

<b>Attention/Hyperactive Concerns:</b>	
<input type="checkbox"/> Difficulty focusing/concentrating/paying attention <input type="checkbox"/> Problem listening when spoken to directly <input type="checkbox"/> Easily distracted with moments of forgetfulness <input type="checkbox"/> Avoids tasks that require sustained mental effort <input type="checkbox"/> Frequently daydreams <input type="checkbox"/> Extremely disorganized or constantly loses things <input type="checkbox"/> Poor "follow through" and doesn't complete tasks	<input type="checkbox"/> Constantly touching things <input type="checkbox"/> Unable to sit still for extended periods of time <input type="checkbox"/> Unable to engage in activities quietly <input type="checkbox"/> Always on the go or seems driven by a motor <input type="checkbox"/> Talks excessively or blurts out thoughts/answers <input type="checkbox"/> Constantly interrupts other people's conversations <input type="checkbox"/> Extremely impatient with self and/or others
<b>Cognitive Concerns:</b>	
<input type="checkbox"/> Inconsistent processing of information <input type="checkbox"/> Unable to consistently follow conversations <input type="checkbox"/> Problem reading/processing "visual" information	<input type="checkbox"/> Problem listening/processing "verbal" information <input type="checkbox"/> Modest cognitive decline from previous level <input type="checkbox"/> Significant cognitive decline from previous level
<b>Educational/Learning Concerns:</b>	
<input type="checkbox"/> Has or in need of an IEP <input type="checkbox"/> Fails to complete/submit assignments <input type="checkbox"/> Difficulty comprehending certain subjects <input type="checkbox"/> Easily frustrated with school work and "shuts-down" <input type="checkbox"/> Acts as the "class clown"/plays too much at school	<input type="checkbox"/> Removed from class for "disruptive" behavior <input type="checkbox"/> Removed from class for "aggressive" behavior <input type="checkbox"/> Walks out of the classroom without permission <input type="checkbox"/> Failed a class or had to repeat a grade <input type="checkbox"/> Decline in grades from previous year(s)
<b>Emotional Concerns:</b>	
<input type="checkbox"/> Emotionally immature for age <input type="checkbox"/> Easily frustrated & shuts-down when overwhelmed <hr/> <input type="checkbox"/> Mildly angry for no particular reason <input type="checkbox"/> Moderate/severe anger for no particular reason <hr/> <input type="checkbox"/> Mildly depressed for no particular reason <input type="checkbox"/> Moderate/severe depression for no reason	<input type="checkbox"/> "Over the top" emotional reaction to things <input type="checkbox"/> Frequent mood swings without any specific reason <hr/> <input type="checkbox"/> Mildly anxious for no particular reason <input type="checkbox"/> Moderate/severe anxiety for no particular reason <hr/> <input type="checkbox"/> Mildly irritable for no particular reason <input type="checkbox"/> Moderate/severe irritability for no particular reason
<input type="checkbox"/> Angry because of a specific situation (specify):	
<input type="checkbox"/> Anxious because of a specific situation (specify):	
<input type="checkbox"/> Depressed because of a specific situation (specify):	
<input type="checkbox"/> Irritable because of a specific situation (specify):	
<b>Behavioral Concerns:</b>	
<input type="checkbox"/> Violates rules of home and/or school <input type="checkbox"/> Argumentative and/or defiant with parents/authority <input type="checkbox"/> Blames others for mistakes or misbehavior <input type="checkbox"/> Strong behavioral reaction to a specific situation <input type="checkbox"/> Lies and/or steals "constantly"  <input type="checkbox"/> Tendency to be "sneaky" and/or manipulative <input type="checkbox"/> Tendency to exploit or "take advantage" of others <input type="checkbox"/> Shows little remorse for aggressive behaviors <input type="checkbox"/> Vindictive or malicious behavior <input type="checkbox"/> Gang involvement/affiliation <hr/> <input type="checkbox"/> Recurrent physical aggression against <b>peers</b> <input type="checkbox"/> Recurrent verbal aggression against peers <input type="checkbox"/> Recurrent physical aggression against <b>adults</b> <input type="checkbox"/> Recurrent verbal aggression against adults <hr/> <input type="checkbox"/> Recurrent physical aggression