Please check Yes / No / Unknown if your child or adolescent has experienced any of the following:

	Yes	No	Unknown
Change in appetite	___	___	_____
Weight gain/loss	___	___	_____
Sleeping too much/too little	___	___	_____
Bed wetting	___	___	_____
Fire-setting	___	___	_____
Runaway	___	___	_____
Mood swings	___	___	_____
Lying	___	___	_____
Lack of concentration	___	___	_____
Impulsivity	___	___	_____
Hyperactivity	___	___	_____
Hallucinations/delusions	___	___	_____
Peer group change	___	___	_____
Significant losses	___	___	_____
Suicidal thoughts	___	___	_____
Suicidal attempts	___	___	_____
Cutting, burning, or self-harm	___	___	_____
Excessive anger outbursts	___	___	_____
Excessive obsessions with:			
- relationships	___	___	_____
- gaming	___	___	_____
- sex	___	___	_____
- alcohol or drugs	___	___	_____
Disrespect of parents or authority	___	___	_____
Stealing	___	___	_____
Learning disability	___	___	_____
Autism Spectrum disorder	___	___	_____
Truancy / skipping school	___	___	_____
Drop in grades	___	___	_____
Past abuse against the child:			
- physical abuse	___	___	_____
- sexual abuse	___	___	_____
- mental / emotional abuse	___	___	_____

*As the parent/grandparent/or guardian, my biggest concern is: