

REAL-GENUINE-HOPE

COMPASSION CORRAL

EQUINE FACILITATED COUNSELING

214-402-8728

COMPASSIONCORRAL.COM

INFORMATION FORM

TODAY'S DATE: _____

PARENT INFORMATION

NAME: _____
FIRST LAST M.I.

ADDRESS: _____
STREET AND NUMBER CITY STATE ZIP

PHONE: _____ AGE: _____ DATE OF BIRTH: ____/____/____

GENDER: _____ MARITAL STATUS: _____

CHURCH AFFILIATION? _____

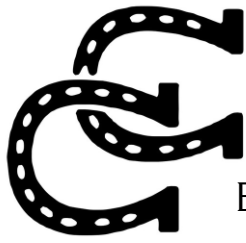
DID SOMEONE REFER YOU? YES/NO IF YES, WHO? _____

MAY I SEND A THANK YOU TO WHOM-EVER REFERRED YOU? YES/NO

A SECOND PHONE NUMBER IN CASE OF AN EMERGENCY: _____

NAME OF PERSON: _____ RELATIONSHIP TO YOU: _____

IN THE EVENT OF AN EMERGENCY AND I MUST CANCEL, WHERE SHOULD I CALL? _____



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CHILDHOOD HISTORY FORM

CHILD'S NAME: _____ DATE: _____

BIRTHDATE _____ AGE _____ SEX _____

ADOPTED ___ YES ___ NO IS YOUR CHILD AWARE OF ADOPTION? ___ YES ___ NO

DIVORCE? YES ___ NO ___ WHEN? _____

IF DIVORCED, DESCRIBE YOUR RELATIONSHIP WITH CHILD'S OTHER BIOLOGICAL PARENT:

OTHERS IN HOUSEHOLD	RELATIONSHIP TO CHILD	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BRIEFLY STATE YOUR MAIN CONCERNS ABOUT YOUR CHILD AND THE DURATION:

WHAT DO YOU THINK MIGHT HAVE CAUSED THIS?

HAS ANYONE ELSE EXPRESSED CONCERNS ABOUT YOUR CHILD?

WHAT ARE YOUR EXPECTATIONS FOR THERAPY

HAS YOUR CHILD EVER BEEN SEEN BY ANOTHER COUNSELOR? YES _____ NO _____
DATES _____ WHO? _____

WHO WILL PARTICIPATE IN CHILD'S THERAPY?

MOM: YES _____ NO _____ DAD: YES _____ NO _____
STEP MOM: YES _____ NO _____ STEP DAD: YES _____ NO _____

ANYTHING THAT CAUSED EITHER PARENT SIGNIFICANT UNHAPPINESS OR WORRY DURING
CHILD'S FIRST THREE YEARS? _____

BIGGEST STRUGGLE IN YOUR FAMILY'S HISTORY _____

CURRENT STRESSORS IN FAMILY _____

PARENTAL UNEMPLOYMENT? _____ DATES: _____

ANY DEATHS YOUR CHILD HAS EXPERIENCED? _____

ANY MOVES? IF SO, WHEN AND WHERE? _____

CHILD EXPOSED TO DISASTER? DESCRIBE: _____

WHAT ARE YOUR CHILD'S RESPONSIBILITIES? _____

WHO IS YOUR CHILD LIKE? _____

WHAT ARE YOUR CHILD'S STRENGTHS? _____

WHAT MAKES YOUR CHILD MAD? _____

WHAT ARE YOUR CHILD'S FAVORITE ACTIVITIES? _____

WHAT DOES YOUR CHILD DISLIKE DOING THE MOST? _____

DESCRIBE YOUR CHILD'S TEMPERAMENT: _____

DID THE CHILD'S MOTHER OR THE CHILD EXPERIENCE ANY COMPLICATIONS DURING
PREGNANCY/DELIVERY?

MEDICAL HISTORY

PLEASE NOTE THE AGE AND ANY OTHER PERTINENT INFORMATION. USE BACK IF NECESSARY.

