PARENT TIC QUESTIONNAIRE

Name/Initials _____   Date _____

Informant _____

For each of the tics listed below, please mark "Yes" or "No" as to whether or not your child has had a tic in the <u>past week</u>.

For each tic you mark as "Yes", please mark how **FREQUENTLY** the tic occurred over the past week according to the following:

<u>C</u>onstant, almost all the time during the day

<u>H</u>ourly, at least once per hour

<u>D</u>aily, at least several times per day

<u>W</u>eekly, just a few times or less

Under **INTENSITY**, rate how intense you believe the tic felt to your child over the past week. For example, if it was very mild, like a weak twitch, that would be a "1" or "2". A much more forceful tic that would be very noticeable to others and may even be painful would be rated as a "6" or even higher. Any tic that would be obviously noticeable to others should be rated as at least a "4".

MOTOR TICS	PRESENT YES NO	FREQUENCY C H D W 4 3 2 1	INTENSITY 0-8
Eye blinking			
Eye rolling / darting			
Head jerk			
Facial grimace			
Mouth/tongue movements			
Shoulder shrugs			
Chest/stomach tightening			
Pelvic tensing movements			
Leg/feet movements			
Arm/hand movements			
Echopraxia (copying another's gestures)			
Copropraxia (obscene gestures)			
Other motor tics			
Complex motor combinations (multiple tics at once)			

FREQUENCY: Constant, almost all the time during the day

Hourly, at least once per hour

Daily, at least several times per day

Weekly, just a few times or less

INTENSITY: Mild: 1-2; Obvious to others: 4 or higher; Very noticeable or painful: 6 or higher.

VOCAL TICS	PRESENT YES NO	FREQUENCY C H D W 4 3 2 1	INTENSITY 0-8
Grunting			
Sniffing			
Snorting			
Coughing			
Animal noises			
Syllables			
Words			
Phrases			
Echolalia (repeating vocalizations of others)			
Coprolalia (obscene words)			
Blocking/stuttering			
Other			
Other vocal tics			
Complex vocal combinations (multiple tics at once)			

SUBMIT