Norfolk Community Health and Care NHS Trust

NDS Parent Observation Questionnaire

CHILD'S NAME		**DATE OF BIRTH (DD/DD/YYYY)**	**/ /**
AGE OF CHILD		**RELATIONSHIP TO CHILD**	
ADDRESS	**POST CODE:**		
CHILDS GENDER / IDENTITY	**M / F / Other:**	**TODAYS DATE (DD/DD/YYYY)**	**/ /**
DO YOU LIVE AT THE SAME ADDRESS AS THE CHILD? (PLEASE CIRCLE AS APPROPRIATE)			**YES / NO**

PLEASE GIVE EXAMPLES & COMMENTS FOR EACH QUESTION IN THE SPACE PROVIDED
SOCIAL COMMUNICATION SKILLS - (The tools the child uses to communicate with others including attention, listening, speech, language, and non-verbal communication skills such as eye contact, facial expression, and gesture)
1. Does your child/young person have any language difficulties (this includes difficulties understanding others, putting their idea's together in an order that's easy to understand or not talking in certain situations)?

2. Does your child/young person have unusual use of intonation (this is the sound including pitch / tone of their voice; this includes high or unusual pitch, unusual stress patterns over certain words or letters etc)?
3. Does your child/young person copy language from their environment (this is call echolalia). This may include copying language directly others or from the TV or internet)?
4. Does your child/young person refer to him/herself as "you", "she" or "he "or have any other difficulties with personal pronouns (including referring to themselves by their name)?
5. Does your child/young person use any unusual words for his/her age or social group that may make his/her speech sound unusual e.g., they sound too formal or speak with an accent not linked to their heritage etc?

6. Does your child / young person have any difficulties using language to communicate their needs including when they are frustrated or when you have introduced them to something new?
7. Does your child/young person talk mainly about his/her own specific topics of interest (things they really enjoy e.g., Pokémon, without asking about things others like)?
ANY ADDITIONAL COMMENTS REGARDING COMMUNICATION SKILLS:
SOCIAL INTERACTION (Your child's relationships with other people to including other family members, siblings and friends).
1. Does your child/young person have any difficulties with joining in with play or an activity with other children or do they make inappropriate attempts to join in play with others (including aggressive or disruptive behaviour and difficulties with sharing or playing alongside others)?

2. Does your child/young person have a lack of awareness of social norms (e.g., commenting on people's personal appearance or not picking up on social cues)?
3. Does your child/young person become over-whelmed in social situations (possibly withdraw or cling to a parent / carer etc)?
4. Does your child/young person have any unusual characteristics about their interaction with adults (this includes intense relationships, preferring to spend time with adults over others of the same age or difficulties in forming relationships with adults)?
5. Does the child/young person get upset by people being in his/her personal space or being rushed to complete something or when a task has to be left unfinished?

6. Does the child use any unusual non-verbal communication (e.g., poor eye contact and/or lack of a range of facial expressions and use of gestures)?
ANY ADDITIONAL COMMENTS REGARDING SOCIAL INTERACTION SKILLS:
FLEXIBLE BEHAVIOUR (to include repetitive behaviours, need for routines and obsessions and imagination)
1. Does your child/young person have difficulties with imagination/ creativity (this may show as difficulty with imaginative play or role play or difficulty with creative writing)?
2. Does your child/young person have difficulties managing during times which are unstructured, e.g., free play in a park, during holiday periods when the day is not structured etc.?
3. Does your child/young person have any difficulties with managing 'change' or unstructured situations such changes to things which have been planned or going to new places?

ADDITIONAL COMMENTS REGARDING: FLEXIBLE BEHAVIOUR/OBSESSIVE BEHAVIOUR AND IMAGINATION:
HYPERACTIVE / IMPULSIVE BEHAVIOUR (the child's level of activity and ability to manage in a classroom setting)
1. Is your child / young person able to remain in their seat for the duration for an extended period of time e.g. at the dinner table, in the cinema, watching TV etc? (please consider whether they frequently get up for toilet breaks, make excuses to move, swing their legs excessively under the table).
2. Does your child / young person engage in fiddling or fidgeting behaviour when they are expected to remain seated? (this may include needing to use blue tac to roll between fingers or frequently picking up things to fiddle or play with).
3. Does your child / young person cross the road safely and able to stop and wait for traffic to pass?

