CORNERSTONE WELLNESS CENTER

PARENT CHECKLIST

CHILD'S NAME: _____ DATE: _____ COMPLETED BY:_____

Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Often has difficulty following through on instructions			
Often has difficulty sustaining attention (e.g. tasks, lectures, or conversations)			
Often has difficulty listening			
Often loses things necessary for tasks (e.g., school materials, glasses, cellphones)			
Often fails to pay close attention to details; makes careless mistakes in school and/or work			
Often is disorganized (e.g. managing sequencial tasks, poor time management, messy)			
Often seems to be forgetful (chores, homework, keeping appointments)			
Often dislikes tasks that require sustained mental effort			
Often distracted by extraneous stimuli (may include unrelated thoughts)			
Often has difficulty waiting turn (e.g., waiting in line)			
Often interrupts or intrudes on others (e.g. uses others things without asking, take over for others)			
Often blurts out answers to questions/ difficulty waiting for turn in conversation			
Often has difficulty playing or engaging in leisure activities quietly			
Often leaves seat in which being seated is expected			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Often runs about or climbs excessively, or restlessness			
Often talks excessively			
Often fidgets with hands or feet or squirms in seat			
Often acts as if "driven by a motor" and cannot remain still			
Often bullies, threatens or intimidates others			
Often initiates physical fights			
Has used a weapon that can cause physical harm to others			
Has been physically cruel to people			
Has been physically cruel to animals			
Has stolen while confronting a victim			
Has forced someone into sexual activity			
Has deliberately engaged in fire setting with the intention of causing serious damage			
Has deliberately destroyed other's property			
Has broken into a house, car or building			
Cons others; Lies to avoid responsibilites or to obtain goods or favors			
Has stolen an item of nontrivial value without confronting the victim (i.e., shoplifting)			
Stays out at night despite parent disapproval			
Has run away from home twice briefly, or once for a lengthly time			
Is truant from school, beginning before age 13			
Often loses temper			
Has been spiteful or vindicative twice in the last six months			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Is often angry and resentful			
Often argues with adults or authority figures			
Often actively defies or refuses to comply with authority figure requests or rules			
Often blames others for his or her mistakes or behavior			
Easily annoyed by others, or touchy			
Often deliberately annoys others			
Excessive distress when separates from attachment figure			
Persistent worry losing attachment figure to illness, injury or death			
Excessive worry about getting lost, being kidnapped, having an accident			
Refusal to go to school because afraid to separate from attachment figure			
Excessive fear of being alone without attachment figure			
Refusal to go to sleep without being near attachment figure			
Nightmares about separation			
Physical complaints (headaches, stomachaches or other body aches) when separated from attachment figure			
Depressed mood (feels sad)			
Irritability			
Decreased pleasure in activities			
Significant problems with appetite (if yes please specify)			
Sleeps too little or too much (if yes please specify)			
Observably agitated, or subdued (if yes please specify)			
Loss of energy			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Feelings of worthlessness			
Feeling guilt easily			
Diminished ability to concentrate			
Difficulty making decisions			
Thoughts of death or suicide			
Low self-esteem (doesn't like self)			
Feelings of hopelessness			
Social difficulties with:			
Eye Contact			
Reading Facial Expressions			
Understanding and use of body language/ tone of voice			
Lack of facial expressions			
Difficulty sharing interests/emotion or affect			
Difficulty of developing, understanding or maintaining relationships			
Difficulties in adjusting behavior to fit varous social contexts			
Absense of interest in friendships			
Lack of make believe play or social imitation to appropriate developmental level			
Difficulty with "normal" back and forth conversation			
Lack of spontaneous sharing of emotions or interests			
Difficulty with empathy			
Difficulty with cooperative play			
Failure to initiate or respond to social interactions (please specify)			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Insistence on sameness in routines, foods, rigid thinking patterns, extreme distress to small changes, transitions			
Focusing on a narrow range of patterns of interests that is abnormal in either intensity or focus (if yes please specify)			
Repetitive motor mannerisms (e.g., use of objects)			
Repetitive use of words or phrases			
Sensitive or indifference to pain/temperature			
Specific sounds, extreme annoyance			
Sensitivity to textures of food			
