CHILD QUESTIONNAIRE SELF REPORT

Confidential

Information requested on this questionnaire will aid us in understanding your problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. You may use the backs of pages if necessary.

Name		Date	
Age	Sex	School	Grade
feeling, or be current on co	havior. Describe andition on the ri	the situation before the acciden	ch of the following aspects of thinking, nt or illness on the left and the recent or at you have had all of your life, then only
Before the ac	cident or illness		Recently and currently
		Concentration	
		_	
		Energy and activity lev	vel .
		- -	
		Depression	
		Elation and other types of hig	gh mood
		- Sleep	
		Anger or Anger Control Pr	oblems
		Agitation or Irritabilit	ty

Before the accident or illness Recently and currently **Running Away or Oppositional Behavior** Appetite for food Sexual behavior and sexual interest Consumption of alcohol and other drugs Hearing Vision and other aspects of sight Ability to find way around - Spatial ability Headaches Pains other than in the head **Fatigue** Understanding what you hear

Your ability to finding words when you know what you want to say

Before the accident or illness Recently and currently Your memory for things people say or things you need to do **Imagery and memory for faces** Reading Calculating - balancing check book **School work** Playing or listening to music Motor behavior - skillful activity **Unusual sensations or strange experiences** Ability to relax and experience pleasure Social behavior - being with people Please use the back page for additional information which you think would be helpful. If another person assisted in completing this form, please enter appropriate information below. Relationship to client Phone____ Address