

Parent

Form Approved
OMB NO. 0920-24EG
Exp. Date XX/XX/20XX

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Completing the survey is voluntary. If you are not comfortable answering a question, just leave it blank.

Today's Date:

Timestamp

What is this child's date of birth?

Child's Age

If your child is 18 years or older, please do not complete this form and request an adult form for your child instead.

Please answer the following questions about your child.

What is this child's race and/or ethnicity? Select all that apply.

- American Indian or Alaska Native. For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
- Asian. For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
- Black or African American. For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
- Hispanic or Latino. For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
- Middle Eastern or North African. For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
- Native Hawaiian or Pacific Islander. For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
- White. For example, English, German, Irish, Italian, Polish, Scottish, etc.

Has a doctor or other health care provider EVER told you that this child has:

An anxiety disorder, such as generalized anxiety disorder, panic disorder, or a phobia?

- Yes
 No

Anxiety is a feeling of constant worrying. Children with severe anxiety problems may be diagnosed as having anxiety disorders.

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Depression?

- Yes
 No

Some common types of depression include major depression (or major depressive disorder), bipolar depression, dysthymia, post-partum depression, and seasonal affective disorder.

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Autism or Autism Spectrum Disorder?

- Yes
 No

Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Attention Deficit Disorder or
Attention-Deficit/Hyperactivity Disorder, that is, ADD
or ADHD? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Obsessive-compulsive disorder or OCD? Yes
 No

Children with OCD feel the need to check things repeatedly, or have certain thoughts or perform routines and rituals over and over.

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Post-traumatic stress disorder or PTSD? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Substance use disorder? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Frequent or severe headaches, including migraine? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

A sleep disorder?

- Yes
 No

Examples of sleep disorders include sleep apnea, insomnia, and narcolepsy.

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Eating disorder?

- Yes
 No

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Self-injurious behavior?

- Yes
 No

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

A concussion or brain injury

- Yes
 No

A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

Has a doctor, other health care provider, or educator EVER told you that this child has...

Examples of educators are teachers and school nurses.

Behavioral or conduct problems?

- Yes
 No

Does this child currently have the condition?

- Yes
 No

Would you describe it as mild, moderate or severe?

- Mild
 Moderate
 Severe

Developmental delay? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Intellectual disability (formerly known as mental retardation)? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Speech disorder? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Language disorder? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Learning disability? Yes
 No

Does this child currently have the condition? Yes
 No

Would you describe it as mild, moderate or severe? Mild
 Moderate
 Severe

Has a doctor or healthcare provider told you that this child currently has:

Allergies (such as food, drug, insect, seasonal, or other)? Yes
 No

Asthma?

- Yes
 No

Autoimmune disease (such as Type 1 Diabetes, Celiac, or Juvenile Idiopathic Arthritis)?

- Yes
 No

Type 2 Diabetes?

- Yes
 No

Epilepsy or seizure disorder?

- Yes
 No

Has this child ever shown extreme expression of anger, often to the point of uncontrollable rage that is disproportionate to the situation at hand?

- Yes
 No

Does this child currently show extreme expression of anger?

- Yes
 No

Would you describe it as mild, moderate, or severe?

- Mild
 Moderate
 Severe

Has this child ever had sensory processing problems?

- Yes
 No

For example, being hypersensitive (over-responsive) to certain sensations (like certain lights, sounds, touch, tastes, or smells) or hyposensitive (under-responsive) and seek out sensory input, to the point that it causes distress.

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Treatment for Tic Disorders and Related Conditions

The next questions ask about medications this child may be taking for their tic disorder or related conditions.

Related conditions include things like ADHD, OCD, anxiety, depression, behavior issues, or other mental health conditions.

Has this child ever taken medication for a tic disorder or related conditions? Yes
 No

At what age did this child first start taking medication for a tic disorder or related conditions? _____

Is this child currently taking medication for a tic disorder or related conditions? Yes
 No

What medications does this child currently take for a tic disorder or related conditions? _____

Please list all.

