Nirmal Singh Brar, M.D., Inc.

Diplomate of the American Board of Psychiatry and Neurology

Child, Adolescent & Adult Psychiatry

1111 E. Hendon Ave., Suite 115
Fresno, CA 93720
(559) 376-7921 FAX (559) 335-4214

Child Psychological History

Date of Appointment: ________________________

Name of person filling out form:_________________________________ Relationship to patient:_________________

Patient Name:____Sex:_____Age:______Date of Birth:_________________

Social Security #:_____________________School: ___________________ Grade: ____ Teacher: ________________

Home Address:____City: _______________________ Zip: ___________

Home Phone:________________________ Work Phone:______________________ Cell Phone:___________________

Email: ____ Referred By:______________________________________

Reason for Referral:____

Litigation pending?_______ Attorney:_____________________________________Phone:________________________

History of Present Problem

How long ago did problems begin: ______________________________

Please describe the problems that you want help with:____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Current	Past		Current	Past	
☐	☐	Suicidal thoughts (date?______________)	☐	☐	Homicidal thoughts (date?_______________)
☐	☐	Depression/sadness	☐	☐	Anxiety/nervousness
☐	☐	Recurrent/intrusive thoughts	☐	☐	Recurrent/intrusive disturbing recollections/dreams
☐	☐	Loss of appetite	☐	☐	Overwhelming need to perform certain behavior/rituals
☐	☐	Weight loss	☐	☐	Excessive fears or phobias
☐	☐	Overeating	☐	☐	Significant concerns with physical problems
☐	☐	Weight gain	☐	☐	Poor frustration tolerance
☐	☐	Difficulty sleeping	☐	☐	Explosive anger
☐	☐	Apathy	☐	☐	Rapid mood changes
☐	☐	Fatigue	☐	☐	Euphoria (feel on top of the world)
☐	☐	Loss of interest in almost all activities	☐	☐	Racing thoughts
☐	☐	Feeling worthless	☐	☐	Decreased need for sleep
☐	☐	Feeling hopeless	☐	☐	Aggressive
☐	☐	Poor self-esteem	☐	☐	Visual or auditory hallucinations
☐	☐	Sexual problems	☐	☐	Stomach aches
☐	☐	Anorexia or Bulimia	☐	☐	Bizarre behavior
☐	☐	Unmotivated	☐	☐	Shy and withdrawn
☐	☐	Dependent	☐	☐	Self-mutilates
☐	☐	Quiet	☐	☐	Self-stimulates
☐	☐	Resists change	☐	☐	Exhibits sexually inappropriate behavior
☐	☐	Wetting bed or clothes	☐	☐	Risk taking
☐	☐	Bowel movements in underwear	☐	☐	Is cruel to other people
☐	☐	Emotional	☐	☐	Swears a lot
☐	☐	Immature	☐	☐	Steals things without people knowing several times
☐	☐	Is very fidgety	☐	☐	Often runs away from home and stays away over night
☐	☐	Can't remain seated	☐	☐	Easily lies to others
☐	☐	Can't wait his/her turn when playing with others	☐	☐	Fire setting
☐	☐	Answers before she/he hears the whole question	☐	☐	Doesn't go to school
☐	☐	Rarely follows other's instructions	☐	☐	Breaks into other people's property
☐	☐	Destroys other people's property	☐	☐	When fighting, has used a weapon
☐	☐	Is cruel to animals	☐	☐	Starts fights with others
☐	☐	Other unusual behavior:____			

Indicate which stressors your child is experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
☐	☐	Death of spouse	☐	☐	Illness of family member	☐	☐	Illness of friend
☐	☐	Personal injury/illness	☐	☐	Parents separated	☐	☐	Parents divorced
☐	☐	Conflicts with family	☐	☐	Conflicts with friends	☐	☐	Conflicts at school
☐	☐	Academic Difficulties	☐	☐	Change in residence	☐	☐	Legal problems
☐	☐	Sexual Assault	☐	☐	Incest/sexual abuse	☐	☐	Physical abuse
☐	☐	Verbal/emotional abuse	☐	☐	Other problems:			