CHILDHOOD DISEASES: _____

OPERATIONS: _____

OTHER HOSPITALIZATIONS: _____

HEAD INJURIES: _____

CONVULSIONS/SEIZURES: _____

PERSISTENT HIGH FEVERS: _____

EYE PROBLEMS: _____

TICS (EYE BLINKING, SNIFFING, OR ANY REPETITIVE MOVEMENT): _____

EAR PROBLEMS: _____

ALLERGIES OR ASTHMA: _____

SLEEP PROBLEMS (RESTLESS, NIGHT WAKING, SLEEPWALKING): _____

BEDWETTING OR SOILING PANTS IN DAYTIME: _____

DESCRIBE YOUR CHILD'S APPETITE: _____

PLEASE LIST OTHER DOCTORS OR PROFESSIONALS CONSULTED: _____

CURRENT MEDICATIONS AND DOSE: _____

FAMILY/SOCIAL HISTORY

INCLUDE ANY BROTHERS OR SISTERS YOU (THE PARENT) HAVE/HAD AS WELL AS YOUR (THE PARENT) NATURAL PARENTS (IN OTHER WORDS, YOUR CHILDHOOD HISTORY). BE SURE TO INCLUDE PAST OR PRESENT BEHAVIOR.

BIRTH MOTHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

BIRTH FATHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

STEP-MOTHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

STEP-FATHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

ADOPTED MOTHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

ADOPTED FATHER CHILDHOOD HISTORY (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG USAGE |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> DOMESTIC VIOLENCE |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> CRIMINAL ACTIVITY | <input type="checkbox"/> HOMOSEXUALITY |

WHICH FAMILY MEMBER HAS THE BEST RELATIONSHIP WITH THE CHILD? _____

INFANCY - TODDLERHOOD

WERE ANY OF THE FOLLOWING PRESENT DURING YOUR CHILD'S FIRST FEW YEARS?

- | | |
|---|---|
| <input type="checkbox"/> DID NOT ENJOY CUDDLING | <input type="checkbox"/> WAS NOT CALMED BY BEING HELD |
| <input type="checkbox"/> DIFFICULT TO COMFORT | <input type="checkbox"/> COLIC |
| <input type="checkbox"/> EXCESSIVE RESTLESSNESS | <input type="checkbox"/> EXCESSIVE IRRITABILITY |
| <input type="checkbox"/> FREQUENT HEAD BANGING | <input type="checkbox"/> CONSTANTLY INTO EVERYTHING |

TEMPERAMENT: PLEASE RATE THE FOLLOWING AS YOUR CHILD APPEARED IN INFANCY AND TODDLERHOOD:

- ACTIVITY LEVEL: UNDERACTIVE AVERAGE ACTIVITY LEVEL OVERACTIVE
ADAPTABILITY: ADAPTED EASILY TO CHANGE RESISTED CHANGE
INTENSITY: AVERAGE FEELINGS WERE OFTEN INTENSE
MOOD: OFTEN HAPPY AVERAGE RANGE OF MOODS
 OFTEN DISSATISFIED OR IRRITABLE

DEVELOPMENTAL MILESTONES

AS BEST YOU CAN RECALL, LIST AGE OF DEVELOPMENT, OR CHECK ITEM AT RIGHT:

	AGE	OR	EARLY	NORMAL	LATE
WALKED WITHOUT ASSISTANCE	_____		_____	_____	_____
SPOKE FIRST WORDS	_____		_____	_____	_____
ANY SPEECH/ARTICULATION PROBLEMS?	_____ YES _____ NO				
TOILET TRAINED DAYTIME	_____		_____	_____	_____
TOILET TRAINED NIGHTTIME	_____		_____	_____	_____

COORDINATION

RATE YOUR CHILD ON THE FOLLOWING SKILLS:

