Child's Name ___________________________________ Date______________________

Person completing the form ____

Please check the symptoms that occurred in the last 6 months.

Worrying		Hopeless	
Too much energy		Aggressive	
Uncontrolled Temper		Afraid of school	
Excessive crying		Problems sleeping	
Family issues		Nightmares	
Anxiety		Anger	
Jealousy		Separation from family	
No friends		Mood changes	
Stealing		Excessive lying	
Easily distracted		Problems getting along with others	
No confidence		Stomach pain or constant complaints	
Cutting or self abuse		Verbal abuse of others	
School failure		Placement in foster care	
Placement with relative/kin		Running away	
Bed wetting		Daytime wetting (after age 5)	
Food hoarding/stealing		Food preoccupation	
Sleeping too much		Inappropriate use of social media	
Hearing voices		Medical issues	
School suspension		Learning differences	
Acting parental		Sexual acting out	
Promiscuous		Poor appetite	
Psychiatric hospitalization		Homicidal ideation (thoughts of hurting others)	
Victim of emotional abuse		Victim of physical abuse	
Victim of sexual abuse		Sexual abuse of others	
Drug use including marijuana (past or present)		Other:	
Other		Other:	