Is your child currently receiving therapy?_______________ From who?____

When did your child start therapy?____________________For what problems(s)?____

____

List current psychiatric medications:____

Has your child received therapy in the past?_____________From who?____

When (Start and finish):______________________________For what problem(s)?_________________________________

____

List past psychiatric medications:____

Has your child been hospitalized for psychological problems?__________When?________________________________

Where was your child hospitalized?____

Has your child ever attempted suicide?_____________When?____________________How?______________________________

Has your child had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:
Name of psychologist: ____
Address: ____
Phone:_________________________ Date of and reason for this evaluation:_________________________
Findings of the evaluation: ____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

Current	Past	Substance
☐	☐	Alcohol
☐	☐	Tobacco How Much? _____________ How Often? _____________ When did your child quit? ___________
☐	☐	Marijuana
☐	☐	Barbiturates ("Downers")
☐	☐	Tranquilizers
☐	☐	Amphetamines ("Speed")
☐	☐	Crank
☐	☐	Crack
☐	☐	Cocaine
☐	☐	Opiates (Heroine, Opium, Codeine, etc.)
☐	☐	Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)
☐	☐	PCP ("angel dust")
☐	☐	Ecstasy
☐	☐	Other: ______________________________

DOCTOR'S NOTES

Birth and Developmental History

Place of Birth:____ Were parents married at time of birth? _______________
Was mother under a doctor's care during the pregnancy? ______Was the child adopted?_______ If so, at what age?____

Check any illnesses during pregnancy:

☐ Anemia ☐ Toxemia ☐ Herpes ☐ Measles ☐ German measles ☐ Bleeding
☐ Kidney disease ☐ Heart disease ☐ Hypertension ☐ Abdominal trauma ☐ Infection ☐ Diabetes

Medications taken during pregnancy:____
Were drugs or alcohol taken during pregnancy? ☐ Yes ☐ No If yes, specify:_______________________________
Was there significant emotional stress during pregnancy? ☐ Yes ☐ No If yes, name stressors: ________________

Was the birth: ☐ On time ☐ Premature (By how long) _______________ ☐ Late (By how long): _______________
Was labor: ☐ Spontaneous ☐ Induced Duration of labor__ (Hours) ☐ Cesarean required ☐ Cesarean planned
Was the presentation: ☐ Normal ☐ Breach ☐ Transverse (Crosswise) ☐ Posterior first
Did the baby experience any of these problems: ☐ Fetal distress ☐ Prolapsed cord ☐ Low placenta (Placenta previa)
☐ Premature separation of the placenta (Abruptio placenta) ☐ Cord wrapped around neck
Any other problems that mother or child had: _______________________ Was general anesthesia used: ☐ Yes ☐ No
Were forceps used? ☐ Yes ☐ No Were there breathing problems? ☐ Yes ☐ No
Color at birth: ☐ Normal ☐ Blue ☐ Yellow Was oxygen used ☐ Yes ☐ No (How long)? ______APGAR Score ___
Birthweight: ______________ Length:_______________

Check those that apply to the first few weeks after birth:

☐ Excessive sleeping ☐ Laziness ☐ Irritability ☐ Excessive crying ☐ Stiffness ☐ Limpness ☐ Tremors
☐ Twitching ☐ Feeding difficulties ☐ Vomiting ☐ Jaundice Other:_________________

Transfusions required? ☐ Yes ☐ No (Why)____
Medication required? ☐ Yes ☐ No (Why)____
Surgery required? ☐ Yes ☐ No (Why)____

Give approximate ages that developmental milestones were achieved:
Head control _____Rolled over________Sat alone ________Walked ______Run ________
Said first word _______Used sentences ______Self feeding w/ utensils ___________ Toilet trained __________
Dress self ______ Tie shoes __________Color within lines ________First menstruation or beginning of puberty:_______

Check any problems that occurred in later development:

☐ Hearing ☐ Speaking ☐ Stuttering ☐ Reading ☐ Writing ☐ Spelling ☐ Arithmetic
☐ Behavior ☐ Hyperactivity ☐ Seizures ☐ Coordination ☐ Attention difficulties

List family members with developmental or learning problems:____

DOCTOR'S NOTES

Medical History

Please check all the conditions that have been diagnosed.

