

Behavioral Checklist

Separate forms to be filled out by parents, patient (if appropriate), teacher, therapist, caregivers, etc. Send form(s) with a self-addressed envelop to assure return. Identify the top three problem areas. The goal is to come to consensus, focusing on no more than three problems at a time.

Patient Name _____ Age _____ Date Completed _____

Completed by: _____ Relationship to Child _____

Medication #1 _____ Current Dose _____ Started _____ Ended _____

Medication #2 _____ Current Dose _____ Started _____ Ended _____

Medication #3 _____ Current Dose _____ Started _____ Ended _____

Are There Problems With:		Never	Seldom	Sometimes		Often	Always		
Yes	No	1	2	3	4	5	6	7	
		Verbal Aggression							
		Physical Aggression							
		Sudden Mood Swings							
		Irritable							
		Tires Quickly							
		Sleeping Difficulty							
		Poor Attention							
		Headaches							
		Anxiety							
		Depression							
		Impulsive							
		Staying on Task							
		Preservation e.g. stuck on one idea							
		Other							
		Other							