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 **CHILD DEVELOPMENTAL HISTORY (AGES 11 and YOUNGER)**

Child’s Name: Gender: [ ]  Male [ ]  Female

Date of Birth:

Grade (if applicable): School/Preschool:

Form completed by:

Relationship to child: Date:

**PRESENTING CONCERNS**

**In your opinion, what led to this referral?** Check all that apply

|  |  |
| --- | --- |
| * Developmental delays
 | * Symptoms of depression
 |
| * Symptoms of anxiety
 | * Suicidal thoughts
 |
| * Thinking problems
 | * Difficulties with parents
 |
| * Adjustment to parents’ divorce
 | * Problems with peers/poor social skills
 |
| * Suspected abuse
 | * Refusal to attend school
 |
| * Suspected autism spectrum disorder
 | * Fears/Anxiety
 |
| * Reading difficulties
 | * Academic difficulties
 |
| * Behavior problems at home
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Behavior problems at school
* Difficulties with Attention/Concentration
 |

**How severe is/are the problem(s)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**When were these problems first noted?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What concerns you most about your child?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What do you find most difficult about raising your child?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is the best thing about your child?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Has your child ever experienced any emotional, verbal, physical, or sexual abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any additional information? \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PREGNANCY and BIRTH**

At the time of this child’s birth, what was the mother’s age? \_\_\_\_\_\_\_\_\_ Father’s age\_\_\_\_\_\_\_\_\_

Did mother receive prenatal care? [ ] None [ ]  Yes - throughout entire pregnancy [ ]  Some \_\_\_\_\_\_\_\_\_\_\_\_

**Check any of the following complications that occurred during the pregnancy:**

[ ] Measles [ ] German measles [ ] Excessive Swelling [ ] Anemia [ ] Toxemia [ ] Vaginal bleeding [ ] Flu

[ ] Rh Incompatibility [ ] Abnormal weight gain [ ] High Blood Pressure [ ] Excessive Vomiting

[ ] Emotional Problems

[ ]  Stressors (describe)

[ ]  Other not listed:

|  |  |  |  |
| --- | --- | --- | --- |
| **Pregnancy Cont.** |  |  | **If yes…** |
| **Injury to Mother:** | [ ]  Yes | [ ]  No | Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hospitalization during pregnancy** | [ ]  Yes | [ ]  No | Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **X-ray during pregnancy:**  | [ ]  Yes | [ ]  No | What month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications used during pregnancy:** | [ ]  Yes | [ ]  No | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alcohol or other drugs used prior to discovering pregnancy** | [ ]  Yes | [ ]  No | When was pregnancy discovered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alcohol used during pregnancy:** | [ ]  Yes | [ ]  No | Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cigarettes used during pregnancy:** | [ ]  Yes | [ ]  No | Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other drugs used during pregnancy:** | [ ]  Yes | [ ]  No | Type and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Length of pregnancy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of labor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Length of stay in hospital?** Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_­­

**Birth weight:** \_\_\_\_\_\_\_\_\_lbs \_\_\_\_\_\_\_\_\_oz **Apgar Score(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s condition at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother’s condition at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check any of the following complications that occurred during or after birth:**

|  |  |  |
| --- | --- | --- |
| * Forceps used
 | * Breech birth
 | * Problems with heart
 |
| * Labor induced
 | * Caesarean delivery
 | * Problems with bones
 |
| * Infection
 | * Seizures
 | * Blood transfusion
 |
| * Cord wrapped around neck
 | * Jaundice
 | * Cyanosis
 |
| * Need supplemental oxygen
 | * Ventilator
 | * NICU stay
 |
| * Incubator
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |

**DEVELOPMENTAL INFORMATION**

**Please indicate/estimate the age at which your child achieved the following milestones.**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Turned over | \_\_\_\_\_\_\_\_\_\_\_\_\_Walked down stairs |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Sat alone | \_\_\_\_\_\_\_\_\_\_\_\_\_Showed an interest in/attraction to sound |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Crawled   | \_\_\_\_\_\_\_\_\_\_\_\_\_Understood first words  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Stood alone  | \_\_\_\_\_\_\_\_\_\_\_\_\_Spoke first words |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Walked alone | \_\_\_\_\_\_\_\_\_\_\_\_\_Toilet trained during the day |
| \_\_\_\_\_\_\_\_\_\_\_\_\_Walked up stairs | \_\_\_\_\_\_\_\_\_\_\_\_\_Toilet trained at night |

