Tic Severity Checklist

Name of patient _____ Record # _____

Rate each symptom by putting the appropriate number in the box each day. (Use the reverse side for any detailed comments).

Date: _____

0 = Not at all or symtpom free
1 = Just a little
2 = Pretty much
3 = Very much
4 = Extreme
5 = Almost Always

Rater:
Patient ❑ Father ❑
Mother ❑ Other ❑

	Simple Motor	M	T	W	Th	F	Sa	Su	Comments
1.	Eyeblinking								
2.	Other facial tics								
3.	Head jerks								
4.	Shoulder jerks								
5.	Arm movements								
6.	Finger or hand movements								
7.	Stomach jerks								
8.	Kicking leg movements								
9.	Tense parts of body								
10.	Other								
	Complex Motor								
11.	Touching parts of body								
12.	Touching other people								
13.	Can't start actions								
14.	Hurts self								
15.	Finger or hand tapping								
16.	Hopping								
17.	Picks at things								
18.	Obscene gestures (copropraxis)								
19.	Eye rolling								
20.	Other								
	Simple phonic								
21.	Noises								
22.	Grunting								
23.	Throat clearing								
24.	Coughing								
25.	Other								
	Complex phonic								
26.	Words								
27.	Repeats own words/sentences								
28.	Repeats other's speech								
29.	Obscene words (coprolalia)								
30.	Insults (lack of inhibition)								
31.	Other								
	Behavior								
32.	Argumentative								
33.	Poor frustration tolerance								
34.	Anger, temper fits								
35.	Provocative								
36.	Other								

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