

Strengths and Difficulties Questionnaire
Retrospective Survey for Change in Caregiver

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best as you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior **before beginning services**.

Your child's name.....

Male/Female

Date of birth.....

Was your child...	Not True	Somewhat True	Certainly True
1. Considerate of other people's feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Restless, overactive, couldn't stay still for long.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often complained of headaches, stomach-aches or sickness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Shared readily with other youth, for example CDs, games, food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often lost temper.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Would rather be alone than with other youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Generally well behaved, usually did what adults requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Many worries or often seems worried.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Helpful if someone was hurt, upset or feeling ill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Constantly fidgetted or squirmed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Had at least one good friend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Often fought with other youth or bullied them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Often unhappy, depressed or tearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Generally liked by other youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Easily distracted, concentration wandered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Nervous in new situations, easily lost confidence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn over - there are a few more questions on the other side

	Not True	Somewhat True	Certainly True
17. Kind to younger children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Often lied or cheated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Picked on or bullied by other youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Often offered to help others (parents, teachers, children).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Thought things out before acting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Stole from home, school or elsewhere.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Got along better with adults than with other youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Many fears, easily scared.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Good attention span, saw chores or homework through to the end.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. **Before beginning services**, did you have any other comments or concerns?

2. Overall, did you think that your child had difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes", please answer the following questions about these difficulties:

3. How long had these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn over - there are a few more questions on the other side

4. Did the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
5. HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Did the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature.....

Date.....

Mother/Father/Other(please specify:)

Thank you very much for your help

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