Thank you for your interest in clinical services at Rachel E. Davis, PhD, PC. This packet contains the intake paperwork that you must complete prior to you/your child's first visit. Please complete the entire packet to the best of your ability and return it via mail, fax, or via message to the patient portal to:

Rachel E. Davis, PhD, PC
7975 W. Sahara Ave., Ste.104
Las Vegas, NV 89117

OR

Fax: (702) 776-8548

OR

Email: **To initiate interactions via the patient portal, you first must call the office at (702) 776-8990 and provide your email address, your child's full name and his/her date of birth. I will then send you an email with a link inviting you to set up your username and password for the patient portal.**

I will not schedule your first appointment until I receive the completed packet. Additionally, please send copies of all relevant medical or therapy records, prior psychological/neuropsychological test results, and educational assessments (i.e., IEP and MDT reports).

Prior to your child's appointments, please make sure that he or she gets plenty of rest and takes any medications as usual (if applicable). If your child wears glasses, has hearing aids, or has any other assistive devices that he or she regularly uses, please bring them to each appointment. You may also bring a snack for your child if you feel that he or she may need one during the appointment.

I accept cash, check, all major credit cards, debit cards, and bank transfers. Additionally, I am happy to prepare a bill for your insurance company on your behalf. However, regardless of whether your insurance company reimburses you, you must pay my fees in full prior to or at the time of service.

Sincerely,

Rachel E. Davis, Ph.D.
Licensed Psychologist
Specializing in Pediatric Neuropsychology

CHILD ASSESSMENT INTAKE PACKET CHECKLIST

This is a Check List of the items I will need prior to scheduling your appointment. You must complete all areas of all forms, to the best of your knowledge, prior to scheduling.

Copy of Parents Driver's Licenses

Child Information and Psycho-Social History Form

Copies of all prior assessment reports from Psychologists or Neuropsychologists

Copies of medical records from Neurologists, Genetic Testing, Therapists

Copy of most recent IEP and MDT

Copy of adoption decree, if applicable

Copy of Social Summary provided to adoptive parents, if applicable

I look forward to working with you and your child. If you have any questions, please feel free to contact me at (702) 776-8990.

Rachel E. Davis, Ph.D.
Licenses Psychologist
Specializing in Pediatric Neuropsychology

Rachel E. Davis, PhD, PC

Licensed Psychologist specializing in Pediatric Neuropsychology

CHILD INFORMATION AND PSYCHO-SOCIAL HISTORY

Child's Name:_____ Date Completed:_____

Date of Birth:_____ Age:_____ Gender: ☐ Male ☐ Female ☐ Nonbinary

Child's Primary Language:_____ Child's Second Language (if any):_____

Address:_____

City:_____ State:_____ Zip:_____

Name of person completing this form:_____

Who has guardianship of this child? ☐ Both Parents ☐ Biological Mother ☐ Biological Father

☐ Stepmother ☐ Stepfather ☐ Foster parent ☐ Court appointed guardian ☐ Other: _____

Parent/Guardian Information

Parent 1 Name: _____ Date of Birth:_____

Address:_____ Relationship to Child:_____

City:_____ State:_____ Zip:_____ Home Phone: (___) ____-____

Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Email:_____

Preferred telephone number: Home/Work/Cell May we leave messages on your preferred number? _____

Employer:_____ Occupation:_____ Primary Language:_____

Parent 2 Name: _____ Date of Birth:_____

Address:_____ Relationship to Child:_____

City:_____ State:_____ Zip:_____ Home Phone: (___) ____-____

Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Email:_____

Preferred telephone number: Home/Work/Cell May we leave messages on your preferred number? _____

Employer:_____ Occupation:_____ Primary Language:_____

Emergency Contact: Name:_____ Relationship_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____

Why are you seeking help for your child at this time?

1. _____
2. _____
3. _____

FAMILY HISTORY

How long has child lived at the current address?_____ Who takes care of child there?_____

Where did child live before?_____ Who took care of child there?_____

Who else lives with your child, what are their ages and relationships to the child?

Name:	Age:	Relationship (e.g., sister or brother)	Male/Female
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How does your child get along with these members of the household? _____

Please list other relatives who do not live with this child, i.e., biological father or mother, other brothers or sisters:

Name:	Age:	Relationship:	How often does your child see this person?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child closer to one parent than the other? ◯ No ◯ Yes If yes, which parent? _____

Has your child ever experienced any parental separations, divorces, or death? ◯ No ◯ Yes

If yes, please describe (who, what, when, how old child was at the time):_____

_____

_____

_____

If parents are separated or divorced, who has legal custody of the child? _____

How often does the noncustodial parent get to see the child? _____

Has your family/child recently experienced significant stress or change (e.g. death of a loved one, a recent move, illness in a family member, significant conflict, birth of a sibling, loss of employment)? How did your child react to this event?

_____

_____

_____

In your family, are there any significant family or marital problems? ◯ No ◯ Yes

Please list any medications (including vitamins, homeopathic, and naturopathic medications) your child is currently taking (and dosage, if you know):

Name of Medication(s)	Taken for:	Prescribing Physician	Dose/Schedule	Response/Side Effects

Did any member of your child's immediate or close extended family (parents, siblings, grandparents, aunts, uncles, cousins) ever had the following, and was it on the mother or father's side of the family. Please check all that apply:

	Biological Mother's Side	Biological Father's Side
Seizure Disorders (e.g., Epilepsy)	☐	☐
Strokes	☐	☐
Alzheimer's Dementia or other dementias	☐	☐
Parkinson's	☐	☐
Neurological Problems	☐	☐
Motor or Vocal Ticks	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Schizophrenia or psychosis	☐	☐
Bipolar Disorder	☐	☐
Drug or alcohol abuse	☐	☐
Intellectual Disability (aka Mental Retardation)	☐	☐
Genetic Disorder(s)	☐	☐
Attention-Deficit/Hyperactivity Disorder	☐	☐
Learning Disorders	☐	☐
Language Delays	☐	☐
Motor coordination problems	☐	☐
Autism, Asperger's, or PDD-NOS	☐	☐
Significant Medical illnesses	☐	☐

Specify: _____

DEVELOPMENTAL HISTORY

Pregnancy

Was your child a planned pregnancy? ☐ No ☐ Yes

Was the mother under a doctor's care? ☐ No ☐ Yes

Were there any previous pregnancies/miscarriages? ☐ No ☐ Yes If yes, how many? _____

While pregnant, did the mother smoke cigarettes? ☐ No ☐ Yes

If yes, how many average per day? _____

Did the mother drink ☐ Wine ☐ Beer ☐ Mixed drinks? How many days a week on average? _____

How many drinks at a time on average? _____

Did the mother use any recreational drugs? ☐ No ☐ Yes

If yes, what drugs? _____

_____

Did the mother have bleeding? ☐ No ☐ Yes If yes, when during the pregnancy? _____

Was the mother on prescribed medications during pregnancy? ☐ No ☐ Yes

If yes, what medications?	Why?
_____	_____
_____	_____
_____	_____
_____	_____

Did the mother have any medical conditions during pregnancy? such as:

☐ intrauterine infections	☐ intrauterine growth failure	☐ loss of consciousness
☐ high blood pressure	☐ low blood pressure	☐ diabetes
☐ toxemia	☐ nutritional deficiency	☐ Measles
☐ flu	☐ excessive swelling	☐ excessive vomiting
☐ anemia	☐ German Measles	☐ emotional problems

☐ other (specify) _____

☐ Maternal injury: Please Describe: _____

☐ Hospitalization during pregnancy: Reason _____

☐ X-Rays during pregnancy: What month? _____

Mother's weight gain was considered ☐ too low ☐ about right ☐ too much

Perinatal

At child's birth, what was the Mother's age? _____ Father's age? _____

Length of pregnancy: _____ weeks Length of labor: _____ hours

Was this child born in a hospital? ◯ Yes ◯ No If not, where was the child born? _____

Birth was: ☐ head first ☐ breech ☐ cesarean ☐ induced ☐ forceps assisted ☐ with anesthesia

Baby's birth weight was _____pounds, _____ounces

If exact birth weight is not recalled, was baby referred to as: ☐ low birth weight (under 5 lbs 8 oz.) OR ☐ extremely low birth weight (under 2 lbs. 3 oz.) _____

Did baby have breathing problems at birth? ◯ Yes ◯ No

Did baby require delivery room resuscitation? ◯ Yes ◯ No

What were baby's Apgar scores at 1 minute:_____ 5 minutes:_____

Was baby in any kind of distress at birth? ☐ No ☐ Yes Explain: _____

_____

_____

Was baby placed in Neonatal Intensive Care Unit? ◯ No ◯ Yes If yes, for how many days? ____ and for what reason(s)? _____

