

CHILD DIAGNOSTIC UNIT BEHAVIORAL CHECKLIST

Client's Name: _____ DOB: _____

Guardians Name: _____

Name of Person Completing Form:
 Parent Guardian Foster Parent DCFS Therapist Other

Address: _____

Phone Number: _____ Email Address: _____

Medicaid Number: _____ PASSE: _____ PASSE Number: _____

Please Circle Appropriate Boxes

Physical Aggression	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Hits Kicks Bites Shoves Trips Pushes Other						
Verbal Aggression	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Curses Yells Demands						
Fire Setting	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Plays with matches Hides lighters Caught item on fire						
Enuresis/Encopresis	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Daytime Nighttime Wears Pull-Ups						
Homicidal Ideation/Attempt	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Threatens others Physically hurts others Plans to hurt someone						
Activities of Daily Living	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Unable to bathe Unable to get dressed Unable to toilet Unable to feed self						
Self Injurious Behaviors	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Cuts self Head bangs Pulls Hair Hits self Scratches self Picks sores Burns self						
Problematic Sexual Behaviors	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Makes comments Makes gestures Touches self Touches others Exposes self Charged files						
Suicidal Ideation/Attempt	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Thinks of death Draws pictures of death Cutting Strangulation/Choking Poison						
Anxiety and Panic	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Fidgets Worries Social or performance situations Separating from family Dark Storms Watchful						
Phobias	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Please List Specific fears:						
Nutrition Concerns	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Overeats Throws up Poor Appetite Hoards Foods Picky Eater						
Mood	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Sad Hopeless Worthless Isolative Irritable Angry Mood swings						
Impulsive Behavior	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Climbs objects Tears things apart Acts without thinking No cause and effect						

Problems with Truth Telling	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Doesn't tell the truth exaggerates negative lies to avoid getting in trouble						
Oppositional	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Refuses directions Lies about completing items Talks back or argues Disregards typical schedules/rules						
Property Destruction	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Holes in walls Tears toys up Defaces school property Defaced vehicle						
Destroys others Property	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Electronics Furniture Toys Sentimental Objects						
Running Away	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Several hours Overnight						
Social Withdrawal	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Refuses activities No friends Avoids social situations Avoids Public Places						
Stealing	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Takes things Hides things Never asks permission Steals from stores Steals from school						
Decreased Concentration	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Unable to focus Zones out Day dreams Distractible						
Hyperactivity	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Always moving Unable to sit still Clumsy Often gets items wrong at school						
Distractible	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Messy Unorganized Forgetful Never on task Watches other/things Poor Focus						
Paranoia	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Thinks others are out to harm him No one's on their side World is a bad place						
Animal Cruelty	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Accidentally hurt animal Purposefully hurt animal Accidentally killed an animal Purposefully killed animal						
Rituals or Compulsions	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Please explain:						
Inflexible/Rigid	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Poor with schedule change Unable to see other's perspectives Stuck on routine						
Sensory Concerns	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Loud noises Crowds Textures/Food Clothing						
Thought Disorder	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Hears things Sees Things Feels things						
Alcohol/Tobacco/Drug Use	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Please Specify:						
Hypersomnia/Insomnia	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME

Day time naps Trouble going to sleep Trouble staying asleep Early riser Bad dreams Sleep walks

Please describe any other behavior (giving dates, frequency, and severity):

Family Involvement:

How often will you visit? Never 1X Weekly 2XWeekly 3XWeekly