4. How does your child/ young person manage during quiet activities such as reading, completing homework etc?
5. Is your child / young person able to queue up for example, in the supermarket or shop or when waiting for an activity (if they struggle with queuing, please give details of the behaviour you notice).
INATTENTIVE BEHAVIOUR (the child's ability to maintain focus)
1. Is your child / young person able to concentrate at home at an age expected level?
2. Does your child / young person engage in mind wandering / day dreaming type behaviour?
3. Does your child/ young person frequently lose things at home and / or forget instructions they have been given?
4. If homework is given, does your child / young person hand it in on time on most occasions? (please also comment if they frequently forget to write it down)

ADDITIONAL COMMENTS REGARDING HYPERACTIVE / IMPULSIVE / INATTENTIVE BEHAVIOUR:

GENERAL BEHAVIOUR
1) Please comment on the general behaviour of your child/young person when they are at home:
2) Do they ever experience intense emotions? (E.g., become very upset / angry / worried when asked to do a small job, please give examples

ADHD RS-IV: Home Version: The following questionnaire can help us better understand the needs of your child. Please answer to the questions to the best of your ability.

Circle the number that best describes your child / young person's home behaviour over the past 6 months.	Never or rarely	Sometimes	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Fidgets with hands or feet or squirms in seat	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
5. Does not seem to listen when spoken to directly	0	1	2	3

Circle the number that best describes the child / young person's classroom behaviour over the past 6 months.	Never or rarely	Sometimes	Often	Very Often
6. Runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
7. Does not follow through on instructions and fails to finish work	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
9. Has difficulty organising tasks and activities	0	1	2	3
10. Is "on the go" or acts as if "driven by a motor"	0	1	2	3
11. Avoids tasks (e.g. schoolwork, homework) that require sustained mental effort	0	1	2	3
12. Talks excessively	0	1	2	3
13. Loses things necessary for tasks or activities	0	1	2	3
14. Blurts out answers before questions have been completed	0	1	2	3
15. Is easily distracted	0	1	2	3
16. Has difficulty awaiting turn	0	1	2	3
17. Is forgetful in daily activities	0	1	2	3
18. Interrupts or intrudes on others	0	1	2	3

For office use only (for healthcare provider interpretation)			
IA subscale raw score		Corresponding IA percentile score	
HI subscale raw score		Corresponding HI percentile score	
Total (IA+HI subscale) score		Total (corresponding IA +HI percentile)score	

OTHER FACTORS
1. Please describe how you feel your child is getting on at school:
2. Does your child/young person have any unusual responses to things which trigger their sense e.g. loud noises, smells, light and reflections etc? Please give examples.
3. Does your child/young person have any co-ordination difficulties e.g can be very clumsy or have difficulty handwriting? Please give examples
4. Please describe your view on your child / young person self-esteem?
5. Does your child / young person present as having tics? (These are movements they may not realise are happening which can occur in their face or throughout the body which your child / young person does not have control of)

6. Does your child / young person experience any health related needs which you feel may impact on their behaviour? Please describe.
7. Are there any other factors which you are aware of, either at home or at school which you feel may impact on your child / young person's behaviour?
8. Does your child / young person sleep well / get enough sleep?
ANY OTHER INFORMATION YOU WOULD LIKE TO ADD THAT WOULD HELP US UNDERSTANDING YOUR CHILD/YOUNG PERSON'S NEEDS?

OTHER PROFESSIONAL INVOLVEMENT: Does the child/young person have any other professional involved with him/her?		
TYPE OF PROFESSIONAL	**NAME**	**CONTACT DETAILS**
EDUCATIONAL PSYCHOLOGIST		
OCCUPATIONAL THERAPIST		
CAMHS		
OTHER/S		

Thank you for completing this checklist which will be used as an integral part of the assessment.