_____

_____

Did baby have any medical conditions at birth? (e.g. jaundice, breathing difficulties, bleeding in the brain, underdeveloped lungs etc.). Please explain:

_____

_____

_____

Number of days in hospital: Mother _____ Child: _____

Infancy

Was your child breast-fed? ◯ No ◯ Yes When was your child weaned? _____

Was your child bottle-fed? ◯ No ◯ Yes When was your child weaned? _____

Please **write in months/years** what age your child first did the following:

_____	Turn Over	_____	Fed him/herself with a spoon
_____	Sit Alone	_____	Assisted in dressing him/herself
_____	Crawl	_____	Show interest in or attracted to sound
_____	Stand Alone	_____	Understand first words
_____	Walk Alone	_____	Speak first words
_____	Walk up stairs	_____	Speak in brief phrases (2 words together)
_____	Walk down stairs	_____	Speak in sentences
_____	Pedal a tricycle	_____	Have a reciprocal conversation

Was baby colicky? ◯ Yes ◯ No When did colic go away? _____ months

Did baby have allergies? ◯ No ◯ Yes (explain): _____

Did baby have any significant problems falling asleep? ◯ No ◯ Yes (explain):_____

_____

_____

Did baby have any serious problems eating? ◯ No ◯ Yes (explain): _____

_____

_____

Baby was: ☐ under-active ☐ overactive ☐ easy ☐ difficult ☐ happy
☐ anxious ☐ cranky ☐ calm ☐ easily soothed
☐ difficult to soothe

Toddler and preschool (2-4 years)

Was your child (more than other children his/her age):

☐ clumsy	☐ anxious or extremely shy	☐ uncoordinated
☐ overly aggressive	☐ inattentive	☐ too energetic/restless
☐ hard to discipline	☐ inarticulate	☐ unhappy
☐ noncompliant	☐ destructive	☐ unable to understand language

Did your child have odd behaviors that were worrisome? Describe: _____

_____

_____

_____

Did your child have difficulty napping? Describe:_____

_____

_____

At what age was your child successfully toilet trained? _____Was toilet training ◯difficult ◯easy

Did your child ever lose control of his/her bladder repeatedly (following toilet training) during the day? ◯No ◯Yes Does this remain a problem currently? ◯Yes ◯No

Did your child ever lose control of his/her bladder repeatedly (following toilet training) during the night? ◯No ◯Yes Does this remain a problem currently? ◯Yes ◯No

Did your child ever lose control of his/her bowels repeatedly (following toilet training) during the day? ◯No ◯Yes Does this remain a problem currently? ◯Yes ◯No

Were there any medical reasons for loss of bladder or bowel control? ◯No ◯Yes If yes, please explain: _____

_____

_____

Did your child attend preschool? ◯No ◯Yes If yes, at what age(s) _____ and name of preschool _____ How many days per week?_____How many hours per day?_____

Was there significant separation anxiety at preschool ? ◯No ◯Yes

Were there problems during preschool? ◯No ◯Yes

If yes, what were these problems?

☐overly aggressive ☐unable to share ☐too energetic ☐uncoordinated
☐shy ☐withdrawn ☐slow to learn
☐difficulty getting along with other kids

Was your child display problem behaviors at home? ◯No ◯Yes

If yes, what?

☐didn't listen ☐clingy ☐didn't obey ☐trouble separating
☐cried a lot ☐worried excessively about something happening to you
☐temper tantrums ☐other (specify) _____

Did your child have significant problems getting along with brothers or sisters? ◯No ◯Yes

If yes, explain: _____

_____

_____

_____

Did/does your child:

Make appropriate eye contact?	◯No ◯Yes
Smile in social situations?	◯No ◯Yes
Behave affectionately?	◯No ◯Yes
Seem disinterested in or unaware of others' presence?	◯No ◯Yes
Talk to be sociable or friendly?	◯No ◯Yes
Show a range of facial expressions?	◯No ◯Yes
Engage in non-purposeful repetitious behaviors (e.g. rocking)?	◯No ◯Yes
Become preoccupied with parts of objects?	◯No ◯Yes
Have narrow or unusual interests?	◯No ◯Yes

Has your child experienced problems in any of the following areas? If yes, please describe.

