Brief Early Childhood Screening Assessment

Feelings and behavior are important parts of health and wellness. Please complete the questions below, so your pediatric provider can take the best possible care of your child. We have developmental specialists who can also help out.

Child Name _____ Date of Birth _____

Your Name _____ Date _____

Please circle the number that best describes your child compared to other children the same age. In addition, please circle the + if you are concerned and would like help with the item.

	Rarely/Not True	Sometimes/ Sort of True	Almost Always/Very True	I want help with this
1. Seems sad, cries a lot.	0	1	2	+
2. Is difficult to comfort when hurt or distressed.	0	1	2	+
3. Loses temper too often.	0	1	2	+
4. Avoids situations that remind them of scary events.	0	1	2	+
5. Hurts others on purpose (biting, hitting, kicking).	0	1	2	+
6. Doesn't seem to listen to adults talking to them.	0	1	2	+
7. Battles over food and eating.	0	1	2	+
8. Is irritable, easily annoyed.	0	1	2	+
9. Argues with adults.	0	1	2	+
10. Breaks things during tantrums.	0	1	2	+
11. Is easily startled or scared.	0	1	2	+
12. Has trouble interacting with other children.	0	1	2	+
13. Fidgets, can't sit quietly.	0	1	2	+
14. Is clingy, doesn't want to separate from parent.	0	11	2	+
15. Seems nervous or worries a lot.	0	1	2	+
16. Blames others for mistakes.	0	1	2	+
17. Has a hard time paying attention to tasks or activities.	0	1	2	+
18. Is always "on the go".	0	1	2	+
19. Reacts too emotionally to small things.	0	1	2	+
20. Is very disobedient.	0	1	2	+
21. Has unusual repetitive behaviors (rocking, flapping).	0	1	2	+
22. Doesn't seem to have much fun.	0	1	2	+
23. I feel too stressed to enjoy my child.	0	1	2	+
24. I am more frustrated than I want to be with my child's behavior.	0	1	2	+

Are you concerned about your child's emotional or behavioral development? Yes Somewhat No

Please include any comments you want to share: _____

Being a parent is not easy, so we are checking in with everyone about some common challenges. If you have more than one child being seen today, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to.

PLEASE CHECK

- ☐ Yes ☐ No Do you need the phone number for Poison Control?
- ☐ Yes ☐ No Do you need a smoke detector for your home?
- ☐ Yes ☐ No Does anyone smoke tobacco at home?
- ☐ Yes ☐ No In the last year, did you worry that your food would run out before you got money or food stamps to buy more?
- ☐ Yes ☐ No In the last year, did the food you bought not last and you didn't have money to get more?
- ☐ Yes ☐ No Do you often feel your child is difficult to take care of?
- ☐ Yes ☐ No Do you sometimes find you need to hit or spank your child?
- ☐ Yes ☐ No Do you wish you had more help with your child?
- ☐ Yes ☐ No Do you often feel under extreme stress?
- ☐ Yes ☐ No In the past month, have you often felt down, depressed, or hopeless?
- ☐ Yes ☐ No In the past month, have you felt very little interest or pleasure in things you used to enjoy?
- ☐ Yes ☐ No In the past year, have you been afraid of your partner?
- ☐ Yes ☐ No In the past year, have you had a problem with drugs or alcohol?
- ☐ Yes ☐ No In the past year, have you felt the need to cut back on drinking or drug use?

Has your child ever:

- ☐ Yes ☐ No Been in a car accident?
- ☐ Yes ☐ No Been separated from you for a prolonged time?
- ☐ Yes ☐ No Seen or heard someone else get hurt (inside or outside of the home)?
- ☐ Yes ☐ No Experienced major medical event or procedure (like surgery)?
- ☐ Yes ☐ No Experienced major loss of someone important (through death, moving away, incarceration, etc.)?
- ☐ Yes ☐ No Lived through a major natural disaster?
- ☐ Yes ☐ No Lived through a major family emergency (like a house fire, medical crisis, etc.)?
- ☐ Yes ☐ No Had other major frightening events happen? Please tell us what happened:

_____

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CHKD Mental Health

Early Childhood Consultation