SYMPTOM CHECKLIST

Please mark all of the following symptoms your child is **now** experiencing with an **N**.
Please mark past (not current) symptoms with a **P**. Thank you.

__ Sadness	__ Fatigue/exhaustion	__ Restless sleep	__ Loss or reduction of energy
__ Feeling empty	__ Restlessness	__ Not sleeping enough	__ Weight loss (_________ lbs.)
__ Tearfulness	__ Social withdrawal	__ Waking too early	__ Weight gain (_________ lbs.)
__ Irritability	__ Indecisiveness	__ Sleeping too much	__ General aches/pains
__ Guilt	__ Low self-esteem	__ Difficulty concentrating	__ Things aren't fun anymore
__ Headaches	__ Feeling worthless	__ Difficulty thinking	__ Loss of interest in things/life
__ Stomach aches	__ Self-blame	__ I wish I didn't exist	__ Suicidal thoughts

__ Worrying/brooding	__ Restless/on edge	__ Easily fatigued	__ Muscle tension
__ Decreased concentration	__ Mind goes blank	__ Decreased concentration	__ Irritability
__ Intense or irrational fears	__ Fear of leaving home	__ Obsessive thoughts	__ Compulsions
__ Feeling stressed out	__ Unresolved trauma	__ Avoid social situations	

__ Panic	__ Palpitations	__ Sweating	__ Trembling
__ Shortened breath	__ Hyperventilating	__ Choking	__ Chest pain
__ Nausea	__ Dizziness	__ Things seem unreal	__ Fear of losing control
__ Fear of dying	__ Tingling sensations	__ Chills/hot flashes	__ Other

__ Poor attention to detail	__ Frequent, careless mistakes	__ Difficulty paying attention
__ Difficulty listening	__ Difficulty following instructions	__ Difficulty finishing tasks
__ Difficulty organizing things	__ Hyperactive	__ Impulsive
__ Excessively fidgety	__ Talks excessively	__ Forgetful

__ Lose temper easily	__ Argumentative	__ Defiant/noncompliant	__ Blames others
__ Deliberately annoying	__ Easily annoyed	__ Excessively “touchy”	__ Aggressive
__ Angry	__ Spiteful/vindictive	__ Cruel to animals	__ Cruel to others
__ Bullies others	__ Initiates physical fights	__ Destroys property	__ Theft/stealing
__ Legal problems	__ Starts fires	__ Robbery	

__ Grossly inflated self-esteem	__ Decreased need for sleep	__ Far more talkative than usual
__ Very rapid, “pressured” talking	__ Ideas racing through mind	__ Excessively distractible
__ Excessive increase in productivity	__ High risk or hypersexual	__ Running away from home
__ Reckless decision making	__ Excessive energy	__ Spending far too much

__ Sig. reduction of calories	__ Excessive exercise	__ Laxative abuse	__ Intense fear of weight
__ Dissatisfaction with body	__ Loss of period	__ Binging	__ Purging
__ Sig. weight loss	__ Obsession with food		

__ Poor eye contact	__ Social difficulties	__ Speech/language delays	__ Odd/unusual behaviors
__ Minimal use of gestures	__ Problems with toileting	__ Odd/unusual interests	__ Tics

Please complete these questions as fully and accurately as possible to help me provide the best possible care for your child. If you need more space to write, please write on the back of these pages. Thank you!

Identifying Information

Child’s Name: ____________________ DOB: ____________________ Age: __________

Child’s Gender: ____________________ Race/Ethnicity: ____________________

Referred by? ____

PRESENTING CONCERNS

What is the primary reason you are bringing your child to see me? ______________________

____

When did this problem begin? ____

____

When did you first notice symptoms? ____

____

How much do these concerns interfere with daily functioning? Extensively Moderately Minimally
(Please circle one)

Since they began, have the symptoms become Worse Unchanged Intermittent Improved
(Please circle one)

FAMILY HISTORY

Please specify if the child's parents are: single married cohabitating divorced widowed
(Please circle one)

Parents' names: ____

If parents are divorced or separated, what are the custody arrangements? ______________________

____

**** If divorced, please bring divorce decree and child custody agreement to the initial interview ****

Length of time parents married/living together? ______________________________

Describe the child's relationship with his/her mother: ______________________________

Describe the child's relationship with his/her father:

Describe the relationship between the child's mother and father:

Has child protective services ever been involved in this child's life? If yes, please explain:

Has there been any history of trauma or abuse of any kind within this child's life? If yes, please explain:

Has either parent been married before? If so, when?

