



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) | _____ Headaches |
| _____ Disrupted sleeping pattern
(too much or not enough) | _____ Nausea / Stomachaches |
| _____ Crying | _____ Nervousness |
| _____ Sadness | _____ Fearfulness |
| _____ Low energy level | _____ Mood Swings |
| _____ Fatigue | _____ Anger |
| _____ Low motivation | _____ High energy level |
| _____ Low self-esteem | _____ Impulsiveness |
| _____ Poor Concentration | _____ Easily Distracted |
| _____ Difficulty making decisions | _____ Racing thoughts |
| _____ Hopelessness | _____ Difficulty in school / work |



- | | |
|--------------------------------------|---------------------------------|
| ___ Helplessness | ___ Difficulty completing tasks |
| ___ Decreased interest in activities | ___ Poor organization |
| ___ Thoughts of hurting self | ___ Forgetfulness |
| ___ Thoughts of hurting others | ___ Fidgeting |
| ___ Irritability | ___ Difficulty remaining seated |
| ___ Overwhelmed | ___ Impatience |
| ___ Frustration | ___ Procrastination |
| ___ Excessive worrying | ___ Talking excessively |
| ___ Restlessness | ___ Interrupting |
| ___ Muscle tension | ___ Becoming bored easily |
| ___ Panic attacks | ___ Losing items |
| ___ Isolation | ___ Nightmares |
| ___ Difficulty following directions | ___ Flashbacks |

Checklist completed by: _____ Date: _____

Reviewed by: _____ Date: _____