

Checklist

Client Name _____ Female Male Non-binary

Date of Birth ____ / ____ / ____ Grade _____

Parent or Guardian Name(s) _____

Email _____ Can we send e-mail to this address? Yes No

Phone _____ Can we leave a voicemail at this phone number? Yes No

Referring Provider Name _____ Date of Referral ____ / ____ / ____

Referring Provider Office Number _____ Fax Number _____

Symptom Checklist

- Changes in lab work
- Changes in trajectory on growth chart
- Perfectionism in the way of tasks or activities
- Rapid weight changes and/or changes in eating behavior
- Changes in hygiene
- Changes in attention, concentration or mood
- Evidence of suicide attempts or self-harm
- Depression or anxiety that doesn't seem to respond to medication
- Changes in sleep or sleep quality
- Increased injury or pressure to perform in athletics
- Difficulty participating in activities or attending school
- Difficulty answering questions or asking for help
- Social Exclusion
- Bullying others
- Lack of interest in activities
- Impulsive, disruptive behavior
- Alterations in wardrobe or appearance (e.g., more baggy clothing, temperature inappropriate clothing)
- Oppositional behavior (e.g., anger outbursts, defying rules, difficulty following directions)
- "Surviving not thriving"
- Drug or alcohol issues

Additional Notes

