CHILD BEHAVIOR PRIORITY CHECKLIST

Priority_other symptoms_v1.4_31Jan2020 **ID # (office use only)**_____ **Today's Date:**_____ **Child's Name**_____

Part I: We want to know what matters to YOU and your child.
This will help us learn what is important to talk about during your visit today.

➡ **Step 1**. In the last month, has your child experienced any of the following? ⬇

☐ Constipation	☐ Diarrhea or loose stools	☐ Behavioral challenges
☐ Insomnia (trouble falling asleep)	☐ Night waking	☐ Feeding/Eating difficulties
☐ **None of the above**		

Step 2:
Has your child ever experienced a seizure or seizures? ☐ Yes ☐ No

⬇ PART II:

Behavior	**STEP 1** In the past month, how much of a problem is it? (check each behavior) Not at all	Mild	Moderate	Severe	Extremely Severe	➡ **STEP 2** Frequency (circle number) 1. Less than once per week 2. 1 -2 times per week 3. 3-5 times per week 4. Every day 5. Many times per day	➡ **STEP 3** Biggest Problem (check one) Which **ONE** behavior would you say is the most challenging /difficult?
Inattention/ Hyperactivity/ Impulsivity						1 2 3 4 5	
Elopement (running off)						1 2 3 4 5	
Noncompliant Behaviors (refusing to do things)						1 2 3 4 5	
Irritability/Frequent Mood Changes						1 2 3 4 5	
Tantrums/Aggression						1 2 3 4 5	
Self-injury						1 2 3 4 5	
Depression/Sadness						1 2 3 4 5	
Anxiety/Frequent Worrying/Fears						1 2 3 4 5	
Repetitive Behaviors						1 2 3 4 5	
Other Behavior(s): _____						1 2 3 4 5	

➡ **Part III:** This question will help describe the overall health and wellbeing of your child.

In general, would you say your child's quality of life is: *(select only one response)*
☐ 5 – Excellent ☐ 4 – Very Good ☐ 3 – Good ☐ 2 – Fair ☐ 1 – Poor

WHAT MATTERS TO ME? I WANT MY HEALTHCARE TEAM TO KNOW: _____

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