	GOOD	AVERAGE	POOR
WALKING	_____	_____	_____
RUNNING	_____	_____	_____
THROWING	_____	_____	_____
CATCHING	_____	_____	_____
SHOELACE TYING	_____	_____	_____
WRITING	_____	_____	_____
ATHLETIC ABILITIES	_____	_____	_____

COMPREHENSION AND UNDERSTANDING

DO YOU CONSIDER YOUR CHILD TO UNDERSTAND DIRECTIONS AND SITUATIONS AS WELL AS OTHER CHILDREN HIS/HER AGE? YES___ NO___

HOW WOULD YOU RATE YOUR CHILD'S OVERALL LEVEL OF INTELLIGENCE?

_____ BELOW AVERAGE _____ ABOVE AVERAGE _____ AVERAGE

PEER RELATIONSHIPS

HOW DOES YOUR CHILD GET ALONG WITH OTHERS HIS/HER AGE? DESCRIBE ANY PROBLEMS.

SCHOOL HISTORY

SCHOOL CURRENTLY ATTENDING: _____ GRADE LEVEL: _____

IS YOUR CHILD IN ANY RESOURCE OR SPECIAL CLASSES? _____

BRIEFLY DESCRIBE YOUR CHILD'S SCHOOL PROGRESS. NOTE USUAL GRADES, ANY PROBLEMS OR SUCCESSES, STRONG SUBJECTS AND WEAK SUBJECTS:

PRESCHOOL – K _____

1ST – 5TH _____

6TH – 8TH _____

9TH – 12TH _____

DESCRIBE ANY CONDUCT PROBLEMS YOUR CHILD HAS HAD IN SCHOOL:

HOW WOULD YOU RATE YOUR CHILD'S HOMEWORK/STUDY SKILLS?

___GOOD ___AVERAGE ___POOR

DESCRIBE DIFFICULTIES: _____

HAS YOUR CHILD HAD TUTORING OR REMEDIAL WORK? _____

DOES YOUR CHILD LIKE TO READ? _____

HOW OFTEN? (CIRCLE ONE) NEVER SELDOM OCCASIONALLY OFTEN

PLEASE RATE READING ABILITY: ___GOOD ___FAIR ___POOR

ANY OTHER COMMENTS ON YOUR CHILD'S PERFORMANCE AND BEHAVIOR:

HOME BEHAVIOR AND MOOD

CHECK WHICH OF THE FOLLOWING APPLIES TO YOUR CHILD:

- | | |
|--|--|
| <p><input type="checkbox"/> FREQUENTLY IRRITABLE OR MOODY</p> <p><input type="checkbox"/> CAN'T SEEM TO ENJOY DOING ANYTHING</p> <p><input type="checkbox"/> SAD SPELLS</p> <p><input type="checkbox"/> CRYING SPELLS</p>
<p><input type="checkbox"/> EASILY BORED</p>
<p><input type="checkbox"/> POOR OR LOW MOTIVATION</p> <p><input type="checkbox"/> LOW SELF-ESTEEM (MAKES
NEGATIVE STATEMENTS ABOUT SELF)</p> <p><input type="checkbox"/> CAN'T SEEM TO CONCENTRATE</p> <p><input type="checkbox"/> HAS HAD THOUGHTS OF OR
MADE COMMENTS ABOUT SUICIDE</p> <p><input type="checkbox"/> EATS (TOO MUCH) OR (TOO LITTLE)</p> <p><input type="checkbox"/> FREQUENT ARGUING AT HOME</p> <p><input type="checkbox"/> FEARFULNESS</p> | <p><input type="checkbox"/> NERVOUS, ANXIOUS</p> <p><input type="checkbox"/> FREQUENT HEADACHES</p> <p><input type="checkbox"/> FREQUENT STOMACH ACHES</p> <p><input type="checkbox"/> HAS HAD A PANIC ATTACK (RAPID
HEARTBEAT, SWEATY PALMS,
FEELING SOMETHING BAD ABOUT
TO HAPPEN)</p> <p><input type="checkbox"/> DIFFICULTY SLEEPING</p> <p><input type="checkbox"/> GOES TO SLEEP VERY LATE</p> <p><input type="checkbox"/> HARD TO GET UP IN MORNING</p> <p><input type="checkbox"/> VERY RESTLESS SLEEP</p> <p><input type="checkbox"/> BAD DREAMS</p> <p><input type="checkbox"/> ACTS LIKE DRIVEN BY A MOTOR</p>
<p><input type="checkbox"/> DOESN'T SEEM TO LEARN FROM
EXPERIENCE</p> <p><input type="checkbox"/> VERY DISORGANIZED (LOSES THINGS,
HAS VERY MESSY ROOM)</p>
<p><input type="checkbox"/> HAS EVER BEEN PHYSICALLY OR
SEXUALLY ABUSED</p> <p><input type="checkbox"/> DRUG OR TOBACCO USE</p> <p><input type="checkbox"/> ARGUES WITH OR RUDE TO TEACHERS</p> <p><input type="checkbox"/> OTHER: _____</p> |
|--|--|