Who usually makes sure this child takes their medication for a tic disorder or related conditions? A parent or guardian
 Another family member or adult
 The child
 Other person (Please specify relationship of other person): _____

In the past 12 months, was there a time when this child resisted taking their medication for a tic disorder or related conditions? Yes
 No

Do not include resistance solely due to physical reasons such as being unable to swallow a pill.

The next questions ask about other treatments for a tic disorder or related conditions.

Related conditions include things like ADHD, OCD, anxiety, depression, behavior issues, or other mental health conditions.

Has this child ever received comprehensive behavioral intervention for tics (CBIT) or habit reversal therapy for a tic disorder? Yes
 No
 Don't know

Is this child currently receiving comprehensive behavior intervention for tics (CBIT) or habit reversal therapy for a tic disorder? Yes
 No
 Don't know

Has this child ever received school-based behavioral treatment, support, or accommodation for a tic disorder or related conditions? Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Is this child currently receiving school-based behavioral treatment, support, or accommodation for a tic disorder or related conditions? Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Has this child ever received behavioral treatment based outside of school for a tic disorder or related conditions?

- Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Is this child currently receiving behavior treatment based outside of school for a tic disorder or related conditions?

- Yes
 No
 Don't know

Do not include CBIT or habit reversal therapy.

Has this child ever received any other treatment for a tic disorder or related conditions?

- Yes (Please specify): _____
 No
 Don't know

Is this child currently receiving any other treatment for a tic disorder or related conditions?

- Yes (Please specify): _____
 No
 Don't know

Does this child currently have a formal educational plan, such as an Individualized Education Program, also called an IEP or a 504 plan?

- Yes
 No
 Don't know

Which one is it, an IEP or a 504 plan?

- IEP
 504
 Something else
 Both IEP and 504 plan

Overall, how satisfied are you with this child's tic disorder treatment and management?

- Very satisfied
 Somewhat satisfied
 Somewhat dissatisfied
 Very dissatisfied

In the past year, has your child received any of the following for any mental, emotional, or behavioral problem, across settings (school, doctor's office)?

Select all that apply.

- Parent training
 Social skills training
 Cognitive behavioral therapy
 Counseling (for example, talk therapy or psychotherapy)
 Other (Please specify): _____
 None of these

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Healthcare Transition (from Pediatric to Adult Health Care)

Do any of this child's doctors or other health care providers treat only children?

- Yes
 No

Have they talked with you about when this child will need to see doctors or other health care providers who treat adults?

- Yes
 No

Has this child's doctor or other health care provider actively worked with this child to:

Make positive choices about their health.

For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity?

- Yes
 No
 Don't know

Gain skills to manage their health and health care.

For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications they may need?

- Yes
 No
 Don't know

Understand the changes in health care that happen at age 18.

For example, by understanding changes in privacy, consent, access to information, or decision-making?

- Yes
 No
 Don't know

Did you and this child receive a summary of your child's medical history (for example, medical conditions, allergies, medications, immunizations)?

- Yes
 No

Have this child's doctors or other health care providers worked with you and this child to create a plan of care to meet their health goals and needs?

- Yes
 No

Do you and this child have access to this plan of care?

- Yes
 No

Does this plan of care address transition to doctors and other health care providers who treat adults?

- Yes
 No
 No, this child already sees providers who treat adults

Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as they become an adult?

- Yes
 No

Has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?

- Yes
 No

Do you have concerns about your child transitioning from pediatric to adult healthcare providers to provide care related to their tic disorder?

- Yes
- No

What are your main concerns?

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

School, Cost, and Service use

DURING THE PAST 12 MONTHS, about how many days did this child miss school because of illness or injury?

Include days missed from any formal home schooling.

- No missed school days
- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days
- This child was not enrolled in school

DURING THE PAST 12 MONTHS, about how many days did this child miss school because of behavior, mood, or tic related concerns?

Include days missed from any formal home schooling.

- No missed school days
- 1-3 days
- 4-6 days
- 7-10 days
- 11 or more days
- This child was not enrolled in school

Which of the following best describes your current employment status?

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work
- Retired

Does this child have another parent or adult caregiver who lives in this household?