☐ AIDS, ARC or HIV	☐ Diabetes	☐ Immune system	☐ Poisoning
☐ Allergies	☐ Enzyme deficiency	☐ Jaundice	☐ Polio
☐ Arthritis	☐ Encephalitis	☐ Kidney problems	☐ Parkinson's disease
☐ Asthma	☐ Ear Infections	☐ Liver disorder	☐ Rheumatic Fever
☐ Abscessed ears	☐ Fevers (104 or higher)	☐ Lung disease	☐ Radiation Exposure/Therapy
☐ Arteriosclerosis	☐ Genetic disorder	☐ Lead poisoning	☐ Scarlet Fever
☐ Bleeding disorder	☐ Head injury	☐ Leukemia	☐ Senility (Dementia)
☐ Blood disorder	☐ Heart problems	☐ Metabolic disorder	☐ Stroke or TIA
☐ Broken bones	☐ Hereditary disorder	☐ Meningitis	☐ Tuberculosis
☐ Brain	☐ Headaches	☐ Measles	☐ Tumor
☐ Cerebral palsy	☐ Hearing problems	☐ Mumps	☐ Thyroid disease
☐ Colds (excessive)	☐ Huntington's disease	☐ Malnutrition	☐ Venereal disease
☐ Chicken pox	☐ Hypertension	☐ Multiple sclerosis	☐ Vision problems
☐ Carbon monoxide	☐ Hormone problems	☐ Oxygen deprivation	☐ Whooping cough
☐ Cancer	☐ Hazardous Substance	☐ Pneumonia	

☐ Other medical/physical problems: ____

Has your child ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No

If yes, check the one they have been diagnosed with.

PARTIAL	GENERALIZED	☐ UNCLASSIFIED
☐ Simple partial	☐ Absence (Petit mal)	
☐ Complex partial	☐ Myonclonic	
☐ Partial evolving into generalized	☐ Clonic	
	☐ Tonic	
	☐ Tonic-clonic (Grand mal)	
	☐ Atonic	

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the dosage

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

List any medications your child is ALLERGIC or sensitive to: ______________________

Past Hospitalizations (When, where and for what):

____
____
____
____

Outpatient Surgeries (When, where and for what):

____
____
____
____

Name of family physician: ______________________
Address: ______________________
Phone: ______________________ Date of your last medical check-up: ______________________

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

	Check here if normal	Abnormal findings
☐ Angiography	☐	______
☐ Blood work	☐	______
☐ Brain scan	☐	______
☐ CT scan	☐	______
☐ EEG	☐	______
☐ Lumbar puncture or spinal tap	☐	______
☐ Magnetic Resonance Imaging (MRI)	☐	______
☐ Neurological office exam	☐	______
☐ PET scan	☐	
☐ Physician’s office exam	☐	______
☐ Skull x-ray	☐	______
☐ Ultrasound	☐	______
☐ Other testing:______	☐	______

DOCTOR’S NOTES

Family History

Father's Name ________________________________ Age _______ Health Problems ______________________________
Education ____________________ Occupation __________________________________ Employer ____________________
Mother's Name ________________________________ Age _______ Health Problems ______________________________
Education ____________________ Occupation __________________________________ Employer ____________________
Date of parent's marriage _____________ Years married _______ Current marital problems? _______
If separated, give date _______________ If divorced, date _________
Previous marriages? (Father) ___________ (Mother) ______________Subsequent marriages? (Father) ______ (Mother) ________
If divorced, current custody arrangement _______________________

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years

Names and ages of brothers and sisters (Include step-brothers and step-sisters):
____
____
____
____

List anyone else who lived in the home during your childhood: ______________________________________

List names of any biologically related family members (E.G. Immediate and distant relatives) with any of the following problems:
Alcohol Abuse ____
Criminal History: ____
Emotional/behavior problems: ____
Medical problems (e.g. Heart disease, Cancer, Seizures) ___________________________________
Learning/developmental problems: ____

DOCTOR'S NOTES

Social History

How long has she/he lived in the current home? _____Apartment or house? _______________How long in this town? ______
How many changes in residence in child's lifetime? ______________________ Ages moves occurred? ____________________
What towns have he/she lived in the past? ____

