seat | 1 | 2 | 3 | 4 |
| 11. Leave my seat in classrooms or in other situations in which remaining seated is expected | 1 | 2 | 3 | 4 |
| 12. Shift around excessively or feel restless or hemmed in | 1 | 2 | 3 | 4 |
| 13. Have difficulty engaging in leisure activities quietly (feel uncomfortable, or am loud or noisy) | 1 | 2 | 3 | 4 |
| 14. I am "on the go" or act as if "driven by a motor" (or I feel like I have to be busy or always doing something) | 1 | 2 | 3 | 4 |
| Office Use Only (Section 2)<br>Total Score: _____ Symptom Count: _____ | | | | |

*(continued)*

| **Section 3 (Impulsivity)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 15. Talk excessively (in social situations) | 1 | 2 | 3 | 4 |
| 16. Blurt out answers before questions have been completed, complete others' sentences, or jump the gun | 1 | 2 | 3 | 4 |
| 17. Have difficulty awaiting my turn | 1 | 2 | 3 | 4 |
| 18. Interrupt or intrude on others (butt into conversations or activities without permission or take over what others are doing) | 1 | 2 | 3 | 4 |
| Office use only (Section 3)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 4 (Sluggish Cognitive Tempo)** | Never or rarely | Some-times | Often | Very often |
| 19. Prone to daydreaming when I should have been concentrating on something or working | 1 | 2 | 3 | 4 |
| 20. Have trouble staying alert or awake in boring situations | 1 | 2 | 3 | 4 |
| 21. Easily confused | 1 | 2 | 3 | 4 |
| 22. Easily bored | 1 | 2 | 3 | 4 |
| 23. Spacey or "in a fog" | 1 | 2 | 3 | 4 |
| 24. Lethargic, more tired than others | 1 | 2 | 3 | 4 |
| 25. Underactive or have less energy than others | 1 | 2 | 3 | 4 |
| 26. Slow moving | 1 | 2 | 3 | 4 |
| 27. I don't seem to process information as quickly or as accurately as others. | 1 | 2 | 3 | 4 |
| Office use only (Section 4)<br>Total Score: _____ Symptom Count: _____ | | | | |

***Total Scores for Entire Scale:***

Sum of Sections Raw Scores 1 – 3 Total ADHD Score _____

Section 1 Symptom Count _____

Sum of Sections 2 and 3 Symptom Counts _____

Total ADHD Symptom Count _____ (Sum of 1 – 3)

SCT Symptom Count _____

*(continued)*

**Section 5**

28. Did you experience *any* of these 27 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

29. If so, how old were you when these symptoms began? (Fill in the blank)

    I was _____ years old.

30. If so, in which of these settings did those symptoms impair your functioning? Place a *check mark* (✓) next to all of the areas that apply to you.

    _____ School
    _____ Home
    _____ Work
    _____ Social Relationships

**If you checked any of the domains in item # 30 indicating settings in which symptoms impair your functioning, please provide examples of your <u>current</u> difficulties in the appropriate spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Work:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

# BAARS-IV: Self-Report: Childhood Symptoms

**Name: _____ Date: _____**

**Sex: (circle one) Male Female Age: _____**

For the first 18 items, please circle the number next to each item below that best describes your behavior when you were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Inattention)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Failed to give close attention to details or made careless mistakes in my work or other activities | 1 | 2 | 3 | 4 |
| 2. Had difficulty sustaining my attention in tasks or fun activities | 1 | 2 | 3 | 4 |
| 3. Didn't listen when spoken to directly | 1 | 2 | 3 | 4 |
| 4. Didn't follow through on instructions and failed to finish work or chores. | 1 | 2 | 3 | 4 |
| 5. Had difficulty organizing tasks and activities | 1 | 2 | 3 | 4 |
| 6. Avoided, disliked, or was reluctant to engage in tasks that required sustained mental effort | 1 | 2 | 3 | 4 |
| 7. Lost things necessary for tasks or activities | 1 | 2 | 3 | 4 |
| 8. Was easily distracted by extraneous stimuli or irrelevant thoughts. | 1 | 2 | 3 | 4 |
| 9. Was forgetful in daily activities | 1 | 2 | 3 | 4 |
| Office Use Only (Section 1)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 2 (Hyperactivity-Impulsivity)** | Never or rarely | Some-times | Often | Very often |
| 10. Fidgeted with hands or feet or squirmed in seat | 1 | 2 | 3 | 4 |
| 11. Left my seat in classrooms or in other situations in which remaining seated was expected | 1 | 2 | 3 | 4 |
| 12. Shifted around excessively or felt restless or hemmed in | 1 | 2 | 3 | 4 |
| 13. Had difficulty engaging in leisure activities quietly (felt uncomfortable, or was loud or noisy) | 1 | 2 | 3 | 4 |
| 14. Was "on the go" or acted as if "driven by a motor" | 1 | 2 | 3 | 4 |
| 15. Talked excessively | 1 | 2 | 3 | 4 |

