CAP RATING SCALE

Child's Name:_____Age_____Date of Rating:____/____/____

Filled Out By:_____ Position: _____

Below is a list of items that describe pupils. For each item that describes the pupil *now or within the last week*, check whether the item is **Not True, Somewhat True, or Very or Often True.** Please check all items as well as you can, even if some do not seem to apply to this pupil.

Morning	Not True	Somewhat Or Sometimes True	Very or Often True	**Afternoon**	Not True	Somewhat or Sometimes True	Very Or Often True
1.Fails to finish things he/she starts				1.Fails to finish things he/she starts			
2.Can't concentrate, can't pay attention for long				2.Can't concentrate, can't pay attention for long			
3.Can't sit still, restless or hyperactive				3.Can't sit still, restless or hyperactive			
4.Fidgets				4.Fidgets			
5.Daydreams or gets lost in his/her thoughts				5.Daydreams or gets lost in his/her thoughts			
6.Impulsive, or acts without thinking				6.Impulsive, or acts without thinking			
7.Difficulty following directions				7.Difficulty following directions			
8.Talks out of turn				8.Talks out of turn			
9.Messy				9.Messy			
10.Inattentive, easily distracted				10.Inattentive, easily distracted			
11.Talks too much				11.Talks too much			
12.Fails to carry out assigned tasks				12.Fails to carry out assigned tasks			

Concerns for Emotional issues such as depression or anxiety? Y___N___ Please add any additional comments below (include another sheet or write on back if necessary, any other observations would be most helpful). Once completed, may give back to parent or fax to 1-888-519-4344, Ronald Magat MD Thank you!