STEPPING STONES COUNSELING CENTER, LLC

CLIENT CHECKLIST – CHILD

Name:_____ Date:_____

Trouble remembering things?	Yes	No
Times of sudden fear that did not make sense?	Yes	No
Trouble doing your school work?	Yes	No
Appetite Changes?	Yes	No
Unusual experiences which are hard to explain?	Yes	No
Feelings like you were someone else?	Yes	No
Thoughts of dying/wanting to run away?	Yes	No
Someone thinks you drink too much or take too many drugs?	Yes	No
Being in too many arguments?	Yes	No
Avoiding things or places which most people do not avoid?	Yes	No
Being in trouble with your parents or school authorities?	Yes	No
Feeling keyed up or on edge, nervous or worried?	Yes	No
Having strange thoughts that won't go away?	Yes	No
Not getting along with friends, classmates, teachers?	Yes	No
Increased stressors in your life?	Yes	No
Sad mood?	Yes	No
Irritability, easily annoyed?	Yes	No
Anger outbursts/rageful?	Yes	No
Poor concentration or you can't turn your head off?	Yes	No
Sleep problems/nightmares/night terrors?	Yes	No
Low energy/trouble getting through the day?	Yes	No
Feeling disappointed in yourself?	Yes	No
Headaches?	Yes	No
Shortness of breath, chest pains, can't catch your breath?	Yes	No
Dizziness, numbness?	Yes	No
Trembling/unusual sweating?	Yes	No
Nausea, diarrhea, abdominal pains?	Yes	No
Pains?	Yes	No
Bullying or harmed by anyone?	Yes	No

Other? Please specify:_____