*(continued)*

| | | | | |
|---|---|---|---|---|
| 16. Blurted out answers before questions had been completed, completed others' sentences, or jumped the gun | 1 | 2 | 3 | 4 |
| 17. Had difficulty awaiting my turn | 1 | 2 | 3 | 4 |
| 18. Interrupted or intruded on others (butted into conversations or activities without permission or took over what others were doing) | 1 | 2 | 3 | 4 |

Office Use Only (Section 2)
Total Score _____ Symptom Count _____

Sum of Sections 1 – 2 for Total Scores _____

Sum of Sections 1 – 2 for Symptom Counts _____

## Section 3

19. Did you experience *any* of these 18 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

20. If so, in which of these settings did those symptoms impair your functioning? Place a *check mark* (✓) next to all of the areas that apply to you.

    _____ School
    _____ Home
    _____ Social Relationships

**If you checked any of the domains in item # 20 indicating settings in which symptoms impaired your functioning, please provide examples of those childhood difficulties in the appropriate spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

# SCT: Self-Report: Childhood Symptoms

**Name: _____ Date: _____**

**Sex: (circle one) Male Female Age: _____**

For the first 9 items, please circle the number next to each item below that best describes your behavior when you were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Sluggish Cognitive Tempo)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Prone to daydreaming when I should have been concentrating on something or working | 1 | 2 | 3 | 4 |
| 2. Had trouble staying alert or awake in boring situations | 1 | 2 | 3 | 4 |
| 3. Easily confused | 1 | 2 | 3 | 4 |
| 4. Easily bored | 1 | 2 | 3 | 4 |
| 5. Spacey or "in a fog" | 1 | 2 | 3 | 4 |
| 6. Lethargic, more tired than others | 1 | 2 | 3 | 4 |
| 7. Underactive or had less energy than others | 1 | 2 | 3 | 4 |
| 8. Slow moving | 1 | 2 | 3 | 4 |
| 9. I didn't seem to process information as quickly or as accurately as others. | 1 | 2 | 3 | 4 |
| Office use only<br><br>Total Score: _____ Symptom Count: _____ | | | | |

**Section 2**

10. Did you experience *any* of these 9 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

11. If so, in which of these settings did those symptoms impair your functioning? Place a *check mark* (✓) next to all of the areas that apply to you.

    _____ School
    _____ Home
    _____ Social Relationships

*(continued)*

**If you checked any of the domains in item # 11 indicating settings in which symptoms impaired your functioning, please provide examples of those childhood difficulties in the spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

## Adult Reading History Questionnaire

**Name:**_____

***Please Note:*** You are encouraged to work with a parent when completing this questionnaire.

Please ***circle*** the number of the response that most nearly describes your attitude or experience for each of the following questions or statements. **Please respond to each item**. It is okay to estimate and to give your best guess.

1. Which of the following most nearly describes your attitude toward school when you were a child:

| Loved school; Favorite activity | | | | Hated school; Tried to get out of going |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

2. How much difficulty did you have learning to read in elementary school?

| None | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

3. How much extra help did you need when learning to read in elementary school?

| Help from: No help | Friends | Teachers/Parents | Tutors or special class: 1 Year | Tutors or special class: 2 or more years |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

4. Did you ever reverse the order of letters or numbers when you were a child?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

5. Did you have difficulty learning letter and/or color names when you were a child?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

6. How would you compare your reading skill to that of others in your elementary classes?

| Above average | | Average | | Below average |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**CONTINUED ON BACK SIDE (TURN OVER)**

7. All students struggle from time to time in school. In comparison to others in your classes, how much did you struggle to complete your work?