- Yes
- No

Which of the following best describes this caregiver's current employment status?

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work
- Retired

DURING THE PAST 12 MONTHS, have you or other family members...

Left a job or taken a leave of absence because of this child's health or health conditions?

- Yes
- No

Cut down on the hours you work because of this child's health or health conditions?

- Yes
- No

Avoided changing jobs because of concerns about maintaining health insurance for this child?

- Yes
- No

Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS?

Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- \$0 (No medical or health-related expenses)
- \$1-\$249
- \$250-\$499
- \$500-\$999
- \$1,000-\$5,000
- More than \$5000

Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's mental health care including prescriptions and office visits DURING THE PAST 12 MONTHS?

- \$0 (No medical or health-related expenses)
 \$1-\$249
 \$250-\$499
 \$500-\$999
 \$1,000-\$5,000
 More than \$5000

Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

The next questions are about your family's medical bills. Include bills for doctors, dentists, hospitals, therapists, medication, equipment, and nursing home or home care.

In the past 12 months, did anyone in your family have problems paying or were unable to pay any medical bills?

- Yes
 No

Does anyone in your family currently have any medical bills that you are unable to pay at all?

- Yes
 No

If this child gets sick or has an accident, how worried are you that your family will be able to pay their medical bills?

- Very worried
 Somewhat worried
 Not at all worried

During the past 12 months, has medical care BEEN DELAYED for this child because of the cost?

- Yes
 No

During the past 12 months, was there any time when this child needed medical care, but DID NOT GET IT because of the cost?

- Yes
 No

At any time in the past 12 months, did this child take prescription medication?

- Yes
 No

During the past 12 months, did you DELAY filling a prescription for this child to save money?

- Yes
 No

During the past 12 months, was there any time when this child needed prescription medication, but DID NOT GET IT because of the cost?

- Yes
 No

During the past 12 months, has this child been DELAYED in getting counseling or therapy from a mental health professional because of the cost?

- Yes
 No

During the past 12 months, was there any time when this child needed counseling or therapy from a mental health professional, but DID NOT GET IT because of the cost?

- Yes
 No

During the past 12 months, has this child been DELAYED in getting counseling or therapy from a mental health professional because you couldn't get an appointment?

- Yes
 No

How long was the delay?

- Less than 3 months
 3-6 months
 7-12 months
 More than 12 months

During the past 12 months, how many times has this child gone to a hospital emergency room about their health? _____

This includes emergency room visits that resulted in a hospital admission.

During the past 12 months, has this child been hospitalized overnight?

- Yes
 No

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Please answer the following questions about this child.

What is this child's sex?

Male
 Female

Which of the following best represents how your child thinks of themselves?

Gay (lesbian or gay)
 Straight, this is not gay (or lesbian or gay)
 Bisexual
 Something else
 I don't know the answer

The next questions are about health insurance. Include health insurance obtained through employment or purchased directly as well as government programs like Medicare, Medicaid, and the Children's Health Insurance Program that provide medical care or help pay medical bills.

Is this child covered by any kind of health insurance or some other kind of health care plan?

Yes
 No

What kinds of health insurance or health care coverage does this child have?

Select all that apply.

- Private health insurance
 Medicare
 Medigap
 Medicaid
 Children's Health Insurance Program (CHIP)
 Military related health care: TRICARE (CHAMPUS) / VA health care / CHAMP-VA
 Indian Health Service
 State-sponsored health plan
 Other government program
 No coverage of any type

Does this child have any of the following?

Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition

Yes
 No

Serious difficulty walking or climbing stairs

Yes
 No

Difficulty dressing or bathing

Yes
 No

Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition

Yes
 No

Deafness or problems with hearing

Yes
 No

Blindness or problems with seeing, even when wearing glasses

Yes
 No

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

Please answer the following questions about yourself and your family.

How are you related to this child?

- Biological or adoptive parent
 - Step-parent
 - Grandparent
 - Foster parent
 - Other: Relative
 - Other: non-Relative
-

What is the HIGHEST level of school you have completed?