against <b>family</b> <input type="checkbox"/> Recurrent verbal aggression against family <hr/> <input type="checkbox"/> Disproportionate rage/tantrums without reason <input type="checkbox"/> Highly upset/rageful when routine is disrupted <input type="checkbox"/> Takes time for rage/tantrums to "calm down" <input type="checkbox"/> Destroys own/others property while angry/rageful	<input type="checkbox"/> Suicidal thoughts/attempts (past) <input type="checkbox"/> Suicidal thoughts/attempts (current) <input type="checkbox"/> Homicidal thoughts/attempts (past) <input type="checkbox"/> Homicidal thoughts/attempts (current) <input type="checkbox"/> Cutting/self-harming (past) <input type="checkbox"/> Cutting/self-harming (current) <input type="checkbox"/> Threatened/used a weapon on another person  <input type="checkbox"/> History of poor choices/judgment <input type="checkbox"/> History of impulsive or "risky" behaviors <input type="checkbox"/> History of running away/leaving without permission <input type="checkbox"/> History of setting/fascination with fires <input type="checkbox"/> History of sexual promiscuity/acting out  <input type="checkbox"/> History of bullying/threatening/intimidating others <input type="checkbox"/> History of physical cruelty to people and/or animals <input type="checkbox"/> History of illegal activities  <input type="checkbox"/> Can control emotions and/or behaviors with some people/setting, BUT chooses to not control in other settings or with certain people  <input type="checkbox"/> Significant behavioral change from medication <input type="checkbox"/> Significant behavioral change from substances <input type="checkbox"/> Significant behavioral change from head injury <input type="checkbox"/> Significant behavioral change from medical txmt
<b>Socialization/Relationship Concerns:</b>	
<input type="checkbox"/> Difficulty socializing with peers <input type="checkbox"/> Difficulty expressing emotions with others <input type="checkbox"/> Difficulty expressing thoughts to peers/other people <input type="checkbox"/> Difficulty understanding relationship "nuances" <input type="checkbox"/> Difficulty understanding other's nonverbal behavior <input type="checkbox"/> Difficulty attaching/seeking comfort from others	<input type="checkbox"/> Overly "friendly" with unknown or unfamiliar people <input type="checkbox"/> Prefers playing alone/parallel/imaginative friends <input type="checkbox"/> Victim of bullying/teasing by peers/other people <input type="checkbox"/> Ongoing relationship problems w/ peer(s) <input type="checkbox"/> Ongoing relationship problems w/ family member <input type="checkbox"/> Ongoing relationship problems with adults/authority

<b>Developmental Concerns:</b>	
<input type="checkbox"/> Significant developmental delays <input type="checkbox"/> Significant deficits in intellectual functions <input type="checkbox"/> Significant problems with "life-skills" <input type="checkbox"/> Significant speech/language/motor-skill delays <input type="checkbox"/> Extreme difficulty separating from home/guardian <input type="checkbox"/> Difficulty attaching to parent/guardian <input type="checkbox"/> Stereotypic behaviors (hand-flapping, rocking) <input type="checkbox"/> Requires constant supervision <input type="checkbox"/> Excessive picking of skin, pulling of hair, biting nails	<input type="checkbox"/> Enuresis (peeing/self) or encopresis (pooping/self) <input type="checkbox"/> Motor and/or verbal tics <input type="checkbox"/> Unusual eating habits <input type="checkbox"/> Unusual sleeping habits or disturbing dreams <input type="checkbox"/> Easily fixated on certain object or person <input type="checkbox"/> Insistence on "sameness" or not changing routines <input type="checkbox"/> Sensory hypersensitivity OR hyposensitivity <input type="checkbox"/> History of head injury/seizures <input type="checkbox"/> Nightmares/night terrors
<b>Trauma Concerns:</b>	
<input type="checkbox"/> Current exposure to traumatic event/person <input type="checkbox"/> Intrusive thoughts of past traumatic event/person <input type="checkbox"/> Nightmares of past traumatic event/person <input type="checkbox"/> Flashbacks of past traumatic event/person <input type="checkbox"/> Emotional distress at exposure to event/person <input type="checkbox"/> Physical reaction at exposure to event/person	<input type="checkbox"/> Avoidance of distressing thoughts/feelings <input type="checkbox"/> Unable to remember aspect of event/person <input type="checkbox"/> Ongoing negative emotions regarding event/person <input type="checkbox"/> Ongoing negative expectations about self/others <input type="checkbox"/> Hypervigilance and/or "startle" reaction <input type="checkbox"/> Pervasive sleep and/or concentration difficulty
