Rating Scale of Tic Disorders
Developmental-Behavioral Pediatrics

RATING SCALE OF TIC DISORDERS

Date _____

Child's name_____

Person completing form: (Circle one) Parent Teacher Adolescent

Instructions: There are three sections to this form. Please follow the discussions contained under each section. This form may be completed by the parent of the above-named child, by his or her teacher, or by the child him/her self, in which case please circle "Adolescent" above.

Section 1

Motor and Muscle Tics

Directions: Listed below are a number of motor tics which children or adolescents may experience. Please indicate next to each whether the type of motor tic is a problem for this child, and if so, please circle a number indicating how frequent you believe the tic occurs and how severe a problem you believe the tic to be for this child. You should always circle two numbers next to each item, one for how frequent the problem is and one for how severe it is. In case you are not sure, a motor tic is an involuntary, repetitive, abrupt, and purposeless motor movement.

Type of tic or movement	Frequency				Severity			
	Not at all	Just a little	Pretty much	Very Much	None	Mild	Moderate	Severe
Eye (blinking, squinting, rolling)	0	1	2	3	0	1	2	3
Forehead	0	1	2	3	0	1	2	3
Cheeks	0	1	2	3	0	1	2	3
Nose	0	1	2	3	0	1	2	3
Jaw	0	1	2	3	0	1	2	3
Mouth	0	1	2	3	0	1	2	3
Head	0	1	2	3	0	1	2	3
Neck	0	1	2	3	0	1	2	3
Shoulders	0	1	2	3	0	1	2	3
Arms	0	1	2	3	0	1	2	3
Chest/Abdomen	0	1	2	3	0	1	2	3
Legs	0	1	2	3	0	1	2	3
Finger/Hands	0	1	2	3	0	1	2	3

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Vocal Tics or Noises

Directions: Please follow the same directions given for the last section. In this case, please indicate whether this child shows any nervous noises, words, or phrases. These are often called vocal tics and are involuntary, repetitive, abrupt, and purposeless speech sounds which the child finds hard to control.

Type of Noise	Frequency				Severity			
	Not at all	Just a little	Pretty much	Very Much	None	Mild	Moderate	Severe
Frequent sniffing	0	1	2	3	0	1	2	3
Throat clearing	0	1	2	3	0	1	2	3
Grunting	0	1	2	3	0	1	2	3
Growling	0	1	2	3	0	1	2	3
Barking	0	1	2	3	0	1	2	3
Clicking	0	1	2	3	0	1	2	3
Hissing	0	1	2	3	0	1	2	3
Yelping	0	1	2	3	0	1	2	3
Repeats Words	0	1	2	3	0	1	2	3
Repeats Phrases	0	1	2	3	0	1	2	3
Swearing	0	1	2	3	0	1	2	3

Complex Nervous Movements

Directions: Listed below are a number of complex movements that children sometimes make. Please indicate whether this child displays any of these in an abrupt manner when there is little if any reason to be doing them. Children often report that they have uncontrolled urges to do these things but that the movements have no purpose. These are often called compulsions, or involuntary urges to do things for no reason.

Type of Movement	Frequency				Severity			
	Not at all	Just a little	Pretty much	Very Much	None	Mild	Moderate	Severe
Skipping	0	1	2	3	0	1	2	3
Hopping	0	1	2	3	0	1	2	3
Jumping	0	1	2	3	0	1	2	3
Twirling	0	1	2	3	0	1	2	3
Squatting	0	1	2	3	0	1	2	3
Bending at Waist	0	1	2	3	0	1	2	3
Kicking	0	1	2	3	0	1	2	3
Hitting	0	1	2	3	0	1	2	3
Touching of Objects	0	1	2	3	0	1	2	3
Touching of Others	0	1	2	3	0	1	2	3
Touching of Self	0	1	2	3	0	1	2	3
Smells Things	0	1	2	3	0	1	2	3
Claps Hands	0	1	2	3	0	1	2	3
Snaps Fingers	0	1	2	3	0	1	2	3
Spitting	0	1	2	3	0	1	2	3

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Section 2

Home and Community Problem Situations (For the Parents and Adolescents)

Directions: Listed below are a variety of home and community situations. Please indicate whether this child displays any nervous tics, noises, or complex movements in any of these situations. If so, please circle the number which best describes how much of a problem this child has in this situation in displaying these nervous movements and noises.

Situation	Is this a problem		Mild			Moderate			severe		
When Alone	Yes	No	1	2	3	4	5	6	7	8	9
Talking to Family	Yes	No	1	2	3	4	5	6	7	8	9
Talking to Friends	Yes	No	1	2	3	4	5	6	7	8	9
Talking to Strangers	Yes	No	1	2	3	4	5	6	7	8	9
Watching TV	Yes	No	1	2	3	4	5	6	7	8	9
Doing Chores	Yes	No	1	2	3	4	5	6	7	8	9
Doing Homework	Yes	No	1	2	3	4	5	6	7	8	9
When playing with others	Yes	No	1	2	3	4	5	6	7	8	9
Getting ready for school	Yes	No	1	2	3	4	5	6	7	8	9
Getting ready for bed	Yes	No	1	2	3	4	5	6	7	8	9
While eating meals	Yes	No	1	2	3	4	5	6	7	8	9
In stores	Yes	No	1	2	3	4	5	6	7	8	9
In church	Yes	No	1	2	3	4	5	6	7	8	9
In restaurants	Yes	No	1	2	3	4	5	6	7	8	9
While riding in cars	Yes	No	1	2	3	4	5	6	7	8	9
During sleep	Yes	No	1	2	3	4	5	6	7	8	9

Section 3

School Problem Situations (For Teachers and Adolescents only)

Directions: Follow the same instructions given in the last section (Section 2). Please indicate whether the child shows any problems with nervous tics, noises, or complex movements in any of these school situations. If so, please indicate how severe the problem is (how hard it is for the child to control his or her movements or noises in this setting).

Situation	Is this a problem		Mild			Moderate			severe		
On the bus	Yes	No	1	2	3	4	5	6	7	8	9
While arriving at school	Yes	No	1	2	3	4	5	6	7	8	9
During class lecture	Yes	No	1	2	3	4	5	6	7	8	9
During individual desk work	Yes	No	1	2	3	4	5	6	7	8	9
Giving oral reports in class	Yes	No	1	2	3	4	5	6	7	8	9
Reading aloud in class	Yes	No	1	2	3	4	5	6	7	8	9
During free time in class	Yes	No	1	2	3	4	5	6	7	8	9
During recess	Yes	No	1	2	3	4	5	6	7	8	9
During lunch time	Yes	No	1	2	3	4	5	6	7	8	9
In the hallways	Yes	No	1	2	3	4	5	6	7	8	9
During special assemblies	Yes	No	1	2	3	4	5	6	7	8	9
On field trips	Yes	No	1	2	3	4	5	6	7	8	9
When called on by teacher	Yes	No	1	2	3	4	5	6	7	8	9

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FOR OFFICE USE ONLY

Section 1 Scores:
No. of Motor tics_____ Mean Frequency_____ Mean Severity_____

No. of Vocal tics_____ Mean Frequency_____ Mean Severity_____

No. of Complex Movements_____ Mean Frequency_____ Mean Severity_____

Section 2 Scores:
No. of Problem Situations_____ Mean Severity_____

Section 3 Scores:
No. of Problem Situations_____ Mean Severity_____