How many friends does your child have in your neighborhood? _____ First name of best friend in neighborhood: _______
How often does he/she play with neighborhood friends? _____ Any conflict problems (What type)? __________________
What are his/her most frequent play activities? ____
How many friends does he/she have at school? _______First name of best friend at school? ________________________
Is your child well liked/accepted at school? ________________Any conflict problems (What type)? __________________
List clubs and organizations that he/she is involved in: ____
____
Is your child involved in a church? ________ Denomination: ________________________Attend how often? ___________
What time/activities do you share with your child? ____
Please describe your last vacation (when & where): ____

DOCTOR'S NOTES

Educational History

Current grade (Or highest grade/degree completed): _________ Current school: ______________________________
Past schools attended (List in order): ____
Hardest subject(s): ___________________________ Favorite subject(s): _____________________________
Grades earned in elementary school: ___________ Junior High G.P.A. _________ High School GPA _________ College GPA _______
Grades repeated: __________________ Learning problems (what subjects): ____________________________________
Special education placement (Type): _________ During which grades: ____
Extracurricular activities (Music, Sports, Clubs, etc.) ____
Expulsions/suspensions/conduct problems (Type of problem and date): ______________________________________
Additional schooling or non-academic training: ____

DOCTOR'S NOTES

Occupational History

☐ Not Applicable

Present employer: ______________________________ Position: ______________________________
Length of employment: ________ Hours worked per week ________ Current responsibilities: ______________________

List previous employment (Include dates and type of work):

____
____

Have your child ever been terminated from a job (Please explain):______________________________
At any time on the job was your child ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? ☐Yes ☐No If yes, explain: ______________________
Have your child ever been injured on the job? ☐Yes ☐No If yes, explain: ______________________

DOCTOR'S NOTES

Legal History

☐ Not Applicable

Present legal problems (Describe): ______________________________
Past arrests (For what?): ______________________________
Convictions (For what?): ______________________________
Time served in juvenile hall, jail or prison (Give dates and locations): ______________________________

DOCTOR'S NOTES

Child General System Checklist

Pease rate your child on each of the symptoms listed below using the following scale. If possible, please have another person who knows your child well (such as a caregiver or other parent) rate your child also to help provide a complete picture. Name of other person: ________________________________

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Parent	Other	Descriptor		
___	___	Depressed or sad mood		
___	___	Decreased interest in things that are usually fun		
___	___	Significant **recent** weight gain or loss, or marked appetite changes, increased or decreased		
___	___	Recurrent thoughts of death or suicide		
___	___	Sleep changes, lack of sleep or marked increase in sleep		
___	___	Physically agitated or “slowed down”		
___	___	Low energy or feelings of tiredness		
___	___	Feelings of worthlessness, helplessness, or guilt		
___	___	Plays alone or appears socially withdrawn		
___	___	Cries easily		
___	___	Negative thinking	MD	5

Parent	Other	Descriptor		
___	___	Periods of an elevated, high or irritable mood		
___	___	Periods of a very high self-esteem or grandiose thinking		
___	___	Periods of decreased need for sleep **without** feeling tired		
___	___	More talkative **than usual** or pressure to keep talking		
___	___	Fast thoughts or frequent jumping from one subject to another		
___	___	Easily distracted by irrelevant things		
___	___	Marked increase in activity level		
___	___	Cyclic periods of angry, mean or violent behavior	BD	4

Parent	Other	Descriptor		
___	___	Panic attacks, which are periods of intense, unexpected fear or emotional discomfort (#/mo____)		
___	___	Avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable.		
___	___	Periods of trouble breathing or feeling smothered		
___	___	Periods of feeling dizzy, faint or unsteady on your feet		
___	___	Periods of heart pounding or rapid heart rate		
___	___	Periods of sweating		
___	___	Periods of choking		
___	___	Periods of nausea or abdominal upset		
___	___	Numbness or tingling sensations		
___	___	Hot or cold flashes		
___	___	Periods of chest pain or discomfort		
___	___	Intense fear of dying	PD	18, 4