<b>Psychosocial Concerns:</b>	
<input type="checkbox"/> Social Services involvement (past or present) <input type="checkbox"/> Out-of-home placement(s) <input type="checkbox"/> Family violence (past, present, or both) <input type="checkbox"/> Family history of mental health issues <input type="checkbox"/> Major change with client/family during past year <input type="checkbox"/> Major change with client during past 2-3 years <input type="checkbox"/> Problems related to family upbringing <input type="checkbox"/> Problems related to support system	<input type="checkbox"/> Problems related to legal/court system <input type="checkbox"/> Problems related to access to psychiatric care <input type="checkbox"/> Problems related to employment/finances <input type="checkbox"/> Noncompliance with medical/psychiatric treatment <input type="checkbox"/> History of child abuse (physical, emotional, sexual) <input type="checkbox"/> History of child neglect (physical, emotional, medical) <input type="checkbox"/> History of adult abuse (physical, emotional, sexual) <input type="checkbox"/> History of adult neglect (physical, emotional, medical)
<b>Distorted Thoughts/Perceptual Concerns:</b>	
<input type="checkbox"/> Current hallucinations or delusional thoughts <input type="checkbox"/> Significant deterioration in daily functioning <input type="checkbox"/> Significantly disorganized thoughts ("crazy-talk") <input type="checkbox"/> Significantly diminished emotional expression <input type="checkbox"/> History of hallucinations or delusional thoughts	<input type="checkbox"/> Thought/perceptual distortions from medication <input type="checkbox"/> Thought/perceptual distortions from substances <input type="checkbox"/> Thought/perceptual distortions from head injury <input type="checkbox"/> Thought/perceptual distortions from medical <input type="checkbox"/> Thought/perceptual distortions from cognitive
<b>Obsessions/Idiosyncratic Behaviors:</b>	
<input type="checkbox"/> Persistent obsessions, thoughts/urges/addictions <input type="checkbox"/> Persistent compulsions/repetitive behaviors	<input type="checkbox"/> Persistent/compulsive eating patterns <input type="checkbox"/> Persistent/unusual body image issues
<b>Dissociative, Conversions, Somatization Concerns:</b>	
<input type="checkbox"/> Two/more distinctly different personalities <input type="checkbox"/> Unexplained memory gaps of events/people <input type="checkbox"/> Persistent detachment from self/situation	<input type="checkbox"/> Excessive thoughts/behavior related to health issues <input type="checkbox"/> Altered motor/sensory function w/out medical data <input type="checkbox"/> Fictitious (made-up) physical/psychological distress
<b>Sexual Concerns:</b>	
<input type="checkbox"/> Sexual arousal from watching unsuspecting person <input type="checkbox"/> Sexual arousal from exposing one's genital <input type="checkbox"/> Sexual arousal from touching unsuspecting person	<input type="checkbox"/> Sexual arousal/behaviors involving a younger child <input type="checkbox"/> Sexual arousal from nonliving object(s) <input type="checkbox"/> Hypersexual/Hyposexual urges
<b>Substance Abuse/Dependency Concerns:</b>	
<input type="checkbox"/> Persistent/increased alcohol usage or pattern <input type="checkbox"/> Persistent/increased drug usage or pattern <input type="checkbox"/> Persistent/increased medication usage or pattern	<input type="checkbox"/> History of alcohol abuse/dependency <input type="checkbox"/> History of drug abuse/dependency <input type="checkbox"/> History of medication abuse/dependency
<b>Therapeutic Treatment:</b>	
<input type="checkbox"/> Currently in therapy <input type="checkbox"/> Currently on psychiatric medication <input type="checkbox"/> Currently in residential or out-of-home placement	<input type="checkbox"/> Previous residential or out-of-home placement <input type="checkbox"/> Previous psychiatric hospitalization <input type="checkbox"/> Previous psychological or educational evaluation