

Strengths and Difficulties Questionnaire

P 2-4

FOLLOW-UP

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 **over the last month**.

Your child's name.....

Male/Female

Date of birth.....

	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, cannot stay still for long.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often complains of headaches, stomach-aches or sickness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Shares readily with other children, for example toys, treats, pencils.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often loses temper.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Rather solitary, prefers to play alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Generally well behaved, usually does what adults request.	<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 is hurt, upset or feeling ill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Constantly fidgeting or squirming.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has at least one good friend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Often fights with other children or bullies 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 children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Easily distracted, concentration wanders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Nervous or clingy in new situations, easily loses 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 argumentative with adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Picked on or bullied by other children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Often offers to help others (parents, teachers, other children).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Can stop and think things out before acting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Can be spiteful to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Gets along better with adults than with other children.	<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, sees chores or homework through to the end.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Do you have any other comments or concerns?

2. Since receiving this service, are your child's problems:

Much Worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>				

3. Has receiving this service been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	A medium amount	A great deal
<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. Over the last month, has 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:

5. Do 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"/>

Do 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
6. HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Do 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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