family medical center of michigan

Joint Commission on Accreditation of Healthcare Organizations

Patient's Name: _____

Today's Date: _____

Please review the following checklist. Check the ones that **your child** is experiencing:

____ Disrupted eating pattern (too much or not enough)

____ Disrupted sleeping pattern (too much or not enough)

____ Crying

____ Sadness

____ Low energy level

____ Fatigue

____ Low motivation

____ Low self-esteem

____ Poor Concentration

____ Difficulty making decisions

____ Hopelessness

____ Headaches

____ Nausea / Stomachaches

____ Nervousness

____ Fearfulness

____ Mood Swings

____ Anger

____ High energy level

____ Impulsiveness

____ Easily Distracted

____ Racing thoughts

____ Difficulty in school / work

8765 Lewis Avenue, Temperance, MI 48182 Phone (734) 847-3802 Fax (734) 847-3418

family medical center of michigan

Joint Commission
on Accreditation of Healthcare Organizations

____ Helplessness

____Decreased interest in activities

____ Thoughts of hurting self

____ Thoughts of hurting others

____ Irritability

____ Overwhelmed

____ Frustration

____ Excessive worrying

____ Restlessness

____ Muscle tension

____ Panic attacks

____ Isolation

____ Difficulty following directions

____ Difficulty completing tasks

____ Poor organization

____ Forgetfulness

____ Fidgeting

____ Difficulty remaining seated

____ Impatience

____ Procrastination

____ Talking excessively

____ Interrupting

____ Becoming bored easily

____ Losing items

____ Nightmares

____ Flashbacks

Checklist completed by: _____ Date: _____

Reviewed by: _____Date:_____

8765 Lewis Avenue, Temperance, MI 48182 Phone (734) 847-3802 Fax (734) 847-3418