- Never attended/kindergarten only
 - Grade 1-11
 - 12th grade, no diploma
 - GED or equivalent
 - High school graduate
 - Some college, no degree
 - Associate degree: occupational, technical, or vocational program
 - Associate degree: academic program
 - Bachelor's degree (Example: BA, AB, BS, BBA)
 - Master's degree (Example: MA, MS, MEng, MEd, MBA)
 - Professional school degree (Example: MD, DDS, DVM, JD)
 - Doctoral degree (Example: PhD, EdD)
-

What is your marital status?

- Married
 - Not married, but living with a partner
 - Never married
 - Divorced
 - Separated
 - Widowed
-

The following questions are about the address where you currently live.

What is your current street address?

Example: 123 Main Street

What is the apartment or unit number (skip if none)?

Example: Apt. 5a

In what city do you currently live?

In what state do you currently live?

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- District of Columbia
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming
- Other

Specify other place (not US state) you live

What is your current zip code (for address above)?

How many people are living or staying at this address?

Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

What is your best estimate of your total family income from all sources, before taxes, in the last year?

- < \$15,000
- \$15,000-\$24,999
- \$25,000-49,999
- \$50,000-74,999
- \$75,000-99,999
- \$100,000-149,999
- \$150,000-199,999
- \$200,000 or higher

Did anyone help you complete this survey?

- Yes, someone helped me, but I completed most of the survey on my own.
- Yes, someone helped me with all or most of the survey.
- No, I completed the survey on my own.

If you are interested in receiving project updates in the future, please enter your email address.

You may decline to be re-contacted now or at any time in the future.

You skipped one or more questions on this page. Please review and complete the question(s) before going to the next page. If you intentionally skipped the question(s), you can go to the next page.

ASQ

Please complete the survey below. Thank you!

Medical Record Number _____

Timestamp _____

Please ask the following questions only for those ages 9 and up.

Note to person administering the ASQ: Please provide the following information to the respondent before asking the questions.

This survey asks about mental health and emotional well-being. If you answer that you have had suicidal thoughts or behaviors, or purposely tried to hurt yourself, we may inform your doctor or other clinic staff. This would be to ensure your safety and provide you with support and care.

By completing this survey, you accept and consent to this protocol. If you have concerns or need immediate help, please tell the clinic staff.

1) In the past few weeks, have you wished you were dead? Yes
 No
 Refused to answer

2) In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes
 No
 Refused to answer

3) In the past week, have you been having thoughts about killing yourself? Yes
 No
 Refused to answer

4) Have you ever tried to kill yourself? Yes
 No
 Refused to answer

4a) How? _____

4b) When? _____

The patient answered "No" to questions 1 through 4; therefore, screening is complete, and it is not necessary to ask question #5. No intervention is necessary; however, clinical judgment can always override a negative screen.

Do you want to ask the patient question #5 (Are you having thoughts of killing yourself right now?) or finish the ASQ? Ask question #5
 Finish the ASQ

This patient is considered a positive screen. Ask question #5 to assess acuity.

5) Are you having thoughts of killing yourself right now? Yes
 No

5b) Please describe:

Patient is acute positive screen (imminent risk identified)

Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.

Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

Provide resources to all patients: 988 Suicide and Crisis Lifeline, 988 (call, text),
<https://988lifeline.org/>

Patient is non-acute positive screen (potential risk identified).

Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.

Alert physician or clinician responsible for patient's care.

Provide resources to all patients: 988 Suicide and Crisis Lifeline, 988 (call, text),
<https://988lifeline.org/>

Initials of person (staff/professional) completing ASQ

Optional: Provide any comments on clinical information entered on this form. Please do not use any patient identifiers.

Overview of ASQ - this information is included above, within skip logic, and only included here for reference.

If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).

If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity.

"Yes" to question #5 = acute positive screen (imminent risk identified)

Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.

Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

"No" to question #5 (but "Yes" or "Refused" to one of questions 1-4) = non-acute positive screen (potential risk identified)

Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.

Alert physician or clinician responsible for patient's care.

