CENTER FOR HUMAN DEVELOPMENT

Client Checklist
Child & Adolescent

Name: _____

	YES	NO	When last experienced	How often?	When problem began
1. Trouble remembering things					
2. Spells of sudden fear that did not make sense					
3. Trouble doing your school work					
4. Appetite changes					
5. Unusual experiences that are hard to explain					
6. Feeling like you were someone else					
7. Thoughts of dying					
8. Wanting to run away					
9. Someone thinks you drink too much or take too many drugs					
10. Being in too many arguments					
11. Avoiding things or places which most people do not avoid					
12. Being in trouble with parents or school authorities					
13. Not getting along with friends, classmates or teachers					
14. Feeling Nervous or worried					
15. Increased stresses in your life					
16. Sad mood					
17. Irritability, easily annoyed					
18. Anger outbursts/rageful					
19. Poor concentration or can't turn your head off					
20. Sleep problems or nightmares/night terrors, can't get to sleep					
21. Low energy/trouble getting through the day					
22. Feeling disappointment in yourself					
23. Headaches					
24. Shortness of breath, chest pains, can't catch your breath					
25. Dizziness, numbness					
26. Trembling/unusual sweating					
27. Nausea, diarrhea, abdominal pains					
28. Pains					
29. Bullying or harmed by anyone					
30. Concerned about your sexuality					
31. History of head injury					
32. Has anyone inappropriately touched you?					
33. Has anyone hurt you?					
34. Other (specify)					

Medications or supplements currently taken	**Dosage**	**For**	**Prescribed by**

Signature _____ **Date** _____