ATTENTION/HYPERACTIVITY RATING FORM (CAP)

Child's Name:_____ Date:_____
Completed by:_____ Time:_____
Medication Name:_____Dose:_____

Below is a list of items that describes some pupils. For each item that describes the pupil, check whether that item is Not True, Somewhat or Sometimes True, or Very or Often True. Please check all items as well as you can, even if some do not seem to apply to this pupil.

	not true	somewhat/ sometimes true	very or often true
1. Fails to finish things he/she starts	( )	( )	( )
2. Can't concentrate, can't pay Attention for very long	( )	( )	( )
3. Can't sit still, is restless, or hyperactive	( )	( )	( )
4. Fidgets	( )	( )	( )
5. Daydreams or gets lost in thoughts	( )	( )	( )
6. Impulsive or acts without thinking	( )	( )	( )
7. Has difficulty in following directions	( )	( )	( )
8. Talks out of turn	( )	( )	( )
9. Messy work	( )	( )	( )
10.Inattentive, easily distracted	( )	( )	( )
11.Talks too much	( )	( )	( )
12. Fails to carry out assigned tasks	( )	( )	( )

Please feel free to write any comments about this pupil's work or behavior within the last two weeks.

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