

K-LCM™/P: The NIMH-Child Life Chart Method - Parent Daily PROSPECTIVE Ratings

Patient ID _____ -- _____ Patient Initials Month _____ Year _____
F M L

Protocol Code _____ Clinician Initials Blinded Rating? No Yes N/A
F M L

Please Check **ALL BEHAVIORS AND SYMPTOMS*** Observed in Your Child **THIS MONTH**:

ACTIVATED		WITHDRAWN	
<input type="checkbox"/> 1 Impulsivity	<input type="checkbox"/> 13 Stealing	<input type="checkbox"/> 25 Periods of sadness	<input type="checkbox"/> 35 Suicidal gesture
<input type="checkbox"/> 2 Irritability	<input type="checkbox"/> 14 Disregard for authority	<input type="checkbox"/> 26 Low self-esteem/ sense of worthlessness	<input type="checkbox"/> 36 Serious suicide attempt
<input type="checkbox"/> 3 Temper tantrums	<input type="checkbox"/> 15 Fighting	<input type="checkbox"/> 27 More withdrawn than usual	<input type="checkbox"/> 37 Physical complaints
<input type="checkbox"/> 4 Sleeps less than usual	<input type="checkbox"/> 16 Destruction of property	<input type="checkbox"/> 28 Cries more easily than usual	<input type="checkbox"/> 38 Sleeps more than usual
<input type="checkbox"/> 5 Hyperactivity	<input type="checkbox"/> 17 Excessive risk taking	<input type="checkbox"/> 29 Unusually clingy and dependent	<input type="checkbox"/> 39 Obsessive thoughts
<input type="checkbox"/> 6 Increased aggression	<input type="checkbox"/> 18 Trouble with the law	<input type="checkbox"/> 30 Less active and energetic than usual	<input type="checkbox"/> 40 Night terrors
<input type="checkbox"/> 7 Skips school	<input type="checkbox"/> 19 Lack of remorse	<input type="checkbox"/> 31 Excessive guilt	<input type="checkbox"/> 41 Does not talk or respond
<input type="checkbox"/> 8 Decreased attention span	<input type="checkbox"/> 20 Frequent lying	<input type="checkbox"/> 32 More anxious (tense/worried) than usual	<input type="checkbox"/> 42 Paranoid thinking
<input type="checkbox"/> 9 Inappropriate sexual behavior	<input type="checkbox"/> 21 Racing thoughts	<input type="checkbox"/> 33 Change in appetite	<input type="checkbox"/> 43 Hearing voices
<input type="checkbox"/> 10 Unusually happy and enthusiastic	<input type="checkbox"/> 22 Bizarre behavior	<input type="checkbox"/> 34 Suicidal thinking	<input type="checkbox"/> 44 Other: _____
<input type="checkbox"/> 11 Excessively talkative	<input type="checkbox"/> 23 Other: _____		<input type="checkbox"/> 45 Other: _____
<input type="checkbox"/> 12 Unreasonably and excessively self-confident	<input type="checkbox"/> 24 Other: _____		

**Interventions
or Treatments**
(list below)

For each **MEDICATION**, please enter the **total dose taken per day**.
 For **OTHER TREATMENT INTERVENTIONS** (e.g., psychotherapy, behavior modification, etc.),
 please check the **days the treatment was received**.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Days of Month																															

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Psychosis <input checked="" type="checkbox"/> if Yes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hours of Sleep																															

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**RATE DEGREE
of Dysfunction:**

<p>Activated (IMPULSIVE, AGGRESSIVE)</p> <p>↑</p>	SEVERE	DYSFUNCTION		DYSFUNCTION	SEVERE
	HIGH MODERATE				HIGH MOD
	LOW MODERATE				LOW MOD
	MILD				MILD
<p>↓</p> <p>Withdrawn (ANXIOUS, DEPRESSED)</p>	MILD	DYSFUNCTION		DYSFUNCTION	MILD
	LOW MODERATE				LOW MOD
	HIGH MODERATE				HIGH MOD
	SEVERE				SEVERE

Number of Switches/Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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**Life Events and
Predominant Symptoms***
(-4 to +4)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Days of Month																															

