

Ohio Youth Problem, Functioning and Satisfaction Scales (Parent Form)

Child's Name: _____ Date: _____ Child's Grade: _____

Form Completed By: Mother Father Step-mother Step-father Other: _____

Section I (Ohio Youth Problem Severity Scale)							
Instructions: Please rate the degree to which your child has experienced the following problems in the past 90 days.		Not at all	Once or Twice	Several Times	Often	Most of the time	All of the time
1	Arguing with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Getting into fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Yelling, swearing, or screaming at others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Fits of anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Refusing to do things teachers or parents ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Causing trouble for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Using drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Breaking rules or breaking the law (out past curfew, stealing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Skipping school or classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Can't seem to sit still, having too much energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Hurting self (cutting or scratching self, taking pills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Talking or thinking about death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Feeling worthless or useless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Feeling lonely and having no friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Feeling anxious or fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Worrying that something bad is going to happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Feeling sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Eating problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section II (Ohio Youth Functioning Scale)						
Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.		Extreme Troubles	Quite a few troubles	Some Troubles	OK	Doing Very Well
21	Getting along with friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Getting along with family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Dating and developing relationships with boyfriends or girlfriends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Getting along with adults outside the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Keeping neat and clean, looking good.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Caring for health needs and keeping good health habits (taking medicines or brushing teeth).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Controlling emotions and staying out of trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Being motivated and finishing projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	Participating in hobbies (baseball cards, coins, stamps, art).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	Participating in recreational activities (sports, swimming, bike riding).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	Completing household chores (cleaning room, other chores).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	Attending school and getting passing grades in school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	Learning skills that will be useful for future jobs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34	Feeling good about self.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	Thinking clearly and making good decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	Concentrating, paying attention, and completing tasks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	Earning money and learning how to use money wisely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38	Doing things without supervision or restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39	Accepting responsibility for actions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40	Ability to express feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Adapted from the Ohio Youth Problem, Functioning and Satisfaction Scales
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Texas Department of Mental Health and Mental Retardation September 2003 (Parent Form)

Instructions: Please circle your response to each question.

- Overall, how satisfied are you with your relationship to your child right now?
 - Extremely satisfied.
 - Moderately satisfied.
 - Somewhat satisfied.
 - Somewhat dissatisfied.
 - Moderately dissatisfied.
 - Extremely dissatisfied.
- How capable of dealing with your child's problems do you feel right now?
 - Extremely capable.
 - Moderately capable.
 - Somewhat capable.
 - Somewhat incapable.
 - Moderately incapable.
 - Extremely incapable.
- How much stress or pressure is in your life right now?
 - Very little.
 - Some
 - Quite a bit.
 - A moderate amount.
 - A great deal.
 - Unbearable Amounts.
- How optimistic are you about your child's future right now?
 - The future looks very bright.
 - The future looks somewhat bright.
 - The future looks OK.
 - The future looks both good and bad.
 - The future looks bad.
 - The future looks very bad.

Instructions: In the past 90 days how many of the following events occurred?

_____ Number of arrests
 _____ Suspensions from school
 _____ Detentions at school
 _____ Days of school missed
 _____ Number of self-harm attempts

Enter the number of days the youth was placed in each of the following situations during the past 90 days. (For example, a youth may have been in a detention center for 3 days, a hospital for 7 days and with the biological mother for 80 days).

_____ two biological parents	Private Residence
_____ biological mother	Private Residence
_____ biological father	Private Residence
_____ home of a relative	Private Residence
_____ home of a family friend	Private Residence
_____ independent living with self or friend	Private Residence
_____ supervised independent living	Private Residence with support
_____ drug/alcohol rehab center	24 hour residential care
_____ group home	24 hour residential care
_____ residential treatment	24 hour residential care
_____ inpatient psychiatric hospital	Institutional setting
_____ medical hospital	Institutional setting
_____ jail	Jail/correctional facility
_____ juvenile detention facility	Jail/correctional facility
_____ foster care	foster home
_____ therapeutic foster care	foster home
_____ specialized foster care	foster home
_____ Homeless/shelter	Homeless/shelter
_____ other	other
_____ unknown	unknown