Olive Tree Counseling, Inc.

1981 E. Palmer-Wasilla Hwy. Suite 220, Wasilla, Alaska 99654
Phone: 907-357-6513 Fax: 907-357-6514

Child Checklist of Characteristics

Child's Name: _______________________________________ Date: _______________ Child's Age: ______

Person completing this form: ________________________ Relationship to child________________________

This form is to be completed by parents for their children. Please mark all the items that apply to this child.

1. ___ Aggressive to people and animals (intimidation or physically cruel)
2. ___ Destruction of property
3. ___ Deceitfulness(lies) or theft
4. ___ Serious violation of rules (runs away, truant from school, started staying out all night before age 13)
5. ___ Often loses temper
6. ___ Often argues with adults
7. ___ Often defies or refused to comply with adults' requests or rules
8. ___ Often deliberately annoys people
9. ___ Often blames other for his or her mistakes or misbehavior
10. ___ Often touchy or easily annoyed by others
11. ___ Often angry and resentful
12. ___ Often spiteful or vindictive
13. ___ Often fails to give close attention to details or makes careless mistakes
14. ___ Has difficulty sustaining attention in tasks or play activities
15. ___ Does not follow through on instructions and fails to finish schoolwork, chores, or tasks
16. ___ Has difficulty organizing tasks and activities
17. ___ Avoids, dislikes, or is reluctant to engage in activities that require sustained effort
18. ___ Loses thing necessary for tasks or activities
19. ___ Is easily distracted
20. ___ Is forgetful in daily activities
21. ___ Fidgets with hands or feet or squirms in seat
22. ___ Leaves seat in classroom
23. ___ Difficulty playing in leisure activities quietly
24. ___ Often "on the go" or acts as if "driven by a little motor"
25. ___ Talks excessively
26. ___ Blurts out answers before questions have been completed
27. ___ Interrupts or intrudes on others
28. ___ Difficulty awaiting a turn
29. ___ Affectionate
30. ___ Confident
31. ___ Funny, Humorous
32. ___ Healthy
33. ___ Trusting
34. ___ Gentle
35. ___ Talented
36. ___ Attention to detail
37. ___ Honest
38. ___ Imaginative
39. ___ Intelligent
40. ___ Eager to Please
41. ___ Refuses to eat or maintain body weight
42. ___ Intense fear of gaining weight or becoming fat even though underweight

43. ___ Perception of weight or body shape has undue influence on self-image
44. ___ Denial of the seriousness of current low body weight
45. ___ Absence of three consecutive menstrual cycles
46. ___ Eats in a specific period of time an amount of food that most people would not eat
47. ___ Child feels a lack of control while over eating
48. ___ Vomits, uses laxatives, or excessively exercised after eating to compensate for food intake
49. ___ Self-evaluation is unduly influenced by body shape and weight
50. ___ Binge eating, and compensative behaviors occur twice/week over a period of 3 months
51. ___ Anxious
52. ___ Sad
53. ___ Withdraws
54. ___ Cries easily, often
55. ___ Difficulty sleeping
56. ___ Worries
57. ___ Immature
58. ___ Imaginary playmates
59. ___ Always complains of feeling sick
60. ___ Nightmares
61. ___ Bedwetting
62. ___ Sudden changes in mood or attitude
63. ___ Recent change in personality, character traits
64. ___ Recent move, new school, loss of friends
65. ___ Relationships with brothers/sisters are poor
66. ___ Self-Harm Behaviors: Cutting or scratching skin, biting self, head banging, pulling out hair
67. ___ Shy
68. ___ Stubborn
69. ___ Suicide talk, attempts____
70. ___ Temper tantrums, rages
71. ___ Sexualized or flirtatious behaviors
72. ___ Hoarding Food
73. ___ Independent
74. ___ Obedient
75. ___ Honest

Medical

☐ Does your child have any allergies? No Yes if yes, please describe______________________________________

☐ How would you describe his/her health/medical status? Excellent good fair poor

☐ Please describe any chronic / current medical conditions____

____

Please list any medications she/he is taking for these conditions____

____

☐ Please describe any past or present psychiatric, counseling or drug / alcohol treatment he/she has received

When/Dates	From Whom?	For What?	With What Results?
__________	________________	_______________	________________________________
__________	________________	_______________	________________________________
__________	________________	_______________	________________________________

☐ Please list any psychiatric medications he/she has taken in past or are currently taking

Medication Name	When/From Whom?	For What?	With What Results?
________________	_____________________	_______________	________________
________________	_____________________	_______________	________________
________________	_____________________	_______________	________________

☐ He / She is at… low medium high risk for HIV

☐ He / She is at… low medium high risk for Hepatitis

☐ He / She has been diagnosed with TB

☐ He / She has been treated for TB

☐ He / She had a blow to the head that causing unconsciousness

☐ He / She has had a blow to the head causing a concussion

☐ He / She received an injury that caused vision and / or hearing loss

☐ Does your child's father or paternal grandparents have any medical or psychological problems? No Yes if yes, please describe____

☐ Does your child's mother or maternal grandparents have any medical or psychological problems? No Yes if yes, please describe____

Family of Origin History:

1. Where was your child born and raised? ____
2. Describe child's relationship with his mother: ____
3. Describe child's relationship with his father: ____
4. Siblings Names Gender Ages Who do they live with Describe Childs relationship with each

Siblings Names	Gender	Ages	Who do they live with	Describe Childs relationship with each
___________________	________	_____	__________________	__________________________________
___________________	________	_____	__________________	__________________________________
___________________	________	_____	__________________	__________________________________

Parents: To your knowledge has your child experienced any of following:

5. Has a parent or other adult in the household often … Sworn at your child, insulted them, put them down, or humiliated them?
   ______ Yes ______No Who? ____
6. Has a parent or other adult in the household acted in a way that made your child afraid that they might be physically hurt?
   Who? ______ Yes ______No Who? ____
7. Has a parent or other adult in the household pushed, grabbed, slapped, or thrown something at them? or Ever hit them so hard that they had marks or were injured? _______Yes ______No Who? ___________________________________
8. Has an adult or person at least 5 years older than your child… Touched or fondled them or touched their body in a sexual way? or Try to or have oral, anal, or vaginal sex with them? ______ Yes _____ No Who? _____________________________
9. Has your child felt that ... no one in their family loves them or they are not important or special?
   Or their family doesn't look out for each other, feel close to each other, or support each other? ____Yes ____No
10. Has your child felt that … they don't have enough to eat or that they have to wear dirty clothes? ____Yes ____No
11. Does your child feel that they have no one to protect them? ____Yes ____No
12. Parents or caregivers that too drunk or high to take them to the doctor when they needed it? ____Yes ____No
13. Were their parents ever separated or divorced? ____Yes ____No
14. Were any of your child's caregivers treated violently, pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? ____ ____Yes ____No
15. Has your child lived with a caregiver who was / is a problem drinker or using street drugs?
    Who? __________________________________ ____Yes ____No
16. Was a household member depressed or mentally ill or did a household member attempt suicide? ____Yes ____No
    Who? ____
17. Did a household member go to prison? ____Yes ____No Who? ____________________________
18. Name and phone number of my child's personal / family physician.
    ____

☐ Please use a separate piece of paper to comment on any additional information you believe is important regarding your child and your desire for your child to attend counseling.