ANY ADDITIONAL COMMENTS YOU WOULD LIKE TO MAKE ABOUT YOUR CHILD (MOOD, BEHAVIOR, PERSONALITY, ETC.):

THANK YOU FOR THE TIME AND EFFORT YOU GAVE IN COMPLETING THIS FORM. PLEASE ALSO COMPLETE ANY CHECK LISTS WHICH ACCOMPANY THIS HISTORY FORM.

MOST CHILDREN EXHIBIT, AT ONE TIME OR ANOTHER, ONE OR MORE OF THE SYMPTOMS LISTED BELOW. PLACE A P NEXT TO THOSE THAT YOUR CHILD HAS EXHIBITED IN THE PAST AND N NEXT TO THOSE THAT YOUR CHILD EXHIBITS NOW. ONLY MARK THOSE SYMPTOMS THAT HAVE BEEN OR ARE PRESENT TO A SIGNIFICANT DEGREE OVER A PERIOD OF TIME. ONLY CHECK AS PROBLEMS BEHAVIOR THAT YOU SUSPECT IS UNUSUAL OR ATYPICAL WHEN COMPARED TO WHAT YOU CONSIDER TO BE NORMAL FOR YOUR CHILD'S AGE.

- ___ THUMB SUCKING
- ___ BABY TALK
- ___ OVERLY DEPENDENT FOR AGE
- ___ FREQUENT TEMPER TANTRUMS
- ___ EXCESSIVE SILLINESS AND CLOWNING
- ___ EXCESSIVE DEMANDS FOR ATTENTION
- ___ CRIES EASILY AND FREQUENTLY
- ___ GENERALLY IMMATURE
- ___ EATS NON-EDIBLE SUBSTANCES
- ___ OVEREATING WITH OVERWEIGHT
- ___ EATING BINGES WITH OVERWEIGHT
- ___ UNDER EATING WITH UNDERWEIGHT
- ___ LONG PERIODS OF DIETING AND FOOD ABSTINENCE WITH UNDER WEIGHT
- ___ PREOCCUPIED WITH FOOD – WHAT TO EAT AND WHAT NOT TO EAT
- ___ PREOCCUPATION WITH BOWEL MOVEMENTS
- ___ CONSTIPATION
- ___ ENCOPRESIS (SOILING)
- ___ ENURESIS (BED WETTING)
- ___ INSOMNIA (DIFFICULTY SLEEPING)
- ___ FREQUENT NIGHTMARES
- ___ NIGHT TERRORS (TERRIFYING NIGHT TIME OUT BURSTS)
- ___ SLEEPWALKING
- ___ EXCESSIVE SEXUAL INTEREST AND PREOCCUPATION
- ___ FREQUENT SEX PLAY WITH OTHER CHILDREN
- ___ EXCESSIVE MASTURBATION
- ___ FREQUENTLY LIKES TO WEAR CLOTHING OF THE OPPOSITE SEX
- ___ EXHIBITS GESTURES AND INTONATIONS OF THE OPPOSITE SEX
- ___ FREQUENT HEADACHES
- ___ FREQUENT STOMACH ACHES
- ___ FREQUENT NAUSEA AND VOMITING
- ___ OFTEN COMPLAINS OF BODILY ACHES AND PAINS
- ___ WORRIES OVER BODILY ILLNESS
- ___ POOR MOTIVATION
- ___ APATHY
- ___ TAKES PATH OF LEAST RESISTANCE
- ___ EVER TRYING TO AVOID RESPONSIBILITY
- ___ POOR FOLLOW THROUGH
- ___ LOW CURIOSITY
- ___ OPEN DEFIANCE TO AUTHORITY
- ___ BLATANTLY UNCOOPERATIVE
- ___ PERSISTENT LYING
- ___ FREQUENT USE OF PROFANITY TO PARENTS, TEACHERS, AND OTHER AUTHORITIES
- ___ TRUANCY FROM SCHOOL
- ___ RUNS AWAY FROM HOME
- ___ VIOLENT OUTBURSTS OF RAGE
- ___ STEALING
- ___ CRUELTY TO ANIMALS, CHILDREN, AND OTHERS
- ___ DESTRUCTION OF PROPERTY
