

Name: _____ Date: _____

Please mark under the heading that best fits you

	Never	Sometimes	Often
1. Complain of aches or pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Spend more time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tire easily, little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have trouble with teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Less interested in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Act as if driven by motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Daydream too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Am afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feel sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Am irritable, angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feel hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less interested in friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fight with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. School grades dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Down on yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Visit doctor and doctor finds nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Want to be with parent more than before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Feel that you are bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Take unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Get hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Seem to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Act younger than children your age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Tease others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blame others for your troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Take things that do not belong to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Refuse to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Office Use Only

Total _____

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