



Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## 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
<b>A</b>	<b>FAMILY</b>					
1	Having problems with brothers & sisters	0	1	2	3	n/a
2	Causing problems between parents	0	1	2	3	n/a
3	Takes time away from family members' work or activities	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Isolating the family from friends and social activities	0	1	2	3	n/a
6	Makes it hard for the family to have fun together	0	1	2	3	n/a
7	Makes parenting difficult	0	1	2	3	n/a
8	Makes it hard to give fair attention to all family members	0	1	2	3	n/a
9	Provokes others to hit or scream at him/her	0	1	2	3	n/a
10	Costs the family more money	0	1	2	3	n/a
<b>B</b>	<b>SCHOOL</b>					
	<b>Learning</b>					
1	Makes it difficult to keep up with schoolwork	0	1	2	3	n/a
2	Needs extra help at school	0	1	2	3	n/a
3	Needs tutoring	0	1	2	3	n/a
4	Receives grades that are not as good as his/her ability	0	1	2	3	n/a
	<b>Behaviour</b>					
1	Causes problems for the teacher in the classroom	0	1	2	3	n/a
2	Receives "time-out" or removal from the classroom	0	1	2	3	n/a
3	Having problems in the school yard	0	1	2	3	n/a
4	Receives detentions (during or after school)	0	1	2	3	n/a
5	Suspended or expelled from school	0	1	2	3	n/a
6	Misses classes or is late for school	0	1	2	3	n/a
<b>C</b>	<b>LIFE SKILLS</b>					
1	Excessive use of TV, computer, or video games	0	1	2	3	n/a
2	Keeping clean, brushing teeth, brushing hair, bathing, etc.	0	1	2	3	n/a
3	Problems getting ready for school	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
4	Problems getting ready for bed	0	1	2	3	n/a
5	Problems with eating (picky eater, junk food)	0	1	2	3	n/a
6	Problems with sleeping	0	1	2	3	n/a
7	Gets hurt or injured	0	1	2	3	n/a
8	Avoids exercise	0	1	2	3	n/a
9	Needs more medical care	0	1	2	3	n/a
10	Has trouble taking medication, getting needles or visiting the doctor/dentist	0	1	2	3	n/a
<b>D</b>	<b>CHILD'S SELF-CONCEPT</b>					
1	My child feels bad about himself/herself	0	1	2	3	n/a
2	My child does not have enough fun	0	1	2	3	n/a
3	My child is not happy with his/her life	0	1	2	3	n/a
<b>E</b>	<b>SOCIAL ACTIVITIES</b>					
1	Being teased or bullied by other children	0	1	2	3	n/a
2	Teases or bullies other children	0	1	2	3	n/a
3	Problems getting along with other children	0	1	2	3	n/a
4	Problems participating in after-school activities (sports, music, clubs)	0	1	2	3	n/a
5	Problems making new friends	0	1	2	3	n/a
6	Problems keeping friends	0	1	2	3	n/a
7	Difficulty with parties (not invited, avoids them, misbehaves)	0	1	2	3	n/a
<b>F</b>	<b>RISKY ACTIVITIES</b>					
1	Easily led by other children (peer pressure)	0	1	2	3	n/a
2	Breaking or damaging things	0	1	2	3	n/a
3	Doing things that are illegal	0	1	2	3	n/a
4	Being involved with the police	0	1	2	3	n/a
5	Smoking cigarettes	0	1	2	3	n/a
6	Taking illegal drugs	0	1	2	3	n/a
7	Doing dangerous things	0	1	2	3	n/a
8	Causes injury to others	0	1	2	3	n/a
9	Says mean or inappropriate things	0	1	2	3	n/a
10	Sexually inappropriate behaviour	0	1	2	3	n/a

**SCORING:**

1. Number of items scored 2 or 3  
*or*
2. Total score  
*or*
3. Mean score

<b>DO NOT WRITE IN THIS AREA</b>	
A. Family	_____
B. School Learning Behaviour	_____
C. Life skills	_____
D. Child's self-concept	_____
E. Social activities	_____
F. Risky activities	_____
<b>Total</b>	_____

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