- ___ CRIMINAL AND/OR DANGEROUS ACTS
- ___ TROUBLE WITH THE POLICE
- ___ VIOLENT ASSAULT
- ___ FIRE SETTING
- ___ LITTLE, IF ANY, GUILT OVER BEHAVIOR THAT CAUSES OTHERS PAIN AND DISCOMFORT
- ___ LITTLE, IF ANY, RESPONSE TO PUNISHMENT FOR ANTISOCIAL BEHAVIOR

___ FEW, IF ANY, FRIENDS
___ DOES NOT SEEK FRIENDSHIPS
___ RARELY SOUGHT BY PEERS
___ NOT ACCEPTED BY PEER GROUP
___ SELFISH
___ ARGUMENTATIVE
___ DOES NOT RESPECT THE RIGHTS OF OTHERS
___ WANTS THINGS OWN WAY WITH EXAGGERATED REACTION IF THWARTED
___ TROUBLE PUTTING SELF IN OTHER'S POSITION
___ EGOCENTRIC (SELF-CENTERED)
___ FREQUENTLY HITS OTHER CHILDREN
___ EXCESSIVELY CRITICAL OF OTHERS
___ EXCESSIVELY TAUNTS OTHER CHILDREN
___ EVER COMPLAINING
___ IS OFTEN PICKED ON AND EASILY BULLIED BY OTHER CHILDREN
___ SUSPICIOUS, DISTRUSTFUL
___ ALOOF
___ "WISE-GUY" OR SMART ALECK ATTITUDE
___ BRAGS OR BOASTS
___ BRIBES OTHER CHILDREN
___ EXCESSIVELY COMPETITIVE
___ OFTEN CHEATS WHEN PLAYING GAMES
___ "SORE LOSER"
___ "DOES NOT KNOW WHEN TO STOP"
___ POOR COMMON SENSE IN SOCIAL SITUATIONS
___ OFTEN FEELS CHEATED OR GYPED
___ FEELS OTHERS ARE PERSECUTING HIM WHEN THERE IS NO EVIDENCE FOR SUCH
___ TYPICALLY WANTS HIS OR HER OWN WAY
___ VERY STUBBORN
___ OBSTRUCTION-ISTIC
___ NEGATIVISTIC (DOES JUST THE OPPOSITE OF WHAT IS REQUESTED)
___ QUIETLY, OR OFTEN SILENTLY, DEFIANT OF AUTHORITY
___ FEIGNS OR VERBALIZES COMPLIANCE OR COOPERATION BUT DOES NOT COMPLY WITH
___ REQUESTS
___ DRUG ABUSE
___ ALCOHOL ABUSE
___ VERY TENSE
___ NAIL BITING
___ CHEWS ON CLOTHES, BLANKETS, ETC.
___ HEAD BANGING
___ HAIR PULLING
___ PICKS ON SKIN
___ SPEAKS RAPIDLY AND UNDER PRESSURE
___ IRRITABILITY, EASILY "FLIES OFF THE HANDLE"
___ ANXIETY ATTACKS WITH PALPITATIONS (POUNDING HEART), SHORTNESS OF BREATH,
___ SWEATING, ETC.
___ DISORGANIZED
___ EXCESSIVE WORRYING OVER MINOR THINGS
___ TICS SUCH AS EYE BLINKING, GRIMACING, OR OTHER SPASMODIC REPETITIOUS MOVEMENTS
___ INVOLUNTARY GRUNTS, VOCALIZATIONS (UNDERSTANDABLE OR NOT)
___ STUTTERING
___ DEPRESSION
___ FREQUENT CRYING SPELLS
___ SUICIDAL PREOCCUPATION, GESTURES, OR ATTEMPTS
___ EXCESSIVE DESIRE TO PLEASE AUTHORITY
___ "TOO GOOD"
___ OFTEN APPEARS INSINCERE AND/OR ARTIFICIAL
___ TOO MATURE, FREQUENTLY ACTS OLDER THAN ACTUAL AGE
___ EXCESSIVE GUILT OVER MINOR INDISCRETIONS
___ ASKS TO BE PUNISHED
___ LOW SELF-ESTEEM