Area	Problem	Describe
Walking	◯No ◯Yes	_____
Unclear Speech	◯No ◯Yes	_____
Feeding	◯No ◯Yes	_____
Weight	◯No ◯Yes	_____
Colic	◯No ◯Yes	_____
Sleep	◯No ◯Yes	_____
Eating	◯No ◯Yes	_____
Learning to ride a bike	◯No ◯Yes	_____
Learning to throw or catch	◯No ◯Yes	_____
Motor skills	◯No ◯Yes	_____
Failure to thrive	◯No ◯Yes	_____
Excessive crying	◯No ◯Yes	_____

Which hand does your child use for:

Writing or drawing	◯Right ◯Left ◯Both
Eating	◯Right ◯Left ◯Both
Other (throwing, etc.)	◯Right ◯Left ◯Both

MEDICAL HISTORY

What illness or condition has your child had. If he/she has had one of these illnesses or conditions please write in at what approximate age(s) and grade(s) when he/she had the illness or condition.

Illness or condition	*Age(s)*	*Grade(s)*
☐ seizures unrelated to high fevers		
☐ convulsions		
☐ high fever (above 104 F degrees)		
☐ significant head injury, with loss of consciousness		
☐ hearing difficulties		
☐ vision problems		
☐ trouble with motor coordination		
☐ unclear speech production		
☐ hyperactivity		
☐ meningitis		
☐ encephalitis		
☐ measles		
☐ mumps		
☐ chicken pox		
☐ tuberculosis		
☐ scarlet fever		
☐ rheumatic fever		
☐ diphtheria		
☐ anemia		
☐ whooping cough		
☐ allergies (please list):		
☐ broken bones		
☐ ear infections		
☐ tube placement in ear(s)		
☐ fainting spells		
☐ loss of consciousness (please describe):		
☐ dizziness		
☐ frequent headaches		
☐ extreme tiredness		
☐ epilepsy		
☐ diabetes		
☐ asthma		
☐ suicide attempts		
☐ sleeping problems		
☐ specific, out of ordinary traumas		

Does your child have any disabilities? If yes, please describe:

Has your child had any serious illnesses? If yes, please explain:

Has your child been hospitalized? If yes, list reasons and age(s):

Has your child had any operations? If yes, list reasons and age(s):_____

Has your child had any accidents? If yes, please describe:

Are your child's immunizations up to date? ◯No ◯Yes

Has your child ever develop motor tics (sudden, brief, recurrent, meaningless movements), such as:

☐ eye blinking ☐ abdominal tensing ☐ shoulder shrugs ☐ head jerks
☐ mouth movements ☐ facial gestures ☐ arm jerks ☐ finger movements
☐ imitation of someone else's movements

Did they last for over one year? ◯ Yes ◯ No

If any of these movements still exist, which ones? _____

Has your child ever developed vocal tics (simple, sudden, meaningless sounds or noises), such as:

☐ throat clearing ☐ barking ☐ sniffing ☐ grunting ☐ snorting
☐ repeating his/her own sounds or words ☐ repeating someone else's sounds or words
☐ repeating socially unacceptable or obscene words

Did they last for over one year? ◯ Yes ◯ No If any still exist, which ones? _____

FRIENDSHIPS

How many friends, other than family members, does your child have? _____

Does your child avoid or have difficulty with:

a. getting along with peers? ◯ Yes ◯ No
b. making or keeping friends? ◯ Yes ◯ No
c. engaging in social situations? ◯ Yes ◯ No
d. being flexible to change? ◯ Yes ◯ No

How would you describe your child's friendships? _____

Please describe how your child gets along with peers?

☐ shy	☐ has many friends	☐ poor loser at games
☐ is very popular	☐ wants to run things	☐ afraid peers do not like him
☐ has trouble making friends	☐ feelings easily hurt	☐ picks on other children
☐ does not compromise easily		

What activities (kinds of things) does your child enjoy?

To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped)?
◯ No ◯ Yes
If yes, What age(s)?_____By whom?_____

Was your child ever physically or emotionally abused? ◯ No ◯ Yes
If yes, What age(s)? _____ By whom? _____

Please describe, as best you can, your child's personality (emotional makeup). Be as descriptive as you can:

What are your child's strengths, special talents, skill areas:

What forms of discipline have you tried and how successful or unsuccessful have your methods been. Also, do both parents discipline the same way? Are you consistent in your handling of consequences?

How does your child usually get along with Parent 1?

How does your child usually get along with Parent 2?

How does your child get along with step/adopted parent(s), if applicable?

What activities does your family do together?

What chores/household responsibilities is your child supposed to do regularly?

