Childhood Symptom Checklist

CHILDS NAME: _____ DOB: _____ DATE: _____

CASE MANAGER: _____ PARENT SIGNATURE: _____

Please mark under the heading what best describes your child:

		NEVER	SOMETIMES	OFTEN
1.	Complains of aches and pains			
2.	Spends more time alone			
3.	Tires easily, has little energy			
4.	Fidgety, unable to sit still			
5.	Has trouble with teacher			
6.	Less interested in school			
7.	Acts as if driven by a motor			
8.	Daydreams too much			
9.	Distracted easily			
10.	Is afraid of new situations			
11.	Feel sad, unhappy			
12.	Is irritable, angry			
13.	Feels hopeless			
14.	Has trouble concentrating			
15.	Less interested in friends			
16.	Fights with other children			
17.	Absent from school			
18.	School grades dropping			
19.	Is down on him or herself			
20.	Visits the doctor with doctor finding nothing wrong			
21.	Has trouble sleeping			
22.	Worries a lot			
23.	Wants to be with you more than before			
24.	Feels he or she is bad			
25.	Take unnecessary risks			
26.	Gets hurt frequently			
27.	Seems to be having less fun			
28.	Acts younger than children his or her age			
29.	Does not listen to rules			
30.	Does not show feelings			
31.	Does not understand other people's feelings			
32.	Teases others			
33.	Blames others for his or her troubles			
34.	Takes things that do not belong to him or her			
35.	Refuses to share			
	Total Score			

Does your child have any emotional or behavioral problems for which she/he needs help? N__ Y ___

Are there any services that you would like your child to receive for these problems? N ___ Y ___

If yes, what services?_____