Teen Survey (12-17)

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

This survey asks questions about your mental health and feelings. If you say that you have thought about hurting yourself or have tried to do so, we may need to inform your parent/guardian and/or your doctor or clinic staff. This is to make sure you are safe and to help you get support and care.

By filling out this survey, you agree to this process. If you have any worries or need help right away, please talk to the clinic staff.

You do not have to complete the survey if you don't want to. If you feel uncomfortable with a question, you can leave it blank.

Today's Date

_____

Timestamp

_____

How old are you, in years?

_____

If you are not between the ages of 12-17, please request an alternative form from the project staff.

Please answer the following questions about yourself.

During the past 12 months, have you been unfairly disciplined at school?
- ◯ Yes
- ◯ No

How often have you been bothered by each of the following symptoms during the past two weeks?

Feeling down, depressed, irritable, or hopeless?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Little interest or pleasure in doing things?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Trouble falling asleep, staying asleep, or sleeping too much?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Poor appetite, weight loss, or overeating?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Feeling tired, or having little energy?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Trouble concentrating on things like school work, reading, or watching TV?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Moving or speaking so slowly that other people could have noticed?

Or the opposite- being so fidgety or restless that you were moving around a lot more than usual?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself in some way?
- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?
- ◯ Yes
- ◯ No

If you are experiencing any of these problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	◯ Not difficult at all ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult
During the past 12 months, how many times did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose?	◯ 0 times ◯ 1 time ◯ 2 or 3 times ◯ 4 or 5 times ◯ 6 or more times

The next few questions are about thoughts of suicide. You can answer "I'm not sure" or "I don't want to answer" to any question.

At any time in the past 12 months, up to and including today, did you seriously think about trying to kill yourself?	◯ Yes ◯ No ◯ I'm not sure ◯ I don't want to answer
During the past 12 months, did you make any plans to kill yourself?	◯ Yes ◯ No ◯ I'm not sure ◯ I don't want to answer
During the past 12 months, did you try to kill yourself?	◯ Yes ◯ No ◯ I'm not sure ◯ I don't want to answer
During the past 12 months, did you get medical attention from a doctor or other health professional as a result of an attempt to kill yourself?	◯ Yes ◯ No ◯ I'm not sure ◯ I don't want to answer
Did you stay in a hospital overnight or longer because you tried to kill yourself?	◯ Yes ◯ No ◯ I'm not sure ◯ I don't want to answer

If you ever feel like you need to talk about mental health issues, emotional pain, or problems with alcohol or drugs, you can call or text the 988 Suicide and Crisis Lifeline at 988. Counselors are available 24/7 to listen and help you find services in your area. They can speak with you in English or Spanish.

Please save this number and website:

988 (call or text)

https://988lifeline.org/

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.

The next questions ask about the transition to adult health care.

Not including dental care, about how long has it been since you last saw a doctor or other health professional about your health?

- ◯ Within the past 12 months
- ◯ A year ago or more, but less than 2 years ago
- ◯ 2 or more years ago
- ◯ Never

At this LAST medical care visit, did you have a chance to speak with a doctor or other health professional privately, without a parent or guardian in the room?

- ◯ Yes
- ◯ No

Was this a wellness visit, physical, or general purpose check-up?

This kind of visit typically includes: height and weight measurements, vaccinations, and vision or hearing checks. The doctor or other health professional may also discuss topics related to your health such as growth and development, diet and exercise, safety, and sleep patterns. These visits are usually scheduled in advance and occur when you are not sick. If a wellness exam was combined with a sick care visit, include this visit. An obstetrician/gynecologist (OB/GYN) may perform this visit.

- ◯ Yes
- ◯ No

About how long has it been since you last saw a doctor or other health professional for a wellness visit, physical, or general purpose check-up?

This kind of visit typically includes: height and weight measurements, vaccinations, and vision or hearing checks. The doctor or other health professional may also discuss topics related to your health such as growth and development, diet and exercise, safety, and sleep patterns. These visits are usually scheduled in advance and occur when you are not sick. If a wellness exam was combined with a sick care visit, include this visit. An obstetrician/gynecologist (OB/GYN) may perform this visit.

- ◯ Within the past 12 months
- ◯ A year ago or more, but less than 2 years ago
- ◯ 2 or more years ago
- ◯ Never

At this LAST wellness visit, physical, or general purpose check-up, did you have a chance to speak with a doctor or other health professional privately, without a parent or guardian in the room?

- ◯ Yes
- ◯ No

During the past 12 months, has a doctor or other health professional talked to you about understanding the changes in health care that happen at age 18?

This can include understanding changes in privacy, consent, access to information, or decision making.

- ◯ Yes
- ◯ No

During the past 12 months, has a doctor or other health professional talked to you about gaining skills to manage your health and health care?

- ◯ Yes
- ◯ No

Have you ever had a visit with a doctor or other health professional that your parents or guardians didn't know about?

- ◯ Yes
- ◯ No

Do you have concerns about transitioning from pediatric to adult healthcare providers for care related to your 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.

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, select the response that seems to describe you for the last 3 months.

When I feel frightened, it is hard to breathe.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I get headaches when I am at school.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I don't like to be with people I don't know well.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I get scared if I sleep away from home.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about other people liking me.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel like passing out.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am nervous.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I follow my mother or father wherever they go.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
People tell me that I look nervous.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I feel nervous with people I don't know well.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I get stomachaches at school.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel like I am going crazy.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about sleeping alone.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true

I worry about being as good as other kids.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel like things are not real.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I have nightmares about something bad happening to my parents.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about going to school.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, my heart beats fast.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I get shaky.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I have nightmares about something bad happening to me.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about things working out for me.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I sweat a lot.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am a worrier.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I get really frightened for no reason at all.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am afraid to be alone in the house.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
It is hard for me to talk with people I don't know well.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel like I am choking.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true

People tell me that I worry too much.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I don't like to be away from my family.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am afraid of having anxiety (or panic) attacks.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry that something bad might happen to my parents.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I feel shy with people I don't know well.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about what is going to happen in the future.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel like throwing up.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about how well I do things.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am scared to go to school.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I worry about things that have already happened.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
When I get frightened, I feel dizzy.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true
I am shy.	◯ Not true or hardly ever true ◯ Somewhat true or sometimes true ◯ Very true or often true

Which of the following best represents how you think of yourself?	◯ Gay (lesbian or gay) ◯ Straight, this is not gay (or lesbian or gay) ◯ Bisexual ◯ Something else ◯ I don't know the answer
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.

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

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

◯ Current
◯ Ever

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

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

◯ Current
◯ Ever

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 touching the shoulder with the chin or lifting the chin up.	◯ Current ◯ Ever
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 jerking a shoulder.	◯ Current ◯ Ever
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 quickly flexing the arms or extending them, nail biting, poking with fingers, or popping knuckles.	◯ Current ◯ Ever
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 kicking, skipping, knee-bending, flexing or extension of the ankles; shaking, stomping or tapping the foot.	◯ Current ◯ Ever

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

tensing the abdomen, tensing the buttocks.

◯ Current
◯ Ever

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

touching

◯ Current
◯ Ever

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)