Does he/she do them satisfactorily? ◯ No ◯ Yes

What school does your child attend:_____

What grade is he/she currently in:_____ Has he/she ever been retained a grade:_____

Please describe your child's academic grades:_____

Please describe your child's attendance, that is, how many days of school missed and for what reason:

Has your child's teacher expressed any concerns about his/her grades or behaviors:_____

What do you expect from this assessment or therapy?

Has your child ever been evaluated by a neurologist? If so, what were the results of that evaluation (e.g., was your child given a diagnosis)?

Has your child ever been evaluated by a psychologist or neuropsychologist? If so, what were the results of that evaluation (e.g., was your child given a diagnosis)?

Has your child ever had a genetics evaluation? If so, what were the results of that evaluation (e.g., was your child given a diagnosis)?

PREVIOUS OR ONGOING THERAPIES

Please list all current and past professional (inpatient and outpatient) counselors, therapists or agencies who have evaluated or treated your child: ☐NONE

Service Provider	City	Dates Seen	Results	Previous or Ongoing?
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing
Who:				☐Previous
For:				☐Ongoing

Behavior Checklist

Within the last six (6) months, how often has your child displayed the following behaviors in excess of what would be expected for a child his/her age?

Behavior	Never or Rarely	Sometimes 1-2 time per month	Moderate Once per week	Very Often 3-4 times per week	Almost Always Daily	Check if occurring for more than a year?
Difficulty with figuring out how to do new things	○	○	○	○	○	○
Difficulty making decisions	○	○	○	○	○	○
Difficulty solving problems that a younger child could do	○	○	○	○	○	○
Disorganized in approach to solving problems	○	○	○	○	○	○
Difficulty doing things in the right order	○	○	○	○	○	○
Problems describing the steps involved in doing something	○	○	○	○	○	○
Difficulty completing an activity in a reasonable amount of time	○	○	○	○	○	○
Difficulty changing a plan or activity when necessary	○	○	○	○	○	○
Problem switching between activities	○	○	○	○	○	○
Easily frustrated	○	○	○	○	○	○

Problems speaking clearly	○	○	○	○	○	○
Hard time finding the right word to use	○	○	○	○	○	○
Rambling on and on without saying much	○	○	○	○	○	○
Jumping from topic to topic in conversation	○	○	○	○	○	○
Odd vocal sounds or unusual language	○	○	○	○	○	○
Problems understanding what others are saying	○	○	○	○	○	○
Does not yet know colors	○	○	○	○	○	○
Problems telling left from right	○	○	○	○	○	○
Problems putting puzzles together	○	○	○	○	○	○
Problems drawing or copying	○	○	○	○	○	○
Difficulty dressing him- or herself	○	○	○	○	○	○
Problems recognizing objects	○	○	○	○	○	○
Getting lost easily	○	○	○	○	○	○
Spatial problems	○	○	○	○	○	○
Poor fine motor skills	○	○	○	○	○	○
Clumsy	○	○	○	○	○	○
Muscle Weakness	○	○	○	○	○	○
Tremor	○	○	○	○	○	○
Tight or spastic muscles	○	○	○	○	○	○
Odd movements (posturing, hand movements)	○	○	○	○	○	○

Behavior	Never or Rarely	Sometimes 1-2 time per month	Moderate Once per week	Very Often 3-4 times per week	Almost Always Daily	Check if occurring for more than a year?
Drops things more than other children	○	○	○	○	○	○
Unusual walk	○	○	○	○	○	○
Problems running	○	○	○	○	○	○
Other coordination problems	○	○	○	○	○	○

Squints or moves closer to the page to read	○	○	○	○	○	○
Problems seeing objects	○	○	○	○	○	○
Loss of feeling	○	○	○	○	○	○
Problems not hearing sounds	○	○	○	○	○	○
Overreacting to sounds (e.g., covering ears)	○	○	○	○	○	○
Difficulty telling hot/cold	○	○	○	○	○	○
Difficulty not smelling odors	○	○	○	○	○	○
Too sensitive to odors	○	○	○	○	○	○
Does not seem to taste food (e.g., craves very spicy foods)	○	○	○	○	○	○
Strong reactions to certain flavors	○	○	○	○	○	○
Overly sensitive to touch	○	○	○	○	○	○
Overly sensitive to light	○	○	○	○	○	○
Frequently complains of headaches or nausea	○	○	○	○	○	○
Reports being dizzy	○	○	○	○	○	○
Complains of pains in joints	○	○	○	○	○	○
Seems excessively tired	○	○	○	○	○	○
Frequent drinks/urinates	○	○	○	○	○	○
Other physical problems	○	○	○	○	○	○
Forgets where he/she leaves things	○	○	○	○	○	○
Forgets things that happened recently (a day)	○	○	○	○	○	○
Forgets things that happened days/weeks ago	○	○	○	○	○	○
Forgets what he is supposed to be doing	○	○	○	○	○	○
Forgets names more than most	○	○	○	○	○	○
Forgets school assignments	○	○	○	○	○	○
Forgets instructions	○	○	○	○	○	○
Other memory problems	○	○	○	○	○	○