| Not at all | Less than most | About the same | More than most | Much more than most |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

8. Did you experience difficulty in high school or college English classes?

| No; Enjoyed and did well | | Some | | A great deal; Did poorly |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

9. What is your current attitude toward reading?

| Very positive | | | | Very negative |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

10. How much reading do you do for pleasure?

| A great deal | | Some | | None |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

11. How would you compare your current reading speed to that of others the same age and education?

| Above average | | Average | | Below average |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

12. How much reading do you do in conjunction with your work? (If retired or not working, how much did you read when you were working?)

| A great deal | | Some | | None |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

13. How much difficulty did you have learning to spell in elementary school?

| None | | Some | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

14. How would you compare your current spelling to that of others of the same age and education?

| Above average | | Average | | Below average |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

15. Did your parents ever consider having you repeat any grades in school due to academic failure (not illness)?

| No | Talked about it, but didn't do it | Repeated one grade | Repeated two grades | Dropped out |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

16. Do you ever have difficulty remembering people's names or names of places?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

17. Do you have difficulty remembering addresses, phone numbers, or dates?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

18. Do you have difficulty remembering complex verbal instructions?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

19. Do you currently reverse the order of letters or numbers when you read or write?

| No | | | | A great deal |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

20. How many books do you read for pleasure each year? (Note: audiobooks that are listened to should **not** be recorded here; books read via an electronic device [e.g., Kindle, iPad] should be recorded here).

| More than 10 | 6-10 | 2-5 | 1-2 | None |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

21. How many magazines do you read for pleasure each month? (Note: magazines read on the Internet should be recorded here).

| 5 or more | 3-4 regularly | 1-2 regularly | 1-2 irregularly | None |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**CONTINUED ON BACK SIDE (TURN OVER)**

22. Do you read daily (Monday-Friday) newspapers? (Note: newspapers read on the Internet should be recorded here).

| Every day | Once a week | Once in a while | Rarely | Never |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

23. Do you read a newspaper on Sunday? (Note: newspapers read on the Internet should be recorded here).

| Completely; Every Sunday | Scan each week | Once in a while | Rarely | Never |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

24. Do you use audiobooks? (circle one)

Yes No

25. How many audiobooks do you listen to for pleasure each year?

| More than 10 | 6-10 | 2-5 | 1-2 | None |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

26. When reading for school, do you use assistive technology (e.g., screen reader, digital text files)? (circle one)

Yes No

27. When reading for pleasure, do you use assistive technology (e.g., screen reader, digital text files)? (circle one)

Yes No

28. Do you have a membership with Recordings for the Blind and Dyslexic? (circle one)

Yes No

29. Did a parent help you fill out this questionnaire? (circle one)

Yes No

# BAARS-IV: Other-Report: Current Symptoms

**Name of person to be rated: _____ Date: _____**

**Your name: _____**

**Your relationship to person being rated: (Circle one)**

**Mother Father Brother/sister Spouse/partner Friend Other (specify): _____**

**Instructions**

You are being asked to describe the behavior of someone whom you know well. How often does that person experience each of these problems? For the first 27 items, please circle the number next to each item below that best describes the person's behavior **DURING THE PAST 6 MONTHS**. Then answer the remaining three questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Inattention)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Fails to give close attention to details or makes careless mistakes in his/her work or other activities | 1 | 2 | 3 | 4 |
| 2. Has difficulty sustaining his/her attention in tasks or fun activities | 1 | 2 | 3 | 4 |
| 3. Doesn't listen when spoken to directly | 1 | 2 | 3 | 4 |
| 4. Doesn't follow through on instructions and fails to finish work or chores | 1 | 2 | 3 | 4 |
| 5. Has difficulty organizing tasks and activities | 1 | 2 | 3 | 4 |
| 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort | 1 | 2 | 3 | 4 |
| 7. Loses things necessary for tasks or activities | 1 | 2 | 3 | 4 |
| 8. Is easily distracted by extraneous stimuli or irrelevant thoughts | 1 | 2 | 3 | 4 |
| 9. Is forgetful in daily activities | 1 | 2 | 3 | 4 |
| Office Use Only (Section 1)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 2 (Hyperactivity)** | Never or rarely | Some-times | Often | Very often |
| 10. Fidgets with hands or feet or squirms in seat | 1 | 2 | 3 | 4 |
| 11. Leaves his/her seat in classrooms or in other situations in which remaining seated is expected | 1 | 2 | 3 | 4 |
| 12. Shifts around excessively or feels restless or hemmed in | 1 | 2 | 3 | 4 |

