

SYMPTOM RATING SCALE

CHILD'S NAME: _____

DATE _____

PERSON COMPLETING THIS FORM _____

MEDICATION AND DOSE _____

Please rate each behavior from 0 (absent) to 9 (serious). Circle only one number beside each item. A zero means that you have not seen the behavior in this child during the past week, and a nine means that you have noticed it and believe it to be either very serious or to occur very frequently.

BEHAVIOR

Symptom	Best									Worst
	0	1	2	3	4	5	6	7	8	
Insomnia or trouble sleeping	0	1	2	3	4	5	6	7	8	9
Nightmares	0	1	2	3	4	5	6	7	8	9
Staring alot or daydreaming	0	1	2	3	4	5	6	7	8	9
Talking less with others	0	1	2	3	4	5	6	7	8	9
Decreased appetite	0	1	2	3	4	5	6	7	8	9
Irritability	0	1	2	3	4	5	6	7	8	9
Uninterested in others	0	1	2	3	4	5	6	7	8	9
Stomachaches	0	1	2	3	4	5	6	7	8	9
Headaches	0	1	2	3	4	5	6	7	8	9
Drowsiness	0	1	2	3	4	5	6	7	8	9
Sadness/unhappiness	0	1	2	3	4	5	6	7	8	9
Prone to cry	0	1	2	3	4	5	6	7	8	9
Anxiousness	0	1	2	3	4	5	6	7	8	9
Euphoric/unusually happy	0	1	2	3	4	5	6	7	8	9
Dizziness	0	1	2	3	4	5	6	7	8	9
Tics or nervous movements	0	1	2	3	4	5	6	7	8	9

Comments: