**Parent and Teacher Tic Rating Scale (PTRS)**

**South East Essex Children’s Services -The Lighthouse Child Development Centre**

By returning the completed form, **we assume that you as the parent or carer are consenting** to the referral being processed by Children’s Services.

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Details** | | | |
| **Name:** |  | | |
| **DOB:** |  | **NHS Number:** |  |
| **Address:** |  | | |
| **GP Details:** |  | | |
| **Details of Parents/ Carers filing in the form** | | | |
| **Name:** |  | | |
| **Address, if different:** |  | | |
| **Contact Number:** |  | | |
| **Email Address:** |  | | |
| **Completed by Parent name:** |  | | |
| **Date of completion:** |  | | |

|  |  |
| --- | --- |
| **Details of School/Teacher filing in the form** | |
| **Name:** |  |
| **School Address:** |  |
| **Completed by Teacher(name):** |  |
| **Email Address:** |  |
| **Date of completion:** |  |

**Motor tics** are involuntary, sudden, brief, and meaningless movements which are repetitive and occur in bouts. **Vocal tics** are sudden sounds or words that occur in bouts. These tics tends to wax and wane (come and go) and several tics can occur over a period of time in months and years.

# Please provide information about the child/young person’s tics (duration, type, number, frequency, intensity and impact) in the next 3 pages.

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Simple** motor tics (they seem brief and meaningless) **complex** motor tics  (they seem purposeful and involve many muscles) | **Age when started** having these tics in years | Did the child or young person have these tics in the **last week**?  -yes Y  -no N | If present **daily**,   1. Long gaps 2. Medium gap of 3 hours 3. No gap, every hour/ all the time | If present **weekly or monthly,** how long for?  Any gap of 3 months or more | Describe how the tics are affecting the child or young person   * pain, injury * anxiety /low mood * bullying/social isolation * self-esteem * learning/communication * stopping what they do |
| Eye blinking |  |  |  |  | ……………………………………………  ……………………………………………  ……………………………………………  ……………………………………………  ……………………………………………  …………………………………………… |
| Eye rolling/squinting |  |  |  |  |
| Nose twitching |  |  |  |  |
| Tongue sticking out |  |  |  |  |
| Lip chewing, licking, or pouting |  |  |  |  |
| Teeth baring or teeth grinding |  |  |  |  |
| Mouth movements, stretching |  |  |  |  |
| Grimacing (pulling faces) |  |  |  |  |
| Head jerking / throwing head back /nodding/lifting chin up |  |  |  |  |
| Shoulder jerking or shrugging |  |  |  |  |
| Arms/hands – bending, touching objects or others, picking /Twirling /writing over and over |  |  |  |  |
| Tummy/buttock tensing |  |  |  |  |
| Leg/foot/toes – kicking, jumping/ skipping, tapping, rotating |  |  |  |  |
| Obscene movements or gestures/repeating other people’s gestures |  |  |  |  |
| Others - describe |  |  |  |  |
| **Please provide further information about tics here if you wish:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Simple vocal tics** (meaningless sounds or noises)  **Complex vocal tics**  (syllables, words, or phrases) | **Age when started** having these tics in years | Did the child or young person have these tics in the **last week**?  -yes **Y**  -no **N** | If present **daily**,   1. Long gaps 2. Medium gap of 3 hours 3. No gap, every hour/ all the time | If present **weekly or monthly**, how long for?  Any gap of 3 months or more | Describe how the tics are affecting the child or young person   * pain, injury * anxiety /low mood * bullying/social isolation * self-esteem * learning/ communication * stopping what they do |
| Coughing |  |  |  |  | ……………………………………………  ……………………………………………  ……………………………………………  ……………………………………………  ……………………………………………  ……………………………………………. |
| Sniffing |  |  |  |  |
| Throat clearing |  |  |  |  |
| Tongue clicking |  |  |  |  |
| Grunting |  |  |  |  |
| Bird noises/ animal noises |  |  |  |  |
| Singing, ooohh etc |  |  |  |  |
| Whistling |  |  |  |  |
| Syllables – describe |  |  |  |  |
| Words – describe |  |  |  |  |
| Phrases – describe |  |  |  |  |
| Obscene words – describe |  |  |  |  |
| Repeating what someone else said – describe |  |  |  |  |
| Repeating self - describe |  |  |  |  |
| Others – describe |  |  |  |  |
| **Please provide further information about tics here if you wish:** | | | | | |

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# Other information

1. The tics occur at home - **Yes/No**, school - **Yes/No** and other settings **Yes/No** - If yes where ……………………………………………………………………………………
2. The tics get worse when the child is stressed, anxious/worried or tired **Yes/No**
3. Can the child or young person stop the tics briefly if asked to do so? **Yes/No** **/Not Sure**
4. Does the child/young person have?
   1. **Anxiety a**. none **b.** just a little **c.** quite a bit **d**. very much
   2. **Obsessions and compulsions**: bothered by silly/bad thoughts or pictures in mind, frequently checks e.g door locked, does things over and over again e.g washing hands, putting things in an order **Yes/No**
   3. Significant **ADHD symptoms** (Hyperactivity, attention problems and impulsive behaviour) or already has a diagnosis of ADHD **Yes/No**
   4. Difficulties with **autism** (social communication, interaction, rigid behaviour with rituals) or has a diagnosis of autism **Yes/No**
5. Anyone in the child’s family has tics / Tourette’s -if yes, give details………………………………………………………………………………………………………………………..
6. **Degree /intensity of tics**: Please circle/put X

None

Minimal

Mild

Moderate

Marked

Severe

Tics very forceful and exaggerated

so may result in injury/accidents

Tics more forceful and exaggerated, easily noticed by others and come to their attention

Tics more forceful comparable to voluntary actions and may come to attention of other people

Tics not more forceful than voluntary actions and not generally noticed by others

Tics not seen, heard or not forceful so not noticed by others

No tics

1. Please circle or put X for the **overall impact** (self-esteem, social acceptance, school functioning, mental/physical health and family life)

None

Minimal

Mild

Moderate

Marked

Severe

Extreme difficulties (e.g. severe depression, suicidal thoughts school avoidance, severely restricted life)

Major difficulties

Moderate difficulties with intermittent distress, frequently teased/bullied

Minor difficulties

Subtle difficulties

Absent

# Thank you very much for completing the form. Please send the form to the address below:

Lighthouse Child Development Centre, Snakes Lane, Southend-on-Sea, SS2 6XT

Or Email pack back to: [epunft.lighthouse.ticsandtourettes@nhs.net](mailto:epunft.lighthouse.ticsandtourettes@nhs.net)