



Patient Name: _____

Date of birth: _____ MRN/File #: _____

Clinician's Name: _____ Date: _____

CADDRA Teacher Assessment Form

Student's Name: _____ Age: _____ Gender: _____

School: _____ Grade: _____

Educator completing this form: _____ Date Completed: _____

How long have you known the student? _____ Time spent each day with student: _____

Student's Educational Designation: _____ None

Does this student have an educational plan? Yes No

ACADEMIC PERFORMANCE	Well Below Grade Level	Somewhat Below Grade Level	At Grade Level	Somewhat Above Grade Level	Well Above Grade Level	n/a
READING						
a) Decoding						
b) Comprehension						
c) Fluency						
WRITING						
d) Handwriting						
e) Spelling						
f) Written syntax (sentence level)						
g) Written composition (text level)						
MATHEMATICS						
h) Computation (accuracy)						
i) Computation (fluency)						
j) Applied mathematical reasoning						
CLASSROOM PERFORMANCE	Well Below Average	Below Average	Average	Above Average	Well Above Average	n/a
Following directions/instructions						
Organizational skills						
Assignment completion						
Peer relationships						
Classroom Behaviour						

CADDRA Teacher Assessment Form

Strengths: What are this student's strengths?

Education plan: If this student has an education plan, what are the recommendations? Do they work?

Accommodations: What accommodations are in place? Are they effective?

Class instructions: How well does this student handle large-group instruction? Do they follow instructions well? Can they wait for a turn to respond? Would they stand out from same-sex peers? In what way?

Individual seatwork: How well does this student self-regulate attention and behaviour during assignments to be completed as individual seatwork? Is the work generally completed? Would they stand out from same-sex peers? In what way?

Transitions: How does this student handle transitions such as going in and out for recess, changing classes or changing activities? Do they follow routines well? What amount of supervision or reminders do they need?

Impact on peer relations: How does this student get along with others? Does this student have friends that seek them out? Do they initiate play successfully?

Conflict and Aggression: – Is this student often in conflict with adults or peers? How do they resolve arguments? Is the student verbally aggressive? Are they the target of verbal or physical aggression by peers?

Academic Abilities: We would like to know about this student's general abilities and academic skills. Does this student appear to learn at a similar rate to others? Does this student appear to have specific weaknesses in learning?

Self-help skills: Independence, problem solving, activities of daily living:

Motor Skills (gross/fine): Does this student have problems with gym, sports, writing? If so, please describe.

Written output: Does this student have problems putting ideas down in writing? If so, please describe.

Primary Areas of concern: What are your major areas of concern/worry for this student? How long has this/these been a concern for you

Impact on student: To what extent are these difficulties for the student upsetting or distressing to the student, to you and/or the other students?

Impact on the class: Does this student make it difficult for you to teach the class?

Medications: If this student is on medication, is there anything you would like to highlight about the differences when they are on medication compared to off?

Parent involvement: What has been the involvement of the parent(s)/guardians?

Are the problems with attention and/or hyperactivity interfering with the student's learning? Peer relationships?

Has the student had any problems with homework or handing in assignments?

Is there anything else you would like us to know? If you feel the need to contact the student's clinician during this assessment, please feel free to do so.

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – PARENT REPORT (WFIRS-P)

Your name: _____

Relationship to child: _____

Circle the number for the rating that best describes how your child's emotional or behavioural problems have affected each item in the last month.

		Never or Not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	FAMILY					
1	Having problems with brothers & sisters					
2	Causing problems between parents					
3	Takes time away from family members' work or activities					
4	Causing fighting in the family					
5	Isolating the family from friends and social activities					
6	Makes it hard for the family to have fun together					
7	Makes parenting difficult					
8	Makes it hard to give fair attention to all family members					
9	Provokes others to hit or scream at him/her					
10	Costs the family more money					
B	SCHOOL					
	Learning					
1	Makes it difficult to keep up with schoolwork					
2	Needs extra help at school					
3	Needs tutoring					
4	Receives grades that are not as good as his/her ability					
	Behaviour					
1	Causes problems for the teacher in the classroom					
2	Receives "time-out" or removal from the classroom					
3	Having problems in the school yard					
4	Receives detentions (during or after school)					
5	Suspended or expelled from school					
6	Misses classes or is late for school					
C	LIFE SKILLS					
1	Excessive use of TV, computer, or video games					
2	Keeping clean, brushing teeth, brushing hair, bathing, etc.					
3	Problems getting ready for school					
4	Problems getting ready for bed					
5	Problems with eating (picky eater, junk food)					
6	Problems with sleeping					

		Never or Not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
7	Gets hurt or injured					
8	Avoids exercise					
9	Needs more medical care					
10	Has trouble taking medication, getting needles or visiting the doctor/dentist					
D	CHILD'S SELF-CONCEPT					
1	My child feels bad about himself/herself					
2	My child does not have enough fun					
3	My child is not happy with his/her life					
E	SOCIAL ACTIVITIES					
1	Being teased or bullied by other children					
2	Teases or bullies other children					
3	Problems getting along with other children					
4	Problems participating in after-school activities (sports, music, clubs)					
5	Problems making new friends					
6	Problems keeping friends					
7	Difficulty with parties (not invited, avoids them, misbehaves)					
F	RISKY ACTIVITIES					
1	Easily led by other children (peer pressure)					
2	Breaking or damaging things					
3	Doing things that are illegal					
4	Being involved with the police					
5	Smoking cigarettes					
6	Taking illegal drugs					
7	Doing dangerous things					
8	Causes injury to others					
9	Says mean or inappropriate things					
10	Sexually inappropriate behaviour					

Number of Items Scored '2' or '3'

A	Family			/
B	School	Learning		/
		Behavior		/
C	Life Skills			/
D	Child's self-concept			/
E	Social activities			/
F	Risky activities			/
G	Total			/

Total Score

A	Family			/
B	School	Learning		/
		Behaviour		/
C	Life Skills			/
D	Child's self-concept			/
E	Social activities			/
F	Risky activities			/
G	Total			/

Mean Score
(N/A items not included in calculation)

A	Family			
B	School	Learning		
		Behavior		
C	Life Skills			
D	Child's self-concept			
E	Social Activities			
F	Risky Activities			
G	Total			

*Calculated from _____ answered questions.

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