Parent	Other	Descriptor		
___	___	Recurrent bothersome thoughts, ideas or images which they try to ignore		
___	___	Trouble getting “stuck” on certain thoughts, or having the same thought over and over		
___	___	Excessive or senseless worrying		
___	___	Others complaint that they worry too much or get “stuck” on the same thoughts		
___	___	Compulsive behaviors that they must do or they become very anxious such as excessive hand washing, checking locks, or counting or spelling		
___	___	Needing to have things done a certain way or they become very upset		
___	___	They do the same thing over and over to an excessive degree	OC	4

Child General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent	Other	Descriptor		
___	___	Trembling, twitching or feeling shaky		
___	___	Muscle tension, aches or soreness		
___	___	Feelings of restlessness		
___	___	Easily fatigued		
___	___	Shortness of breath or feeling smothered		
___	___	Heart pounding or racing		
___	___	Sweating or cold clammy hands		
___	___	Dry mouth		
___	___	Dizziness or lightheadedness		
___	___	Nausea, diarrhea or other abdominal distress		
___	___	Hot or cold flashes		
___	___	Frequent urination		
___	___	Trouble swallowing or “lump in throat”		
___	___	Feeling keyed up or on edge		
___	___	Quick startle response of feeling jumpy		
___	___	Difficulty concentrating or “mind going blank”		
___	___	Trouble falling or staying asleep		
___	___	Irritability	GAD	6
___	___	Lacks confidence in abilities		
___	___	Needs lots of reassurance		
___	___	Needs to e perfect		
___	___	Seems fearful and anxious		
___	___	Seems shy or timid		
___	___	Easily embarrassed		
___	___	Sensitive to criticism		
___	___	Bites fingernails or chews clothing		
___	___	Persistent refusal to go to school		
___	___	Excessive fear of interacting with other children or adults		
___	___	Persistent, excessive fear of ☐ heights ☐ closed spaces ☐ specific animals ☐ other: _______________		
___	___	Excessive anxiety concerning separation from home or from those that the child is attached.		
___	___	Excessive fear of being judged by others which causes you to avoid or get anxious in situations	OA	4
___	___	Recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.)Please list: _________		
___	___	Recurrent distressing dreams of a past event		
___	___	A sense of reliving a past upsetting event		
___	___	A sense of panic or fear to events that resemble an upsetting past event		1
___	___	Spends effort avoiding thoughts or feelings associated with a past trauma		
___	___	Persistent avoidance of activities/situations which cause remembrance of upsetting event		
___	___	Inability to recall an important aspect of a past upsetting event		
___	___	Marked decreased interest in important activities		
___	___	Feeling detached or distant from others		
___	___	Feeling numb or restricted in their feelings		
___	___	Feels that their future is shortened		3
___	___	Startles easily		
___	___	Feels like they are always watching for bad things to happen		
___	___	Marked physical response to events that remind them of a past upsetting event (i.e. sweating when getting in a car if they have been in a car accident)	PTS	2

Child General System Checklist

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Parent	Other	Descriptor		
___	___	Refusal to maintain body weight above a level most people consider healthy		
___	___	Intense fear of gaining weight or becoming fat even though underweight		
___	___	Feelings of being fat, even though underweight	AN	3
___	___	Recurrent episodes of binge eating large amounts of food		
___	___	A lack of control over eating behavior		
___	___	Engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise		
___	___	Persistent over concern with body shape and weight	BN	2
___	___	Involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking) How long have motor tics been present?_____ How often?_______ Describe: ________________________		
___	___	Involuntary vocal sounds or verbal tics (such as coughing, puffing, whistling, swearing) How How long have motor tics been present?_____ How often?_______ Describe:________________________		
___	___	Passage of feces in inappropriate places (e.g., clothing or floor).		
___	___	Bed wetting. If present, how often?________		
___	___	Delusional or bizarre thoughts (thoughts you know others would think are false)		
___	___	Seeing objects, shadows or movements that are not real		
___	___	Hearing voices or sounds that are not real		
___	___	Periods of time where your thoughts or speech were disjointed or didn't make sense to you or others		
___	___	Social isolation or withdrawal		
___	___	Severely impaired ability to function at home or at work		
___	___	Peculiar behaviors		
___	___	Lack of personal hygiene or grooming		
___	___	Inappropriate mood for the situation (i.e., laughing at sad events)		
___	___	Marked lack of initiative	PsD	3
___	___	Do they snore loudly		
___	___	Do they stop breathing when they sleep		
___	___	Do you feel fatigued or tired during the day	SA	
___	___	Do they often feel cold when others feel fine or they are warm		
___	___	Do they often feel warm when others feel fine or they are cold		
___	___	Do they have problems with brittle or dry hair		
___	___	Do they have problems with dry skin		
___	___	Do they have problems with sweating		
___	___	Do they have problems with chronic anxiety or tension	ThyA	2
___	___	Problems with social relatedness before the age of 5, either by failing to respond appropriately to others or becoming indiscriminately attached to others.		
___	___	Multiple changes in caregivers before the age of 5 years.		

