

BIEN ÊTRE PSYCHIATRY

Child & Adolescent Screening Form (Ages 6-17)

To be completed by parent/guardian

Child's Name:

DOB:

Parent/Guardian:

Date:

Thank you for completing this form. Every child has strengths as well as challenges. Your observations help us understand your child's emotional, behavioral, social, and academic functioning. There are no right or wrong answers.

Rate how much each concern affected your child during the past month:

0 = Not at all 1 = A little 2 = Moderately 3 = Quite a bit 4 = Extremely

EMOTIONAL HEALTH

Concern	0	1	2	3	4
Seems sad, down, or depressed	☐	☐	☐	☐	☐
Worries excessively	☐	☐	☐	☐	☐
Appears nervous or anxious	☐	☐	☐	☐	☐
Cries easily or frequently	☐	☐	☐	☐	☐
Has low confidence or self-esteem	☐	☐	☐	☐	☐

ATTENTION & EXECUTIVE FUNCTION

Concern	0	1	2	3	4
Has difficulty paying attention	☐	☐	☐	☐	☐
Is easily distracted	☐	☐	☐	☐	☐
Has difficulty organizing work	☐	☐	☐	☐	☐
Is forgetful or loses things	☐	☐	☐	☐	☐
Has difficulty completing tasks	☐	☐	☐	☐	☐

EMOTIONAL REGULATION & BEHAVIOR

Concern	0	1	2	3	4
Is irritable or easily frustrated	☐	☐	☐	☐	☐
Has frequent arguments or defiance	☐	☐	☐	☐	☐
Has anger outbursts	☐	☐	☐	☐	☐
Acts impulsively	☐	☐	☐	☐	☐
Has difficulty accepting limits	☐	☐	☐	☐	☐

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SOCIAL FUNCTIONING

Concern	0	1	2	3	4
Has difficulty making friends	☐	☐	☐	☐	☐
Shows social anxiety or avoidance	☐	☐	☐	☐	☐
Has conflict with peers	☐	☐	☐	☐	☐
Prefers isolation	☐	☐	☐	☐	☐

SCHOOL FUNCTIONING

Concern	0	1	2	3	4
Has academic performance concerns	☐	☐	☐	☐	☐
Has difficulty completing homework	☐	☐	☐	☐	☐
Has school attendance concerns	☐	☐	☐	☐	☐
Has concerns reported by teachers	☐	☐	☐	☐	☐

SLEEP & DAILY FUNCTIONING

Concern	0	1	2	3	4
Has difficulty falling asleep	☐	☐	☐	☐	☐
Wakes frequently during the night	☐	☐	☐	☐	☐
Has excessive daytime fatigue	☐	☐	☐	☐	☐
Has appetite concerns	☐	☐	☐	☐	☐

OCD, TICS & SENSORY CONCERNS

Concern	0	1	2	3	4
Has repetitive thoughts or worries	☐	☐	☐	☐	☐
Repeats behaviors or checks things	☐	☐	☐	☐	☐
Has motor or vocal tics	☐	☐	☐	☐	☐
Has sensory sensitivities	☐	☐	☐	☐	☐

OVERALL IMPACT

Which areas are causing the greatest difficulty at home, at school, or with relationships?

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SAFETY

Please answer every safety question. A 'yes' response does not automatically mean your child is in immediate danger, but it helps the clinician know what should be discussed promptly.

Has your child expressed thoughts of self-harm?	☐ No	☐ Yes
Has your child attempted suicide?	☐ No	☐ Yes
Has your child engaged in self-injurious behavior?	☐ No	☐ Yes
Has your child made threats toward others?	☐ No	☐ Yes
Are there any current or immediate safety concerns?	☐ No	☐ Yes

PLEASE EXPLAIN ANY SAFETY CONCERNS

If your child is in immediate danger, has a plan or intent to harm themselves or someone else, or cannot be kept safe, call 911 or go to the nearest emergency department. In the United States, call or text 988 for the Suicide & Crisis Lifeline.

STRENGTHS & ADDITIONAL COMMENTS

What are your child's strengths, and is there anything else you would like the clinician to know?

COMPLETED BY

Parent/Guardian Name:		Relationship:	
Signature:		Date:	

This form is a screening aid and does not establish a diagnosis. Responses will be reviewed together with the clinical history and evaluation.