*(continued)*

| | | | | |
|---|---|---|---|---|
| 13. Has difficulty engaging in leisure activities quietly (feels uncomfortable, or is loud or noisy) | 1 | 2 | 3 | 4 |
| 14. Is "on the go" or act as if "driven by a motor" (or he/she feels like he/she has to be busy or always doing something) | 1 | 2 | 3 | 4 |
| Office Use Only (Section 2)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 3 (Impulsivity)** | Never or rarely | Some-times | Often | Very often |
| 15. Talks excessively (in social situations) | 1 | 2 | 3 | 4 |
| 16. Blurts out answers before questions have been completed, completes others' sentences, or jumps the gun | 1 | 2 | 3 | 4 |
| 17. Has difficulty awaiting his/her turn | 1 | 2 | 3 | 4 |
| 18. Interrupts or intrudes on others (butts into conversations or activities without permission or takes over what others are doing) | 1 | 2 | 3 | 4 |
| Office use only (Section 3)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 4 (Sluggish Cognitive Tempo)** | Never or rarely | Some-times | Often | Very often |
| 19. Is prone to daydreaming when he/she should be concentrating on something or working | 1 | 2 | 3 | 4 |
| 20. Has trouble staying alert or awake in boring situations | 1 | 2 | 3 | 4 |
| 21. Is easily confused | 1 | 2 | 3 | 4 |
| 22. Is easily bored | 1 | 2 | 3 | 4 |
| 23. Is spacey or "in a fog" | 1 | 2 | 3 | 4 |
| 24. Is lethargic, more tired than others | 1 | 2 | 3 | 4 |
| 25. Is underactive or has less energy than others | 1 | 2 | 3 | 4 |
| 26. Is slow moving | 1 | 2 | 3 | 4 |
| 27. Doesn't seem to process information as quickly or as accurately as others. | 1 | 2 | 3 | 4 |
| Office use only (Section 4)<br>Total Score: _____ Symptom Count: _____ | | | | |
| Sum of Sections 1 – 3 for Total Scores _____<br>Sum of Sections 1 – 3 for Symptom Counts _____ | | | | |

*(continued)*

**Section 5**

28. Did this person experience *any* of these 27 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

29. If so, how old was the person when those symptoms began? (Fill in the blank)

    They were _____ years old.

    OR if you do not know, place a check mark (✓) below

    _____ I don't know.

30. If so, in which of these settings did those symptoms impair the person's functioning? Place a *check mark* (✓) next to all of the areas that apply to the person.

    _____ School
    _____ Home
    _____ Work
    _____ Social Relationships

**If you checked any of the domains in item # 30 indicating settings in which symptoms impair the person's functioning, please provide examples of the person's <u>current</u> difficulties in the appropriate spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Work:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

# BAARS-IV: Other-Report: Childhood Symptoms

**Name of person to be rated: _____ Date: _____**

**Your name: _____**

**Your relationship to person being rated: (Circle one)**

**Mother Father Brother/sister Spouse/partner Friend Other (specify): _____**

You are being asked to describe the behavior of someone whom you know well. How often did that person experience each of these problems? For the first 18 items, please circle the number next to each item below that best describes their behavior when they were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Inattention)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Failed to give close attention to details or made careless mistakes in his/her work or other activities | 1 | 2 | 3 | 4 |
| 2. Had difficulty sustaining his/her attention in tasks or fun activities | 1 | 2 | 3 | 4 |
| 3. Didn't listen when spoken to directly | 1 | 2 | 3 | 4 |
| 4. Didn't follow through on instructions and failed to finish work or chores. | 1 | 2 | 3 | 4 |
| 5. Had difficulty organizing tasks and activities | 1 | 2 | 3 | 4 |
| 6. Avoided, disliked, or was reluctant to engage in tasks that required sustained mental effort | 1 | 2 | 3 | 4 |
| 7. Lost things necessary for tasks or activities | 1 | 2 | 3 | 4 |
| 8. Was easily distracted by extraneous stimuli or irrelevant thoughts. | 1 | 2 | 3 | 4 |
| 9. Was forgetful in daily activities | 1 | 2 | 3 | 4 |
| Office Use Only (Section 1)<br>Total Score: _____ Symptom Count: _____ | | | | |
| **Section 2 (Hyperactivity-Impulsivity)** | Never or rarely | Some-times | Often | Very often |
| 10. Fidgeted with his/her hands or feet or squirmed in his/her seat | 1 | 2 | 3 | 4 |
| 11. Left his/her seat in classrooms or in other situations in which remaining seated was expected | 1 | 2 | 3 | 4 |
| 12. Shifted around excessively or felt restless or hemmed in | 1 | 2 | 3 | 4 |