Easily distracted by sounds	○	○	○	○	○	○
Easily distracted by sights	○	○	○	○	○	○
Easily distracted by own thoughts	○	○	○	○	○	○
Mind seems to go blank at times	○	○	○	○	○	○
Loses train of thought	○	○	○	○	○	○
Difficulty concentrating on what you tell him/her but able to do preferred activity for long periods of time (e.g., watch television)	○	○	○	○	○	○
Attention starts out fine but cannot maintain	○	○	○	○	○	○

Behavior	Never or Rarely	Sometimes 1-2 time per month	Moderate Once per week	Very Often 3-4 times per week	Almost Always Daily	Check if occurring for more than a year?
Other attention problems	○	○	○	○	○	○
Careless	○	○	○	○	○	○
Rarely follows others' instructions	○	○	○	○	○	○
Does not listen to other people	○	○	○	○	○	○
Goes from one activity to another without finishing anything	○	○	○	○	○	○
Frequently loses things needs for school	○	○	○	○	○	○
Forgetful in daily activities	○	○	○	○	○	○
Is disorganized	○	○	○	○	○	○
Is very fidgety	○	○	○	○	○	○
Cannot remain seated	○	○	○	○	○	○
Cannot wait his turn when playing	○	○	○	○	○	○
Answers before hearing entire question	○	○	○	○	○	○
Cannot play quietly	○	○	○	○	○	○
Seems to be always talking	○	○	○	○	○	○
Often is rude or interrupts others	○	○	○	○	○	○
Seems like driven by a motor	○	○	○	○	○	○
Is impulsive	○	○	○	○	○	○
Easily loses temper	○	○	○	○	○	○
Argues with adults	○	○	○	○	○	○
Refuses to comply with requests	○	○	○	○	○	○
Blames others for mistakes	○	○	○	○	○	○
Is easily annoyed or irritated	○	○	○	○	○	○
Does dangerous things without considering the consequences	○	○	○	○	○	○
Seems angry or resentful	○	○	○	○	○	○
Steals things	○	○	○	○	○	○
Runs away from home overnight	○	○	○	○	○	○
Lies	○	○	○	○	○	○
Sets fires	○	○	○	○	○	○
Truant from school	○	○	○	○	○	○
Destroys others property	○	○	○	○	○	○
Is cruel to animals	○	○	○	○	○	○
Is physically aggressive to others	○	○	○	○	○	○
Has raped others	○	○	○	○	○	○
Uses weapons when fighting	○	○	○	○	○	○
Starts physical fights with others	○	○	○	○	○	○
Is cruel to others	○	○	○	○	○	○
Attached to things not people	○	○	○	○	○	○
Bizarre behavior	○	○	○	○	○	○
Bedwetting	○	○	○	○	○	○
Bowel movements in underwear	○	○	○	○	○	○

Behavior	Never or Rarely	Sometimes 1-2 time per month	Moderate Once per week	Very Often 3-4 times per week	Almost Always Daily	Check if occurring for more than a year?
Poor eating habits	○	○	○	○	○	○
Emotional	○	○	○	○	○	○
Depressed	○	○	○	○	○	○
Fearful	○	○	○	○	○	○
Anxious/Nervous	○	○	○	○	○	○
Immature	○	○	○	○	○	○
Nightmares, night terrors, sleepwalks	○	○	○	○	○	○
Resists change	○	○	○	○	○	○
Risk taking	○	○	○	○	○	○
Self-mutilates	○	○	○	○	○	○
Self-stimulates	○	○	○	○	○	○
Shy and withdrawn	○	○	○	○	○	○
Poor sleep habits	○	○	○	○	○	○
Swears a lot	○	○	○	○	○	○
Unmotivated	○	○	○	○	○	○
Quiet	○	○	○	○	○	○