- ___ EXCESSIVE SELF-CRITICISM
- ___ VERY POOR TOLERATION OF CRITICISM
- ___ FEELINGS EASILY HURT
- ___ DISSATISFACTION WITH APPEARANCE OR BODY PART(S)
- ___ EXCESSIVE MODESTY OR EXPOSURE
- ___ PERFECTIONIST, RARELY SATISFIED WITH PERFORMANCE
- ___ FREQUENTLY BLAMES OTHERS AS A COVER UP FOR OWN SHORT COMINGS
- ___ LITTLE CONCERN FOR PERSONAL APPEARANCE OR HYGIENE
- ___ LITTLE CONCERN OR PRIDE IN PERSONAL PROPERTY
- ___ "GETS HOOKED" ON CERTAIN IDEAS AND REMAINS PREOCCUPIED
- ___ COMPULSIVE REPETITION OF SEEMINGLY MEANINGLESS PHYSICAL ACTS
- ___ SHY
- ___ INHIBITED SELF-EXPRESSION IN DANCING, SINGING, LAUGHING, ETC.
- ___ RECOILS FROM AFFECTIONATE PHYSICAL CONTACT
- ___ WITHDRAWN
- ___ FEAR ASSERTING SELF
- ___ INHIBITS OPEN EXPRESSION OF ANGER
- ___ ALLOWS SELF TO BE EASILY TAKEN ADVANTAGE OF
- ___ FREQUENTLY POUTS AND/OR SULKS
- ___ MUTE (REFUSES TO SPEAK) BUT CAN
- ___ GULLIBLE/NAÏVE
- ___ PASSIVE AND EASILY LED
- ___ EXCESSIVE FANTASIZING, "LIVES IN HIS/HER OWN WORLD"
- ___ FLAT EMOTIONAL TONE
- ___ SPEECH IS NON-COMMUNICATIVE OR POORLY COMMUNICATIVE
- ___ HEARS VOICES
- ___ SEES VISIONS

FEARS/PHOBIAS

- ___ DARK
- ___ NEW SITUATIONS
- ___ STRANGERS
- ___ BEING ALONE
- ___ DEATH
- ___ SEPARATION FROM PARENT
- ___ SCHOOL
- ___ VISITING OTHER CHILDREN'S HOMES
- ___ GOING AWAY TO CAMP
- ___ ANIMALS
- ___ OTHER FEARS (NAME)