

PARENT CHECKLIST

(To be completed by the parent or legal guardian of young children)

Child's Name: _____ **Age:** _____

Race/Ethnicity: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip** _____

Home Phone: _____

School: _____ **Grade:** _____ **Special Ed?** Yes No

Child is Living With: _____ **Relationship to Child:** _____

Person Completing Form: _____

Father's Name: _____ **SS#:** _____

Race/Ethnicity: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip** _____
(If different from above)

Home Phone: _____

Father's Marital Status (check one):

- Single Married Separated Divorced Remarried Widowed

Father's Employer: _____ **Work Phone:** _____

Mother's Name: _____ **SS#:** _____

Race/Ethnicity: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip** _____
(If different from above)

Home Phone: _____

Mother's Marital Status (check one):

- Single Married Separated Divorced Remarried Widowed

Mother's Employer: _____ **Work Phone:** _____

Other Children in the Home: _____

Developmental Information

My child has experienced the following number of changes in residence in their lifetime:

- Less than 2 3-6 6 or more

My child has always lived with me: Yes No

There were complications during pregnancy with my child: Yes No

If yes, please explain: _____

There were complications during or immediately after my child's birth: Yes No

If yes, please explain: _____

My child's progress in developing the following skills was:

Sitting Up Slow Average Fast

Crawling Slow Average Fast

Walking Slow Average Fast

Talking Slow Average Fast

Toilet Training Slow Average Fast

Has your child had/have any major accidents, illnesses, hospitalizations or surgeries? Yes No

If yes, please explain: _____

Does your child have allergies? Yes No

If yes, please explain: _____

My child has used prescribed medication for emotional problems: Yes No

My child is currently taking medication: Yes No

Types: _____ Physician: _____

My child, before age 5, was:

- | | | |
|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Active | <input type="checkbox"/> Distant |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Passive | <input type="checkbox"/> Affectionate |

Relationships

In general, my child gets along with (check one for each):

- | | | | |
|---------------------|-------------------------------|-------------------------------|-------------------------------|
| Bothers and sisters | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Friends | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Parents | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Other adults | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

School Information

What grades does your child usually receive?

- A's B's C's D's F's

My child had behavior problems in school in the following grade(s) (include truancy):

- K 1-3 4-6 7-9 10-12

My child had academic (reading, writing, math ...) problems in school in the following grades:

- K 1-3 4-6 7-9 10-12

My child has repeated the following grade(s): _____

My child was tested by the school for special education needs: Yes No

My child: Is Has been in Special Education classes
 LD ED CD

Community Information

My child has had more than one police contact: Yes No

If yes, age of first contact: _____

Some other members of our family also have had police contact: Yes No

My child has appeared in court on other charges: Yes No

My child has received counseling: Yes No

If yes, when and where: _____

My child has been hospitalized for psychiatric problems: Yes No

My child uses drugs or alcohol: Yes No

My child has outside interests and hobbies: Yes No

My child is best described as: Leader Follower

My child's friends are a positive influence: Yes No

My child makes friends easily: Yes No

My child has long lasting friendships: Yes No

Family Information

Someone in our family has been sexually abused: Yes No

Someone in our family has been physically abused: Yes No

My child has been exposed to violence within the home: Yes No

The adults in our family share in discipline of the child(ren): Yes No

The adults in our family agree on the right way to raise children: Yes No

My child has been exposed to too much yelling, arguing and fighting at home: Yes No

The adults in our home are able to talk over problems and agree on solutions: Yes No

Some other family member has had a serious illness or injury: Yes No

Some other family member has been hospitalized for psychiatric problems: Yes No

An adult in our family has or does use alcohol, illicit drugs or prescription drugs in a way that has been harmful to our family: Yes No

Behavior Checklist

The following traits describe my child (check those that apply):

- Follow directions
- Does chores
- Neat personal appearance
- Attends school
- Outgoing/friendly
- Interacts with family
- Tolerates frustration
- Trustworthy
- Truthful

- Sleep disturbances
- Nightmares
- Bed wetting
- Excessive sleeping
- Temper outbursts
- Impolite/rude
- Does not do chores
- Rebellious
- Easily frustrated
- Defensive
- Swears
- Argumentative
- Hostile
- Irritable
- Moody
- Feels worthless
- Whines
- Passive
- Poor diet/nutrition
- Sexual problems
- Stealing (from home or others)
- Anxious/tense

- Energetic
- Keeps curfew
- Has many interests
- Polite
- Talks about feelings
- Responsible
- Patient
- Easy going

- Over-active
- Concentration problems
- Restless, fidgety
- Brags
- Impulsive
- Loss of energy
- Insecure
- Puts self down
- Withdrawn
- Poor appetite
- Suicidal thoughts
- Suicide attempts
- Cries easily
- Loss of interest in activities
- Impatient
- Curfew violations
- Lying
- Fearful
- Complaining
- Feels overwhelmed
- Shy
- Polite