Child General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent	Other	Descriptor
___	___	Impairment in communication as manifested by at least one of the following: (check those that apply) ☐ Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime ☐ In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others ☐ Repetitive use of language or add language ☐ Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
___	___	Impairment in social interaction with at least two of the following (Check those that apply) ☐ Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interactions ☐ Failure to develop peer relationships appropriate to developmental level ☐ Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest) ☐ Lack of social or emotional reciprocity
___	___	Repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (Check those that apply) ☐ Preoccupation with an area that is abnormal either in intensity or focus ☐ Rigid adherence to specific, nonfunctional routines or rituals ☐ Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements) ☐ Persistent preoccupation with parts of objects

---

Parent	Other	Descriptor	
___	___	Steals	
___	___	Bullies, threatens, or intimidates others	
___	___	Initiates physical fights	
___	___	Is cruel to animals	
___	___	Forces others into things they do not want to do (sexually or criminally)	
___	___	Sets fires	
___	___	Destroys property	
___	___	Breaks into other’s home, school or place of business	
___	___	Lies	
___	___	Stays out at night despite parental prohibitions	
___	___	Runs away over night	
___	___	Cuts school	
___	___	Doesn’t seem sorry for hurting others	CD 4

Parent	Other	Descriptor	
___	___	Negative, hostile or defiant behavior	
___	___	Loses temper	
___	___	Argues with adults	
___	___	Actively defies or refuses to comply with adults’ requests of rules	
___	___	Deliberately annoys others	
___	___	Blames others for their mistakes or misbehavior	
___	___	Touchy or easily annoyed by others	
___	___	Angry and resentful	
___	___	Spiteful or vindictive	ODD 4

Child General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent Other Descriptor

Reading

___ ___ A poor reader
___ ___ Has difficulty reading phonetically
___ ___ Has difficulty sounding out unknown words
___ ___ Does not like reading
___ ___ Makes mistakes when reading like skipping words or lines
___ ___ Read the same line twice
___ ___ Reverses letters when reading (such as b/d, p/q)
___ ___ Switch letters in words when reading (such as god and dog)
___ ___ Reading is slow or choppy
___ ___ Complains about eyestrain or fatigue
___ ___ Eyes hurt or water when reading
___ ___ Squints, blinks or rubs eyes when reading
___ ___ Is light sensitive. Bothered by bright or fluorescent lights, glare, sunlight, headlights or streetlights
___ ___ Has trouble reading words that are on white, glossy paper
___ ___ Becomes tired, experiences headaches, mood changes, feels restless or an inability to stay focused when reading
___ ___ When reading words or letters they shift, shake, blur, move, run together, disappear or become difficult to perceive.
___ ___ Has problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving
___ ___ Has problems remembering what is read even though all of the words were read
___ ___ Has difficulty understanding the main idea or identifying important details when reading

Writing

___ ___ Needs words repeated when taking spelling tests
___ ___ Poor spelling grades or test scores
___ ___ Misspells known words in written work.
___ ___ Has “messy” handwriting
___ ___ Work tends to be messy
___ ___ Prefers to print rather than writing in cursive
___ ___ Letters run into each other or there is no space between words
___ ___ Has trouble staying within lines
___ ___ Has problems with grammar or punctuation
___ ___ Has trouble copying off the board or from a page in a book
___ ___ Has trouble getting thoughts from his/her brain to the paper
___ ___ Can tell a story but cannot write it