Excessive smelling or touching of objects			
Visual fascination with lights, movement			
Aversion to the feel of clothing			
Aversion to touch from others			
Problems with coordination or fine motor skills (if yes please specify)			
Excessive worry			
Excessive nervousness			
Easily tired			
Restlessness/ keyed up			
Difficulty concentrating/mind going blank			
Irritability			
Muscle tension			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Sleep disturbance			
Anxiety in social situations (e.g., conversations, meeting new people, being evaluated)			
Abrupt occurring of the following during tantrums or high stress			
Pounding or rapid heart beat			
Sweating			
Trembling or shaking			
Shortness of breath			
Feelings of choking			
Chest pain or discomfort			
Nausea or stomachache			
Feeling dizzy or lightheaded			
Chills or feeling hot			
Numbness or tingling			
Feelings that things aren't real			
Feeling detached from oneself			
Fear of losing control or going crazy			
Fear of dying			
Obsessive:			
Fear of being responsible for things going wrong			
Fear that something terrible may happen (e.g., fire, burgulary, dealth of a loved one, becoming ill) if yes please specify			
Concern with dirt or germs			
Hoarding or collecting (if yes please specify)			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Need for symmetry or exactness			
Compulsions:			
Counting			
Checking and rechecking			
Health including weight			
Need to ask questions			
Need to touch			
Recurrent pulling of his/her hair resulting in hair loss			
Preoccupation with perceived flaws in physical appearance including repetitive behaviors (e.g., mirror checking, skin picking, comparing appearance to others)			
Motor tics (e.g., eye blinking, shoulder shrugging, facial movements)			If yes, specify onset
Vocal tics (e.g., throat clearing, sniffling, or grunting; repeating the last heard word or phrase)			If yes, specify onset
Rarely or minimally seeks comfort when physically or emotionally hurt			
Rarely or minimally reponds to comfort when physically or emotionally hurt			
Infrequent social and emotional reponsiveness to others			
Limited expressions of happiness			
Irritability, sadness, or fear even during nonthreatening interactions with caregivers			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Lack of fear when approaching or interacting with unfamiliar adults			
When interacting with unfamiliar adults does not have appropriate verbal or physical boundaries			
Does not check back with adults after venturing away in unfamiliar settings			
Willingness to go off with an unfamiliar adult with little hesitation			
Severe temper outbursts: verbal or physical (if yes; frequency?)			
Daydreaming			
Trouble staying awake/alert			
Mentally foggy/easily confused			
Stares a lot			
Spacey, mind is elsewhere			
Lethargic			
Under-active			
Slow-moving/sluggish			
Doesn't process questions or explanations accurately			
Drowsy/sleepy appearance			
Lost in thoughts			
Slow to complete tasks			
Lacks initiative/effort fades			
Difficulty in achievement in the following areas:			
Math computation			
Math reasoning			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Letter/word recognition			
Reading fluency			
Reading comprehension			
Written expression			
Spelling			
Exposure to actual or threatening death, serious injury, or sexual abuse in one or more of the following ways:			
Directly experiencing the trauma			
Personally witnessing the trauma			
Finding out about a traumatic event experienced by a friend or family member			
Repeated exposure to details of traumatic events (e.g. frequently learning about child abuse)			
Recurrent involuntary distressing memories			
Recurrent distressing dreams			
Flashbacks (i.e., feels as if the traumatic event is reoccuring)			
Physical and psychological distress at situations that remind			
Avoidance of memories, thoughts or feelings about the event			
Avoidance of people, places, conversations, activities, objects or			
Inability to remember an important aspect of the event			
Negative beliefs about self or others about the event (if yes please specify)			
Distorted thoughts about the event that cause the person to blame self or others			
Persistent anger, fear, shame, sadness, guilt			
Less interested in activites			

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Please indicate yes or no if any of the following have been a significant problem for over a 6-month period, please do not mark in the middle:	YES	NO	COMMENTS
Feeling detached from others			
Inability to experience positive emotions such as love and happiness			
Angry outbursts			
Self-destructive behavior			
Overly aware of his/her environment			
Easily startled			
Problems with concentration			
Sleep disturbances			
Restriction of food intake leading to low body weight			
Intense fear of gaining weight or becoming fat			
Recurrent episodes of binge eating			
Lack of control over eating			
Compensatory behaviors			
Vomiting			
Misuse of laxatives			