

Olive Tree Counseling, Inc.

5730 E Pilgrim Ct. Suite A, 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 has been diagnosed with TB
- He / She had a blow to the head that causing unconsciousness
- 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:

- Where was your child born and raised? _____
- Describe child's relationship with his mother: _____
- Describe child's relationship with his father: _____
- | 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:

- 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? _____
- 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? _____
- 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? _____
- 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? _____
- 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
- Has your child felt that ... they don't have enough to eat or that they have to wear dirty clothes? ___ Yes ___ No
- Does your child feel that they have no one to protect them? ___ Yes ___ No
- Parents or caregivers that too drunk or high to take them to the doctor when they needed it? ___ Yes ___ No
- Were their parents ever separated or divorced? ___ Yes ___ No
- 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
- Has your child lived with a caregiver who was / is a problem drinker or using street drugs?
 Who? _____ ___ Yes ___ No
- Was a household member depressed or mentally ill or did a household member attempt suicide?
 Who? _____ ___ Yes ___ No
- Did a household member go to prison? ___ Yes ___ No Who? _____
- 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.