Body Awareness/Spatial Relationships

___ ___ Has difficulty with concepts such as up, down, over or under
___ ___ Has trouble knowing left from right
___ ___ Has trouble keeping things within columns or coloring within lines
___ ___ Tends to be clumsy, uncoordinated
___ ___ Has difficulty with eye hand coordination
___ ___ Tends to bump into things when walking

Oral Expressive Language

___ ___ Stutters or other speech problems
___ ___ Has difficulty expressing self in words

Child General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent Other Descriptor

___ ___ Has trouble finding the right word to say in conversations
___ ___ Talks around a subject or trouble getting to the point in conversations
___ ___ Makes grammatical errors
___ ___ Has poor vocabulary

Receptive Language / Auditory Processing

___ ___ Mishears words
___ ___ Often asks people to repeat what is said
___ ___ Has trouble keeping up or understanding what is being said in a conversation
___ ___ Tends to misunderstand people and give them wrong answers in a conversation
___ ___ Has trouble understanding directions
___ ___ Has trouble telling which direction a sound is coming from
___ ___ Has trouble filtering out background noises

Math

___ ___ Difficulty learning math facts (adding, subtracting, multiplying and dividing)
___ ___ Poor math grades or test scores
___ ___ Difficulty learning new math concepts or operations
___ ___ Difficulty with abstract concepts and reasoning
___ ___ Makes “careless mistakes” in math
___ ___ Tends to switch numbers around
___ ___ Has difficulty with word problems

Sequencing

___ ___ Has trouble getting everything in the right order when speaking
___ ___ Has trouble telling time
___ ___ Has trouble using the alphabet in order
___ ___ Has trouble saying the months of the year in order

Abstraction

___ ___ Has trouble understanding jokes people tell
___ ___ Tends to take things too literally

Organization

___ ___ Notebook/paperwork is messy or disorganized
___ ___ Room is messy
___ ___ Tends to shove everything into the backpack, desk or closet
___ ___ Has multiple piles around the room
___ ___ Has trouble planning time
___ ___ Frequently late or in a hurry
___ ___ Often does not write down assignments or tasks and ends up forgetting what to do.

Memory

___ ___ Has trouble with memory
___ ___ Remembers things from long ago but not recent events
___ ___ It is hard to memorize things for school or work
___ ___ Knows something one day but does not remember it to the next
___ ___ Forgets what was going to say right in the middle of saying it
___ ___ Trouble following directions that have more than one or two steps

Child General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent	Other	Descriptor
Social Skills		
___	___	Has few or no friends
___	___	Has trouble reading body language or facial expressions of others
___	___	Feelings are often or easily hurt
___	___	Tends to get into trouble with friends, teachers, or parents
___	___	Feels uncomfortable around people not known well
___	___	Teased by others
___	___	Friends do not call and ask to do things with them
___	___	Does not get together with others outside of school
Sensory Integration Issues		
___	___	Seems to be more sensitive to the environment than others
___	___	More sensitive to noise than others
___	___	Particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing
___	___	Has unusual sensitivity to certain smells
___	___	Has unusual sensitivity to light
___	___	Sensitive to movement or craves spinning activities
___	___	Tends to be clumsy or accident prone

Child Brain System Checklist

Pease rate your child on each of the symptoms listed below using the following scale. If possible, please have another person (such as a caregiver or other parent) rate your child. Name of other person: ___________________

