

# Western Mental Health Center

## Child Checklist of Characteristics

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Person completing this form: \_\_\_\_\_

Please review this checklist, which contains concerns (as well as positive traits), and mark any items that describe your child. Feel free to add any others at the end under "any other characteristics."

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices  
in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating - poor manners, refuses, appetite increase or decrease, odd combination, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around", has only younger playmates
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties - truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental Retardation

- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor — competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors — biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual — sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemy, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics — involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothing
- Work problems, employment, workaholic/overworking, can't keep a job

Any other characteristics:

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Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?

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*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.*

# Adverse Childhood Experience (ACE) Questionnaire

## Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...  
Swear at you, insult you, put you down, or humiliate you?  
**or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes No If yes enter 1 \_\_\_\_\_
  
2. Did a parent or other adult in the household **often** ...  
Push, grab, slap, or throw something at you?  
**or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes No If yes enter 1 \_\_\_\_\_
  
3. Did an adult or person at least 5 years older than you **ever**...  
Touch or fondle you or have you touch their body in a sexual way?  
**or**  
Try to or actually have oral, anal, or vaginal sex with you?  
Yes No If yes enter 1 \_\_\_\_\_
  
4. Did you **often** feel that ...  
No one in your family loved you or thought you were important or special?  
**or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No If yes enter 1 \_\_\_\_\_
  
5. Did you **often** feel that ...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No If yes enter 1 \_\_\_\_\_
  
6. Were your parents **ever** separated or divorced?  
Yes No If yes enter 1 \_\_\_\_\_
  
7. Was your mother or stepmother:  
**Often** pushed, grabbed, slapped, or had something thrown at her?  
**or**  
**Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?  
**or**  
**Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
  
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
  
9. Was a household member depressed or mentally ill or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
  
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_

Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score

# Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

**Please turn over - there are a few more questions on the other side**

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Mother/Father/Other (please specify:)

**Thank you very much for your help**

CLIENT# \_\_\_\_\_

PRIMARY CARE SCREENER

1. \*\*Are you currently receiving Palliative (Pain management) care? Yes or No
2. \*\*BMI Percentile (ages <20 years): \_\_\_\_\_%
3. Do you have a primary care provider? Yes or No
  - a. Who? \_\_\_\_\_
  - b. Last time seen: Date: \_\_\_\_\_
4. Do you have a history of asthma or shortness of breath? Yes or No
  - a. Rating:
    - i. Normal
    - ii. Concerned
    - iii. Panic Attack
  - b. When was your last onset of shortness of breath?
    - i. Date: \_\_\_\_\_
5. Are you over 50 and had a colonoscopy? Yes or No If yes, when: Date: \_\_\_\_\_
6. Are you over 40 and had a mammogram? Yes or No If yes, when: Date: \_\_\_\_\_
7. Do you have any medical concerns or symptoms:

Height: \_\_\_\_\_  
Weight: \_\_\_\_\_

8. Do you have any chronic/ongoing medical problems:

9. \*\*Are you currently pregnant? Yes or No
10. Are you currently using contraception? Yes or No
11. Blood pressure Guide
  - a. If 140-90 and no factors give handout
  - b. If 180-100 refer to primary care physician
  - c. If 150/85 refer to primary care physician
  - d. If 130/80 and have heart disease and diabetes refer to primary care physician