**Does your child continue to have toileting accidents? □Yes □No**

**If so, where does this happen?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were/are there any medical reasons for the toileting accidents?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child experienced any of the following problems? If so please describe:**

|  |  |
| --- | --- |
| * Walking difficulty
 |  |
| * Unclear speech
 |  |
| * Feeding/ eating difficulties
 |  |
| * Underweight
 |  |
| * Overweight
 |  |
| * Difficulty learning to skip
 |  |
| * Difficulty learning to throw or catch
 |  |
| * Difficulty learning to ride a bike
 |  |

**During the first 4 years, were any of the following problems noted? If so, please describe:**

|  |  |
| --- | --- |
| * Eating
 |  |
| * Motor skills
 |  |
| * Sleeping too much
 |  |
| * Sleeping too little
 |  |
| * Temper tantrums
 |  |
| * Failure to thrive
 |  |
| * Separating from parents
 |  |
| * Excessive crying
 |  |

**Is your child? □right-handed □left-handed □both □undecided**

**Has your child lost any skills (e.g., use to say sentences but has now stopped)?**

**MEDICAL INFORMATION**

**Please check any of the following that your child has had, and indicate the age?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Age** |  |  | **Age** |
| * Measles
 | \_\_\_\_\_\_\_\_\_\_ |  | * German Measles
 | \_\_\_\_\_\_\_\_\_\_ |
| * Mumps
 | \_\_\_\_\_\_\_\_\_\_ |  | * Rheumatic Fever
 | \_\_\_\_\_\_\_\_\_\_ |
| * Chicken Pox
 | \_\_\_\_\_\_\_\_\_\_ |  | * Diphtheria
 | \_\_\_\_\_\_\_\_\_\_ |
| * Tuberculosis
 | \_\_\_\_\_\_\_\_\_\_ |  | * Meningitis
 | \_\_\_\_\_\_\_\_\_\_ |
| * Whooping Cough
 | \_\_\_\_\_\_\_\_\_\_ |  | * Encephalitis
 | \_\_\_\_\_\_\_\_\_\_ |
| * Anemia
 | \_\_\_\_\_\_\_\_\_\_ |  | * Seizures
 | \_\_\_\_\_\_\_\_\_\_ |
| * Diabetes
 | \_\_\_\_\_\_\_\_\_\_ |  | * Asthma
 | \_\_\_\_\_\_\_\_\_\_ |
| * Rashes
 | \_\_\_\_\_\_\_\_\_\_ |  | * Hay fever
 | \_\_\_\_\_\_\_\_\_\_ |
| * Eczema
 | \_\_\_\_\_\_\_\_\_\_ |  | * Seasonal allergies
 | \_\_\_\_\_\_\_\_\_\_ |
| * Broken Bones
 | \_\_\_\_\_\_\_\_\_\_ |  | * Pneumonia
 | \_\_\_\_\_\_\_\_\_\_ |
| * Food allergies
 | \_\_\_\_\_\_\_\_\_\_ |  | * Frequent headaches
 | \_\_\_\_\_\_\_\_\_\_ |
| * Stomach aches
 | \_\_\_\_\_\_\_\_\_\_ |  | * Other
 | \_\_\_\_\_\_\_\_\_\_ |
| * Head Trauma
 |  |  |  |  |

**Hearing: Vision:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequent ear infections | * Yes
 | * No
 | Vision problems | * Yes
 | * No
 |
| Tubes | * Yes
 | * No
 | Wears Glasses | * Yes
 | * No
 |
| Hearing problems | * Yes
 | * No
 |  |  |  |
| Sensitive to certain sounds | * Yes
 | * No
 | Sensitive to certain  lights or colors | * Yes
 | * No
 |
| Has your child’s hearing been evaluated? | * Yes
 | * No
 | Has your child’s vision been evaluated? | * Yes

  | * No
 |

Hearing Evaluation Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

 Who tested hearing? (e.g., doctor, school, ECI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Vision Evaluation Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