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Parent	Other	Descriptor		
___	___	Fails to give close attention to details or makes careless mistakes		
___	___	Trouble sustaining attention in routine situations (i.e. homework, chores, paperwork)		
___	___	Trouble listening		
___	___	Fails to finish things		
___	___	Poor organization for time or space (such as backpack, room, desk, paperwork)		
___	___	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort		
___	___	Loses things		
___	___	Easily distracted		
___	___	Forgetful		
___	___	Poor planning skills		
___	___	Lacks clear goals or forward thinking		
___	___	Difficulty expressing feelings		
___	___	Difficulty expressing empathy for others		
___	___	Excessive daydreaming		
___	___	Feeling bored		
___	___	Feeling apathetic or unmotivated		
___	___	Feeling tired, sluggish or slow moving		
___	___	Feeling spacey or “in a fog”		8,6,4
___	___	Fidgety, restless or trouble sitting still		
___	___	Difficulty remaining seated in situations where remaining seated is expected		
___	___	Runs about or climbs excessively in situations in which it is inappropriate		
___	___	Difficulty playing quietly		
___	___	“On the go” or acts as if “driven by a motor”		
___	___	Talks excessively		
___	___	Blurts out answers before questions have been completed		
___	___	Difficulty waiting turn		
___	___	Interrupts or intrudes on others (e.g. butts into conversations or games)		
___	___	Impulsive (saying or doing things without thinking first	<3	8,6,4
___	___	Excessive or senseless worrying		
___	___	Upset when things do not go your way		
___	___	Upset when things are out of place		
___	___	Tendency to be oppositional or argumentative		
___	___	Tendency to have repetitive negative thoughts		
___	___	Tendency toward compulsive behaviors		
___	___	Intense dislike for change		
___	___	Tendency to hold grudges		
___	___	Trouble shifting attention from subject to subject		
___	___	Trouble shifting behavior from task to task		
___	___	Difficulties seeing options in situations		
___	___	Tendency to hold on to own opinion and not listen to others		
___	___	Tendency to get locked into a course of action, whether or not it is good		
___	___	Needing to have things done a certain way or you become very upset		
___	___	Others complain that they worry too much		
___	___	Tend to say no without first thinking about question		
___	___	Tendency to predict fear	ACG	10, 7, 4

Child Brain System Checklist

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Parent	Other	Descriptor		
___	___	Frequent feelings of sadness		
___	___	Moodiness		
___	___	Negativity		
___	___	Low energy		
___	___	Irritability		
___	___	Decreased interest in others		
___	___	Decreased interest in things that are usually fun or pleasurable		
___	___	Feelings of hopelessness about the future		
___	___	Feelings of helplessness or powerlessness		
___	___	Feeling dissatisfied or bored		
___	___	Excessive guilt		
___	___	Suicidal feelings		
___	___	Crying spells		
___	___	Lowered interest in things usually considered fun		
___	___	Sleep changes (too much or too little)		
___	___	Appetite changes (too much or too little)		
___	___	Chronic low self-esteem		
___	___	Negative sensitivity to smells/odors	DLS	10,7,4

Parent	Other	Descriptor		
___	___	Frequent feelings of nervousness or anxiety		
___	___	Panic attacks		
___	___	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)		
___	___	Periods of heart pounding, rapid heart rate or chest pain		
___	___	Periods of trouble breathing or feeling smothered		
___	___	Periods of feeling dizzy, faint or unsteady on their feet		
___	___	Periods of nausea or abdominal upset		
___	___	Periods of sweating, hot or cold flashes		
___	___	Tendency to predict the worst		
___	___	Fear of dying or doing something crazy		
___	___	Avoid places for fear of having an anxiety attack		
___	___	Conflict avoidance		
___	___	Excessive fear of being judged or scrutinized by others		
___	___	Persistent phobias		
___	___	Low motivation		
___	___	Excessive motivation		
___	___	Tics (motor or vocal)		
___	___	Poor handwriting		
___	___	Quick startle		
___	___	Tendency to freeze in anxiety provoking situations		
___	___	Lacks confidence in their abilities		
___	___	Seems shy or timid		
___	___	Easily embarrassed		
___	___	Sensitive to criticism		
___	___	Bites fingernails or picks skin	BG	10,7,4

Child Brain System Checklist

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Parent	Other	Descriptor
___	___	Short fuse or periods of extreme irritability
___	___	Periods of rage with little provocation
___	___	Often misinterprets comments as negative when they are not
___	___	Irritability tends to build, then explodes, then recedes, often tired after a rage
___	___	Periods of spaciness or confusion
___	___	Periods of panic and/or fear for no specific reason
___	___	Visual or auditory changes, such as seeing shadows or hearing muffled sounds
___	___	Frequent periods of déjà vu (feelings of being somewhere you have never been)
___	___	Sensitivity or mild paranoia
___	___	Headaches or abdominal pain of uncertain origin
___	___	History of head injury or family history of violence or explosiveness
___	___	Dark thoughts, may involve suicidal or homicidal thoughts
___	___	Periods of forgetfulness or memory problems

TL 8,6,4