

Please print. Be sure to answer all items.

CHILD BEHAVIOR CHECKLIST FOR AGES 1½ - 5

For office use only
ID # _____

CHILD'S FULL NAME	First _____ Middle _____ Last _____
CHILD'S GENDER <input type="checkbox"/> Boy <input type="checkbox"/> Girl	CHILD'S AGE _____
CHILD'S BIRTHDATE Mo. _____ Date _____ Yr. _____	CHILD'S ETHNIC GROUP OR RACE _____
CHILD'S BIRTHDATE Mo. _____ Date _____ Yr. _____	

PARENTS' USUAL TYPE OF WORK, even if not working now. Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.

FATHER'S TYPE OF WORK: _____
MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY: (print your full name) _____

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. **Be sure to answer all items.**

Your relationship to child:

Mother Father Other (specify): _____

Below is a list of items that describe children. For each item that describes the child *now or within the past 2 months*, please circle the 2 if the item is *very true or often true* of the child. Circle the 1 if the item is *somewhat or sometimes true* of the child. If the item is *not true* of the child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to the child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

- | | |
|---|---|
| <p>0 1 2 1. Aches or pains (without medical cause; do not include stomach or headaches)</p> <p>0 1 2 2. Acts too young for age</p> <p>0 1 2 3. Afraid to try new things</p> <p>0 1 2 4. Avoids looking others in the eye</p> <p>0 1 2 5. Can't concentrate, can't pay attention for long</p> <p>0 1 2 6. Can't sit still; restless, or hyperactive</p> <p>0 1 2 7. Can't stand having things out of place</p> <p>0 1 2 8. Can't stand waiting; wants everything now</p> <p>0 1 2 9. Chews on things that aren't edible</p> <p>0 1 2 10. Clings to adults or too dependent</p> <p>0 1 2 11. Constantly seeks help</p> <p>0 1 2 12. Constipated, doesn't move bowels (when not sick)</p> <p>0 1 2 13. Cries a lot</p> <p>0 1 2 14. Cruel to animals</p> <p>0 1 2 15. Defiant</p> <p>0 1 2 16. Demands must be met immediately</p> <p>0 1 2 17. Destroys his/her own things</p> <p>0 1 2 18. Destroys things belonging to his/her family or other children</p> <p>0 1 2 19. Diarrhea or loose bowels (when not sick)</p> <p>0 1 2 20. Disobedient</p> <p>0 1 2 21. Disturbed by any change in routine</p> <p>0 1 2 22. Doesn't want to sleep alone</p> <p>0 1 2 23. Doesn't answer when people talk to him/her</p> <p>0 1 2 24. Doesn't eat well (describe): _____</p> <p>0 1 2 25. Doesn't get along with other children</p> <p>0 1 2 26. Doesn't know how to have fun; acts like a little adult</p> <p>0 1 2 27. Doesn't seem to feel guilty after misbehaving</p> <p>0 1 2 28. Doesn't want to go out of home</p> <p>0 1 2 29. Easily frustrated</p> | <p>0 1 2 30. Easily jealous</p> <p>0 1 2 31. Eats or drinks things that are not food—<i>don't</i> include sweets (describe): _____</p> <p>0 1 2 32. Fears certain animals, situations, or places (describe): _____</p> <p>0 1 2 33. Feelings are easily hurt</p> <p>0 1 2 34. Gets hurt a lot, accident-prone</p> <p>0 1 2 35. Gets in many fights</p> <p>0 1 2 36. Gets into everything</p> <p>0 1 2 37. Gets too upset when separated from parents</p> <p>0 1 2 38. Has trouble getting to sleep</p> <p>0 1 2 39. Headaches (without medical cause)</p> <p>0 1 2 40. Hits others</p> <p>0 1 2 41. Holds his/her breath</p> <p>0 1 2 42. Hurts animals or people without meaning to</p> <p>0 1 2 43. Looks unhappy without good reason</p> <p>0 1 2 44. Angry moods</p> <p>0 1 2 45. Nausea, feels sick (without medical cause)</p> <p>0 1 2 46. Nervous movements or twitching (describe): _____</p> <p>0 1 2 47. Nervous, highstrung, or tense</p> <p>0 1 2 48. Nightmares</p> <p>0 1 2 49. Overeating</p> <p>0 1 2 50. Overtired</p> <p>0 1 2 51. Shows panic for no good reason</p> <p>0 1 2 52. Painful bowel movements (without medical cause)</p> <p>0 1 2 53. Physically attacks people</p> <p>0 1 2 54. Picks nose, skin, or other parts of body (describe): _____</p> |
|---|---|

Be sure you have answered all items. Then see other side.

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do not include brothers & sisters)

None 1 2 or 3 4 or more

About how many times a week does your child do things with any friends outside of regular school hours?

(Do not include brothers & sisters)

Less than 1 1 or 2 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has no brothers or sisters
b. Get along with other kids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Behave with his/her parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Play and work alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

VII. 1. Performance in academic subjects.

Does not attend school because _____

Check a box for each subject that child takes

Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., or other nonacademic subjects.

	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does your child receive special education or remedial services or attend a special class or special school?

No Yes—kind of services, class, or school:

3. Has your child repeated any grades? No Yes—grades and reasons:

4. Has your child had any academic or other problems in school? No Yes—please describe:

When did these problems start? _____

Have these problems ended? No Yes—when?

Does your child have any illness or disability (either physical or mental)? No Yes—please describe:

What concerns you most about your child?

Describe the best things about your child.