Provide Resources to All Patients:

- 988 Suicide and Crisis Lifeline, Call or Text 988
- Visit <https://988lifeline.org/> to chat

YGTSS

Please complete the survey below. Thank you!

Medical Record Number _____

Timestamp _____

This instrument to be completed by trained professional.

Motor Tics

Age of first motor tics, in years _____

Describe first motor tic: _____

Was tic onset sudden or gradual? _____

Age of worst motor tics, in years? _____

Motor Tic Symptom Checklist

Please select if the patient currently (during the past week) has each tic OR if they ever (but not currently) had the tic. State age of onset (in years) if patient has had this behavior.

The patient has experienced, or others have noticed, involuntary and apparently purposeless bouts of:

eye movements

- Current
 Ever

eye blinking, squinting, a quick turning of the eyes, rolling of the eyes to one side, or opening eyes wide very briefly.

What was the age of onset of this behavior? _____

eye gestures such as looking surprised or quizzical, or looking to one side for a brief period of time, as if s/he heard a noise.

- Current
 Ever

What was the age of onset of this behavior? _____

nose, mouth, tongue movements, or facial grimacing

- Current
 Ever

nose twitching, biting the tongue, chewing on the lip or licking the lip, lip pouting, teeth baring, or teeth grinding.

What was the age of onset of this behavior? _____

broadening the nostrils as if smelling something, smiling, or other gestures involving the mouth, holding funny expressions, or sticking out the tongue.

- Current
 Ever

What was the age of onset of this behavior?

head jerks/movements

- Current
 Ever

touching the shoulder with the chin or lifting the chin up.

What was the age of onset of this behavior?

throwing the head back, as if to get hair out of the eyes.

- Current
 Ever

What was the age of onset of this behavior?

shoulder jerks/movements

- Current
 Ever

jerking a shoulder.

What was the age of onset of this behavior?

shrugging the shoulder as if to say "I don't know."

- Current
 Ever

What was the age of onset of this behavior?

arm or hand movements

- Current
 Ever

quickly flexing the arms or extending them, nail biting, poking with fingers, or popping knuckles.

What was the age of onset of this behavior?

passing hand through the hair in a combing like fashion, or touching objects or others, pinching, or counting with fingers for no purpose, or writing tics, such as writing over and over the same letter or word, or pulling back on the pencil while writing.

- Current
 Ever

What was the age of onset of this behavior?

leg, foot, or toe movements

- Current
 Ever

kicking, skipping, knee-bending, flexing or extension of the ankles; shaking, stomping or tapping the foot.

What was the age of onset of this behavior?

taking a step forward and two steps backward, squatting, or deep knee-bending.

- Current
- Ever

What was the age of onset of this behavior?

abdominal/trunk/pelvis movements

- Current
- Ever

tensing the abdomen, tensing the buttocks.

What was the age of onset of this behavior?

other simple motor tics.

- Current
- Ever

Please write example(s):

What was the age of onset of this behavior?

Other complex motor tics

- Current
- Ever

touching

What was the age of onset of this behavior?

tapping

- Current
- Ever

What was the age of onset of this behavior?

picking

- Current
- Ever

What was the age of onset of this behavior?

evening-up

- Current
- Ever

What was the age of onset of this behavior?

reckless behaviors

- Current
- Ever

What was the age of onset of this behavior?

stimulus-dependent tics (a tic which follows, for example, hearing a particular word or phrase, seeing a specific object, smelling a particular odor).

- Current
- Ever

What was the age of onset of this behavior?

Please write example(s):

rude/obscene gestures; obscene finger/hand gestures.

- Current
- Ever

What was the age of onset of this behavior?

unusual postures.

- Current
- Ever

What was the age of onset of this behavior?

bending or gyrating, such as bending over.

- Current
- Ever

What was the age of onset of this behavior?

rotating or spinning on one foot.

- Current
- Ever

What was the age of onset of this behavior?

copying the action of another (echopraxia)

- Current
- Ever

What was the age of onset of this behavior?

sudden tic-like impulsive behaviors.

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

tic-like behaviors that could injure/mutilate others.

