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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 or bullying? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 | \_\_\_\_\_\_\_\_\_\_ |  | * COVID-19 | \_\_\_\_\_\_\_\_\_\_ |
| * Head Trauma | \_\_\_\_\_\_\_\_\_\_ |  | * Post-COVID symptoms | \_\_\_\_\_\_\_\_\_\_ |

**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/Depression | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 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 |  |

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**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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