

Office use only

ID: \_\_\_\_\_

Follow-up Interval: \_\_\_\_\_

Your Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Parent Follow-Up Form Presenting Problems

To help us assess your child's progress, please rate how often your child has had the following problems in the last 10-12 weeks.

Type of Presenting Problem	How frequent of a concern is this for you?				
	Never	Rarely	Sometimes	Frequently	Most of the Time
<b>1. Mood Symptoms</b>					
a) Seems unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Irritable/angry mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Gets very upset when something does not work out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Suicidal thoughts/behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Anxiety Symptoms</b>					
a) Often anxious, fearful, worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Obsessive or compulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Separation anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lack of self confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Difficulty with change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Social Problems</b>					
a) Difficulty making and keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Socially awkward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Bullies other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Assumes others won't like him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. School Problems</b>					
a) Speech/Language problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Poor grades	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Trouble completing assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Trouble focusing on school work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Doesn't listen to teachers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Attention/Hyperactivity Problems</b>					
a) Hyperactive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Highly distractible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. High-Risk Behavior</b>					
a) Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lying/cheating with parents/authority figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Family Conflict</b>					
a) Fights with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Conflict with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. Communication/Sensory Problems</b>					
a) Performs repetitive rituals/movement/gestures/speech (like rocking, spinning or hand-flapping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Obsessive interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Poor eye contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Prefers being or playing alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Speaks with abnormal tone or rhythm (like a singsong voice or robot-like speech)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Presenting Problem	How frequent of a concern is this for you?				
	Never	Rarely	Sometimes	Frequently	Most of the Time
<b>9. Eating concerns</b>					
a) Overeating or obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10. Other (please fill in)</b>					
a)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**School Functioning**

11. Have there been any changes (e.g. more time in special education, more time in general education classes, changes in type of service, changes in classroom size, receiving an aide, receiving speech/occupational therapy) in your child’s educational services in the past 10-12 weeks?

Yes     No

11a. If yes, please describe the changes and why they occurred.

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12. How has your child been doing in school in the past 10-12 weeks (approximately 3 months)?

Poor     Below Average     Average     Above Average     Excellent

12b) Please describe examples of improvements or continued problems in school functioning:

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**Peer Relationships**

13. How have your child’s social/peer relationships been in the past 10-12 weeks?

Poor     Below Average     Average     Above Average     Excellent

13a. Please describe examples of improvements or continued problems in peer relationships:

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13b. Describe your child’s abilities to...(Please check only one for each, in reference to the past 10-12 weeks)

	Poor	Below Average	Average	Above Average	Excellent
c) Initiate interaction with peers	<input type="checkbox"/>				
d) Develop & maintain friendships	<input type="checkbox"/>				
e) Enjoy friendships	<input type="checkbox"/>				
f) Appear satisfied with social life	<input type="checkbox"/>				
g) Get along with peers	<input type="checkbox"/>				

**Family Functioning**

14. Overall, how well has your child been getting along with other family members in the past 10-12 weeks?

- Poorly                       Fair                       Good                       Excellent

14a) Please describe examples of improvements or continued problems in family functioning:

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Please describe your child's... (Please check only one of each)

	Poor	Below Average	Average	Above Average	Excellent
b) Relationship with parents	<input type="checkbox"/>				
c) Relationship with siblings	<input type="checkbox"/>				
d) Enjoyment to interact with family	<input type="checkbox"/>				

**Additional Questions:**

15. Please describe your child's behavior in the past 10-12 weeks... (Please check only one)

	Poor	Below Average	Average	Above Average	Excellent
a) Level of happiness	<input type="checkbox"/>				
b) Ability to feel good about self	<input type="checkbox"/>				
c) Ability to turn to relationships when something goes wrong	<input type="checkbox"/>				
d) Ability to not get hard on self when something goes wrong	<input type="checkbox"/>				
e) Ability to seek attention in positive and pleasurable ways	<input type="checkbox"/>				

14f) Please describe any other examples of improvements or continued problems:

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14g) Is there anything else that you would like to tell us about any changes you have noticed in your child since your child started therapy?

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