 Who tested vision? (e.g., doctor, school, ECI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Sleep Appetite**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Past** | **Present** |  | **Past** | **Present** |  |
|  |  | No sleep difficulties |  |  | Normal increase in weight/height |
|  |  | Trouble falling asleep |  |  | Unusual weight gain \_\_\_\_\_lbs. |
|  |  | Wakes up frequently at night |  |  | Unusual weight loss \_\_\_\_\_lbs. |
|  |  | Still tired after a good night’s sleep |  |  | Concerns about height/growth? |
|  |  | Does not get enough sleep |  |  | Increase in appetite |
|  |  | Restless in bed |  |  | Decrease in appetite |
|  |  | Nightmares |  |  | Gags on certain textures |
|  |  | Night terrors |  |  | Purposely throws up after eating |
|  |  | Refuses to go to bed |  |  | Food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Change in sleep pattern |  |  | Eats excessively  |
|  |  | Sleeps too much |  |  | Picky eater |
|  |  | Wakes up too early |  |  | Will only eat certain types of |
|  |  | Falls asleep in school |  |  | food. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Refuses to get up in the morning |  |  | On a special diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Snores |  |  |  |
|  |  | Sleeps with parent or sibling  |  |  |  |
|  |  | Sleep Apnea (appears to hold breath when asleep) |  |  |  |

**Please indicate if your child has ever had any of the following? If so describe.**

|  |  |
| --- | --- |
| * Seizure disorder
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Accident prone
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Bites nails or cuticles
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Sucks thumb
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Grinds teeth
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Has tics or twitches
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Bangs head
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Rocks back and forth
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Fever over 104 degrees
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Head injury
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Loss of consciousness
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Current medications, indicate dosage:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous medications (Indicate when s/he stopped taking them):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Has your child ever had psychological or psychiatric exam?**  | * **Yes**
 | * **No**
 |

Provider’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Has your child ever had psychological counseling or therapy?**  | * **Yes**
 | * **No**
 |

Therapist’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Has your child ever had a neurological exam?** | * **Yes**
 | * **No**
 |

Neurologist’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any hospitalizations and/or surgeries and the dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate if any family members have had the following and specify that person’s relationship to the child.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Cancer
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Alcohol abuse
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Diabetes
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Drug abuse
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Epilepsy
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Behavior disorder
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Migraine headaches
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Emotional problems
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Physical handicap
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Mental illness
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tuberculosis
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Intellectual disorder
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Huntington’s chorea
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Anxiety
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Muscular dystrophy
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Reading problems
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Sickle cell anemia
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Learning disability
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tay-sachs disease
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Speech problem
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tourette’s syndrome
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Language problem
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Cerebral palsy
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Severe head injury
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Birth defect
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Other
 | \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**TEMPERAMENT and BEHAVIOR:**

**Which describe your child’s temperament before the age of two?**

|  |  |  |  |
| --- | --- | --- | --- |
| * Calm
 | * Active
 | * Sociable
 | * Withdrawn
 |
| * Alert
 | * Unhappy
 | * Happy
 | * Tired
 |
| * Affectionate
 | * Crying
 | * Difficult
 | * Irritable
 |
| * Angry
 | * Fearful
 | * Cranky
 | * Playful
 |
| * Other\_\_\_\_\_\_\_\_
 |  |  |  |

**Which describe your child now?**

|  |  |  |  |
| --- | --- | --- | --- |
| * Calm
 | * Active
 | * Sociable
 | * Withdrawn
 |
| * Tired
 | * Cries a lot
 | * Irritable/Cranky
 | * Playful
 |
| * Affectionate
 | * Difficult
 | * Distracted
 | * Funny
 |
| * Withholds affection
 | * Happy
 | * Sad
 | * Impulsive
 |
| * Tearful
 | * Overreacts
 | * Moody
 | * Worries
* Feels lonely often
 |
| * Self-conscious
 | * Gets mad easily
 | * Easily upset by changes in routine
 |  |
| * Even tempered
 | * Hides Feelings
 | * Easily overstimulated
 |  |
| * Lacks self-control
 | * Difficult to calm
 | * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |

**What is the best thing about your child?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  **What makes your child angry?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
|  **Does your child have any specific fears?** | * **Yes**
 | * **No**
 |

 Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  **Does your child engage in any ritualistic or compulsive behavior?** | * **Yes**
 | * **No**
 |

 Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child engaged in any of the following behaviors?**

|  |  |
| --- | --- |
| * None
 | * Stolen with confrontation
 |
| * Stolen without confrontation
 | * Tries to Run away
 |
| * Lies often
 | * Deliberate fire-setting
 |
| * Hits other children
 | * Hits adults
 |
| * Destruction of property
 | * Cruel to animals
 |
| * Used/tried to use a weapon in a fight
 | * Often initiates physical fights
 |
|  **What time does your child usually go to bed on school nights? ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**What do you find most difficult about raising your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is mainly in charge of discipline at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do all caregivers agree on discipline? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Which of the following methods of discipline are used at home?** |
| * Verbal Reprimands
 | * Time out
 | * Loss of privileges
 |
| * Rewards
 | * Physical punishment
 | * Give in to child
 |
| * Ignore behavior
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Discuss behavior
 | * Earn privileges
 |
|  **What discipline techniques are effective?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  **What discipline techniques are ineffective? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Has your child experienced any of the following stressful events during the past year?** Check all that apply |
| * Parents separated or divorced
 | * Family accident or illness
 | * Death in the family
 |
| * Parent changed jobs
 | * Changed schools
 | * Family moved
 |
| * Family financial problems
 | * Chronic health problems
 |  |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |

|  |
| --- |
|  **How many moves has your child had to make within the last three years?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **FAMILY INFORMATION and RELATIONSHIPS**

|  |  |
| --- | --- |
| **Mother’s Name:**  | **Father’s Name:**  |
| Occupation:  | Occupation:  |
| Employer:  | Employer:  |
| Ethnicity:  | Ethnicity:  |
| Highest Grade Completed:  | Highest Grade Completed:  |

**Please list all persons residing with the family and their relationship to the child.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Gender | Relationship to child |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If parents are divorced, separated, or not with the child, who has custody?

If child is not living with a parent, does s/he see this parent [ ]  Yes [ ]  No

If so, how often?

Primary language spoken by the child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary language spoken at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| **How does your child relate to others?** Check all that apply  |
| * Has many close friends
 | * Has several close friends
 | * Has few close friends
 |
| * Has no close friends
 | * Makes friends easily
 | * A leader
 |
| * A follower
 | * Fights with playmates
 | * Prefers to play alone
 |
| * Prefers younger children
 | * Prefers older children
 | * Prefers adults
 |
| * Interacts well with siblings
 | * Difficulty with siblings
 | * Teased by others
 |
| * Teases others
 | * Feels rejected by peer group
 | * Is jealous of others
 |
| * Has friends who get in trouble
 | * Wants friends, but doesn’t know how to make or keep them
 |

  |

|  |
| --- |
|  **Does your child ever say?** check all that apply  |
| * I like my friends
 | * I like sitting with friends at lunch
 | * Kids hate me
 |
| * Kids are fun
 | * No one likes me
 | * Kids make fun of me
 |
| * I like my classmates
 | * I don’t have any friends
 | * Kids pick on me
 |
| * I like recess
 | * I wish kids talked to me
 |  |

**How does your child spend his/her free/play time?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACADEMIC INFORMATION**

|  |
| --- |
|  **List the schools your child has attended?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child been in a bi-lingual classroom?** [ ]  No [ ]  Yes. If yes – how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which of the following did your child attend?** Check all that apply

|  |  |
| --- | --- |
| * Infant day care
 | * Kindergarten
 |
| * Preschool
 | * None
 |

**Which of the following describe your child’s kindergarten and first grade years?** Check all that apply

|  |  |
| --- | --- |
| * Enjoyed school
 | * Felt neutral about school
 |
| * Afraid of school
 | * Complained of being sick to avoid school
 |
| * Always in trouble at school
 | * Disliked school
 |
| * Got along well with the teacher
 | * Got along poorly with the teacher
 |
| * Frequently absent
 | * Aggressive
 |
| * Active
 | * Distractible
 |
| * Disobedient
 | * Cooperative
 |
| * Liked to help the teacher
 | * Lost temper easily
 |

**If applicable, which of the following describe your child’s experiences since the first grade?**

Check all that apply

|  |  |
| --- | --- |
| * Good grades
 | * Frequently absent
 |
| * Failing grades
 | * Tested for special education
 |
| * Average grades
 | * Tested for the gifted program
 |
| * Cooperative student
 | * Tutored
 |
| * Suspended, \_\_\_\_\_\_number of times
 | * Retained, what year\_\_\_\_\_\_\_\_\_\_
 |
| * Expelled, \_\_\_\_\_\_number of times
 | * Loses temper easily
 |

**What are your child’s current subject strengths?**

|  |  |  |  |
| --- | --- | --- | --- |
| * None
 | * Math
 | * History
 | * Art
 |
| * Spelling
 | * Social Studies
 | * English
 | * Science
 |
| * Music
 | * Athletics/PE
 | * Reading
 | * Other
 |