*(continued)*

| | | | | |
|---|---|---|---|---|
| 13. Had difficulty engaging in leisure activities quietly (felt uncomfortable, or was loud or noisy) | 1 | 2 | 3 | 4 |
| 14. Was "on the go" or acted as if "driven by a motor" | 1 | 2 | 3 | 4 |
| 15. Talked excessively | 1 | 2 | 3 | 4 |
| 16. Blurted out answers before questions had been completed, completed others' sentences, or jumped the gun | 1 | 2 | 3 | 4 |
| 17. Had difficulty awaiting his/her turn | 1 | 2 | 3 | 4 |
| 18. Interrupted or intruded on others (butted into conversations or activities without permission or took over what others were doing) | 1 | 2 | 3 | 4 |

Office Use Only (Section 2)
Total Score _____ Symptom Count _____

Sum of Sections 1 – 2 for Total Scores _____

Sum of Sections 1 – 2 for Symptom Counts _____

**Section 3**

19. Did the person experience *any* of these 18 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

20. If so, in which of these settings did those symptoms impair the person's functioning? Place a *check mark* (✓) next to all of the areas that apply to the person.

    _____ School
    _____ Home
    _____ Social Relationships

**If you checked any of the domains in item # 20 indicating settings in which symptoms impaired the person's functioning, please provide examples of those childhood difficulties in the spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

# SCT: Other-Report: Childhood Symptoms

**Name of person to be rated: _____ Date: _____**

**Your name: _____**

**Your relationship to person being rated: (Circle one)**

**Mother Father Brother/sister Spouse/partner Friend Other (specify): _____**

**Instructions**

You are being asked to describe the behavior of someone whom you know well. How often did that person experience each of these problems? For the first 9 items, please circle the number next to each item below that best describes their behavior when they were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

| **Section 1 (Sluggish Cognitive Tempo)** | Never or rarely | Some-times | Often | Very often |
|---|---|---|---|---|
| 1. Was prone to daydreaming when he/she should have been concentrating on something or working | 1 | 2 | 3 | 4 |
| 2. Had trouble staying alert or awake in boring situations | 1 | 2 | 3 | 4 |
| 3. Was easily confused | 1 | 2 | 3 | 4 |
| 4. Was easily bored | 1 | 2 | 3 | 4 |
| 5. Was spacey or "in a fog" | 1 | 2 | 3 | 4 |
| 6. Was lethargic, more tired than others | 1 | 2 | 3 | 4 |
| 7. Was underactive or had less energy than others | 1 | 2 | 3 | 4 |
| 8. Was slow moving | 1 | 2 | 3 | 4 |
| 9. Didn't seem to process information as quickly or as accurately as others. | 1 | 2 | 3 | 4 |
| Office use only<br><br>Total Score: _____ Symptom Count: _____ | | | | |

*(continued)*

**Section 2**

10. Did the person experience *any* of these 9 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

11. If so, in which of these settings did those symptoms impair the person's functioning? Place a *check mark* (✓) next to all of the areas that apply to the person.

    _____ School
    _____ Home
    _____ Social Relationships

**If you checked any of the domains in item # 11 indicating settings in which symptoms impaired the person's functioning, please provide examples of those childhood difficulties in the spaces below.**

**School:** _____

_____

**Home:**_____

_____

**Social Relationships:**_____

_____

**FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.**

**Regents' Center for Learning Disorders Credit Card Agreement**

**Name on Card:**_____

**Signature of Cardholder:**_____

**Amount to Charge:**_____

**Card Type:**_____

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**Card Number:**_____

**Expiration Date:**_____