Is there a family history of mental health conditions? If so, please describe:

What spiritual, cultural, and/or religious practices are important to you?

Please list the following information for everyone currently living in your child's home:

Name	Age	Gender	Relationship to Child

Please mark all that currently apply, or have ever applied to your child's life (**N = now, P = past**)

__ Marital conflict	__ Separation/divorce	__ Parent/child conflicts	__ Sibling conflict
__ Extended family conflict	__ Peer relationships	__ School problems	__ Recent move
__ Work-related stress	__ Financial stressors	__ Job loss or change	__ Legal problems
__ Substance abuse	__ Medical problems	__ Housing problems	__ Recent death
__ Trauma/abuse history	__ Spiritual or religious conflict		_ Other (specify)

MEDICAL/DEVELOPMENTAL HISTORY

How would you describe your child's current physical health? excellent good fair poor
(Please circle one)

Please list all medications your child currently takes (including dosages):

Please list all medications your child was previously prescribed (including dosages):

Has your child had significant side effects from medications? If yes, please explain:

Please rate the effectiveness of the medications your child has taken (1 – 10): ____________

Please check any of the following that are part of your child's medical history:

__ Seizure	__ Neurological disorder	__ Traumatic brain injury	__ Loss of consciousness
__ Stroke	__ Blood pressure problems	__ Thyroid problems	__ High Fever

Were there any complications during the mom's pregnancy with this child? If yes, please explain:

Were there any complications with the labor or delivery of this child? If yes, please explain:

After how many months or weeks of pregnancy was your child delivered? ______

How much did this child weigh at birth? ______

Did your child require any specialized medical care following birth? If yes, please explain:

Please describe your child's progress on developmental milestones (D = delayed, T = typical, E = early)

Task	Typical Development	Your Child's Development		
Lifts head	1 – 3 Months	___ D	___ T	___ E
Smiles	1 – 3 months	___ D	___ T	___ E
Babbles	4 – 11 months	___ D	___ T	___ E
Sits alone	5 – 8 months	___ D	___ T	___ E
Stands	6 – 10 months	___ D	___ T	___ E
Walks	11 – 14 months	___ D	___ T	___ E
First words	11 – 15 months	___ D	___ T	___ E
Pretend play	12 – 24 months	___ D	___ T	___ E
Toilet trained	20 – 48 months	___ D	___ T	___ E
Speaking in sentences	2 – 3 years	___ D	___ T	___ E
Riding tricycle	2 – 3 years	___ D	___ T	___ E
Playing cooperatively	4 – 6 years	___ D	___ T	___ E
Writing letters/numbers	4 – 6 years	___ D	___ T	___ E

Social History:

Does your child have a history of legal problems? (If yes, please explain)

How well does your child make or maintain friends?

Has your child frequently been bullied by, or bullied others? If yes, please explain:

How well does your child get along with teachers or other adults?

Academic History

Name of child's school?

What is his/her current grade?

Has he/she ever skipped a grade?

Has he/she ever been held back?

Has he/she ever received special education services in school?

If yes, what type of special education services did he / she receive:

What is the name of your child's current special education teacher(s)?

What is your child's typical grade range in school or current GPA?

Has your child ever been suspended or expelled from school? If yes, please explain:

Substance use and abuse

For the following substances, please:
Write "E" if you think your child has experimented with it, but does not currently use it
Write "U" if you think your child currently uses any of these (not to the point of getting drunk or high)
Write "A" next to those substances you think your child occasionally or regularly uses to get drunk or high
Write "D" next to those substances you think your child has *ever been* or *is now addicted* to or *dependent* upon

__ Caffeine	__ PCP/Angel Dust	__ Alcohol	__ Marijuana	__ Amphetamines
__ Inhalants	__ LSD/Hallucinogens	__ Cocaine or crack	__ Opiates	__ Heroin
__ Tobacco	__ Prescription drugs	__ Ecstasy	__ Acid	

Has your child ever been treated for substance abuse? If yes, please specify:

Prior Behavioral Healthcare

Has your child previously received mental health services? ____________________

If yes, please answer the following questions:

When did therapy begin and end? ____________________

Where did therapy take place? ____________________

With whom did you work? ____________________

What happened as a result? ____________________

GOALS FOR THERAPY

What would you like to see accomplished through therapy? What do you hope will change or improve?