**What are your child’s current subject weaknesses?**

|  |  |  |  |
| --- | --- | --- | --- |
| * None
 | * Math
 | * History
 | * Art
 |
| * Spelling
 | * Social Studies
 | * English
 | * Science
 |
| * Music
 | * Athletics/PE
 | * Reading
 | * Other
 |
|  |
|  **Which are your child’s current skill strengths?** Check all that apply  |
| * None
 | * Getting assignments done
 | * Intelligence
 |
| * Concentration
 | * Vocabulary/expression
 | * Behaving correctly
 |
| * Organization
 | * Understanding concepts
 | * Spelling
 |
| * Memorization
 | * Pleasing the teacher
 | * Taking tests
 |
| * Papers and reports
 | * Reading speed
 | * Turning in homework
 |
| * Handwriting
 | * Reading comprehension
 | * Test preparation
 |
| * Checking work carefully
 | * Working hard
 | * Other
 |
| * Paying attention
 | * Completing homework
 |  |

|  |
| --- |
| **Which are your child’s current skill weaknesses?** Check all that apply  |
| * None
 | * Getting assignments done
 | * Intelligence
 |
| * Concentration
 | * Vocabulary/expression
 | * Behaving correctly
 |
| * Organization
 | * Understanding concepts
 | * Spelling
 |
| * Memorization
 | * Pleasing the teacher
 | * Taking tests
 |
| * Papers and reports
 | * Reading speed
 | * Turning in homework
 |
| * Handwriting
 | * Reading comprehension
 | * Test preparation
 |
| * Checking work carefully
 | * Working hard
 | * Other
 |
| * Paying attention
 | * Completing homework
 |  |

|  |
| --- |
|  |

**How many hours does your child spend on electronics each day (i.e., phone, tablet, gaming console, etc.)? \_\_\_\_**

**Does your child use electronics before bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If so, how many hours/minutes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GOALS**

 **What goals would you/your child like to accomplish in treatment?**

 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychologist/Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD SYMPTOM CHECKLIST**

Please read each symptom/behavior listed and indicate how often your child has experienced it (frequency), and how long your child has experienced it (duration).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms** | **Rarely** | **3-4 times****month** | **3-6 times****week** | **Daily** | **How****Long** |
|  1. Anxious, tense mood, difficulty controlling worry | **0** | **1** | **2** | **3** |  |
|  2. Panic attacks (intense and sudden fear) | **0** | **1** | **2** | **3** |  |
|  3. Anxiety and/or avoidance in social situations | **0** | **1** | **2** | **3** |  |
|  4. Specific intense fears (e.g., driving, needles, etc.) *Specify:* | **0** | **1** | **2** | **3** |  |
|  5. Obsessions and/or compulsions (excessive concern with  cleanliness, orderliness, checking things, etc.). | **0** | **1** | **2** | **3** |  |
|  6. Fatigue, feeling tired even with good sleep | **0** | **1** | **2** | **3** |  |
|  7. Sleep problems—too much or too little | **0** | **1** | **2** | **3** |  |
|  8. Feeling worthless, low self-esteem | **0** | **1** | **2** | **3** |  |
|  9. Decreased interest in previously enjoyed activities | **0** | **1** | **2** | **3** |  |
|  10. Thoughts of suicide or death | **0** | **1** | **2** | **3** |  |
|  11. Excessive worry about weight/body image | **0** | **1** | **2** | **3** |  |
|  12. Irritable mood, snapping at others, easily angered  | **0** | **1** | **2** | **3** |  |
|  13. Unexplained “up” mood, restless, lots of energy | **0** | **1** | **2** | **3** |  |
|  14. Impulsive behavior that your child wouldn’t “normally” do | **0** | **1** | **2** | **3** |  |
|  15. Racing thoughts that he/she cannot control | **0** | **1** | **2** | **3** |  |
|  16. Seeing/hearing things that are not real | **0** | **1** | **2** | **3** |  |
|  17. Recurrent, intrusive thoughts or images | **0** | **1** | **2** | **3** |  |
|  18. Easily startled, overly “watchful” | **0** | **1** | **2** | **3** |  |
|  19. Difficulty trusting others and feeling safe | **0** | **1** | **2** | **3** |  |
|  20. Difficulty concentrating and focusing on tasks | **0** | **1** | **2** | **3** |  |
|  21. Having urges to break or smash things | **0** | **1** | **2** | **3** |  |

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