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

self-injurious tic-like behavior(s).

- Current
- Ever

What was the age of onset of this behavior?

Please describe this behavior.

other involuntary and apparently purposeless motor tics (that do not fit in any previous categories).

Please describe any other patterns or sequences of motor tic behaviors:

Phonic (Vocal) Tics

Age of first vocal tics, in years

Describe first vocal tic:

Was tic onset sudden or gradual?

Age of worst vocal tics, in years

Phonic Tic Symptom Checklist

Please select if the patient currently (during the past week) has each tic OR if they ever (but not currently) had the tic. State age of onset (in years) if patient has had this behavior.

The patient has experienced, or others have noticed, involuntary and apparently purposeless bouts of:

coughing.

- Current
- Ever

What was the age of onset of this behavior?

throat clearing.

- Current
- Ever

What was the age of onset of this behavior?

sniffing.

- Current
- Ever

What was the age of onset of this behavior?

whistling.

- Current
- Ever

What was the age of onset of this behavior?

animal or bird noises.

- Current
- Ever

What was the age of onset of this behavior?

other simple phonic tics.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

syllables.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

words.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

rude or obscene words or phrases.

- Current
- Ever

What was the age of onset of this behavior?

Please list:

repeating what someone else said, either sounds, single words or sentences. Perhaps repeating what's said on TV (echolalia).

- Current
- Ever

What was the age of onset of this behavior?

repeating something the patient said over and over again (palilalia).

- Current
- Ever

What was the age of onset of this behavior?

other tic-like speech problems, such as sudden changes in volume or pitch.

- Current
- Ever

What was the age of onset of this behavior?

Please describe:

Describe any other patterns or sequences of phonic tic behaviors:

What was the age of onset of this behavior?

Severity Ratings: Number (Past 7-10 days)

Current Motor Number

Current Phonic Number

Rating Scale

(0) None (no tics)

(1) Single tic

(2) Multiple discrete tics (2-5)

(3) Multiple discrete tics (>5)

(4) Multiple discrete tics plus at least one orchestrated pattern of multiple simultaneous or sequential tics where it is difficult to distinguish discrete tics.

(5) Multiple discrete tics plus several (>2) orchestrated paroxysms of multiple simultaneous or sequential tics where it is difficult to distinguish discrete tics.

Severity Ratings: Frequency (Past 7-10 days)

Current Motor Frequency

Current Phonic Frequency

Rating Scale

(0) None: No evidence of specific tic behaviors.

(1) Rarely: Specific tic behaviors have been present during previous week. These behaviors occur infrequently, often not on a daily basis. If bouts of tics occur, they are brief and uncommon.

(2) Occasionally: Specific tic behaviors are usually present on a daily basis, but there are long tic-free intervals during the day. Bouts of tics may occur on occasion and are not sustained for more than a few minutes at a time.

(3) Frequently: Specific tic behaviors are present on a daily basis. Tic free intervals as long as 3 hours are not uncommon. Bouts of tics occur regularly but may be limited to a single setting.

(4) Almost Always: Specific tic behaviors are present virtually every waking hour of every day, and periods of sustained tic behaviors occur regularly. Bouts of tics are common and are not limited to a single setting.

(5) Always: Specific tic behaviors are present virtually all the time. Tic free intervals are difficult to identify and do not last more than 5 to 10 minutes at most.

Severity Ratings: Intensity (Past 7-10 days)

Current Motor Intensity

Current Phonic Intensity

Rating Scale

(0) Absent: Tics are not present at all

(1) Minimal: Tics are not visible or audible (based solely on patient's private experience) or tics are less forceful than comparable voluntary actions and are typically not noticed because of their intensity.

(2) Mild: Tics are not more forceful than comparable voluntary actions or utterances and are typically not noticed because of their intensity.

(3) Moderate: Tics are more forceful than comparable voluntary actions, but are not outside the range of normal expression for comparable voluntary actions or utterances. They may call attention to the individual because of their forceful character.

(4) Marked: Tics are more forceful than comparable voluntary actions or utterances and typically have an "exaggerated" character. Such tics frequently call attention to the individual because of their forceful and exaggerated character.

