CONNECT GROUP

SYMPTOM CHECKLIST – to be filled out by parent/guardian

Student ____ Date____________________

Parent(s)/Guardian _________________________________

Statement of problem(s) for which you are registering your student:

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Please rate the degree to which your child has been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	**Never**	**Sometimes**	**Often**
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems last year			
Family problems			
Problems getting along w/others			
Violence			
Health problems			

When did the symptoms first begin?_____/_____/_____ (date)

Have you ever been treated for these symptoms?_____Yes _____No