(5) Severe: Tics are extremely forceful and exaggerated in expression. These tics call attention to the individual and may result in risk of physical injury (accidental, provoked, or self-inflicted) because of their forceful expression.

Severity Ratings: Complexity (Past 7-10 days)

Current Motor Complexity

Current Phonic Complexity

Rating Scale

(0) None: Tics are not present OR if present, all tics are clearly "simple" (sudden, brief, purposeless) in character.

(1) Borderline: Some tics are not clearly "simple" in character.

(2) Mild: Some tics are clearly "complex" (purposeful in appearance) and mimic brief "automatic" behaviors, such as grooming, syllables, or brief meaningful utterances such as "ah huh", or "hi", that could be readily camouflaged.

(3) Moderate: Some tics are more "complex" (more purposeful and sustained in appearance) and may occur in orchestrated bouts that would be difficult to camouflage, but could be rationalized or "explained" as normal behavior or speech (picking, tapping, saying "you bet" or "honey", brief echolalia).

(4) Marked: Some tics are very "complex" in character and tend to occur in sustained orchestrated bouts that would be difficult to camouflage and could not be easily rationalized as normal behavior or speech because of their duration and/or their unusual, inappropriate, bizarre or obscene character (a lengthy facial contortion, touching genitals, echolalia, speech atypicalities, longer bouts of saying "what do you mean" repeatedly or saying "fu" or "sh").

(5) Severe: Some tics involve lengthy bouts of orchestrated behavior or speech that would be impossible to camouflage or successfully rationalize as normal because of their duration and/or extremely unusual, inappropriate, bizarre or obscene character (lengthy displays or utterances often involving copropraxia, self-abusive behavior, or coprolalia).

Severity Ratings: Interference (Past 7-10 days)

Current Motor Interference

Current Phonic Interference

Rating Scale

(0) None: This means there are no tics present at all.

(1) Minimal: When tics are present, they do not interrupt the flow of behavior or speech.

(2) Mild: When tics are present, they occasionally interrupt the flow of behavior or speech.

(3) Moderate: When tics are present, they frequently interrupt the flow of behavior or speech.

(4) Marked: When tics are present, they frequently interrupt the flow of behavior or speech, and they occasionally disrupt intended action or communication.

(5) Severe: When tics are present, they frequently disrupt intended action or communication.

Severity Ratings: Impairment (Past 7-10 days)

Current Motor Impairment

Current Phonic Impairment

Rating Scale

(0) None

(10) Minimal: Tics associated with subtle difficulties in self-esteem, family life, social acceptance or school/job functioning (infrequent upset or concern about tics vis a vis the future, periodic, slight increase in family tensions because of tics; friend or acquaintances may occasionally notice or comment about tics in an upsetting way.

(20) Mild: Tics associated with minor difficulties in self-esteem, family life, social acceptance, or school/job functioning.

(30) Moderate: Tics associated with some clear problems in self-esteem, family life, social acceptance, or school/job functioning (episodes of dysphoria, periodic distress and upheaval in the family, frequent teasing by peers or episodic social avoidance, periodic interference in school/job performance because of tics).

(40) Marked: Tics associated with major difficulties in self-esteem, family life, social acceptance, or school/job functioning.

(50) Severe: Tics associated with extreme difficulties in self-esteem, family life, social acceptance, or school/job functioning (severe depression with suicidal ideation, disruption of the family [separation/divorce, residential placement], disruption of social ties, severely restricted life because of social stigma and social avoidance, removal from school/job).

Initials of person completing this form.

Optional: Provide any comments on clinical information entered on this form. Please do not use any patient identifiers.

For the person conducting the assessment: How familiar are you with this individual (being assessed with YGTSS)?

- Not familiar (for example: this was my first encounter with this individual, or previous encounters were very brief)
- Somewhat familiar (for example: I have interacted with this individual on more than one occasion and for more than just a brief encounter)
- Very familiar (I have interacted with this individual on several occasions AND am very familiar with their tic symptoms)