



Carlisle



CONSULTING & COUNSELING SERVICES, LLC

Behavioral Health Referral Check List

Please think of your child in several settings and complete this form.

Name: _____ School/Location: _____
Grade: _____ Date of Birth: _____ Insurance Type/Number: _____

- | | |
|--|---|
| <input type="checkbox"/> Often distracted | <input type="checkbox"/> Does not follow through on instructions |
| <input type="checkbox"/> Fails to give close attention to details | <input type="checkbox"/> Difficulty organizing tasks |
| <input type="checkbox"/> Difficulty sustaining attention in tasks | <input type="checkbox"/> Often loses things necessary for tasks |
| <input type="checkbox"/> Picks at things (nails, clothing, hair, etc.) | <input type="checkbox"/> Worries unnecessarily |
| <input type="checkbox"/> Talks back to authority figures (attitude) | <input type="checkbox"/> Has problems with speech (stuttering, baby talk) |
| <input type="checkbox"/> Often angry and resentful | <input type="checkbox"/> Lies to obtain goods or favors |
| <input type="checkbox"/> Wants to give orders | <input type="checkbox"/> Experiences fear and anxiety in new situations |
| <input type="checkbox"/> Excitable or impulsive | <input type="checkbox"/> Does not follow rules, makes wrong decisions |
| <input type="checkbox"/> Difficulty or impulsive | <input type="checkbox"/> Often runs about or climbs excessively |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Forced someone into sexual activity |
| <input type="checkbox"/> Pouts and has a bad temper | <input type="checkbox"/> Blurts out answers before questions have been asked |
| <input type="checkbox"/> Sucks or chews thumb, finger, or clothing | <input type="checkbox"/> Has difficulty awaiting their turn |
| <input type="checkbox"/> Does not seem to listen when spoken to directly | <input type="checkbox"/> Often interrupts or intrudes on others |
| <input type="checkbox"/> Tendency to daydream | <input type="checkbox"/> Often forgetful in daily activities |
| <input type="checkbox"/> Has a chip on his or her shoulder | <input type="checkbox"/> Physically cruel to people/animals |
| <input type="checkbox"/> Often fidgets with hands or feet, squirms in seat | <input type="checkbox"/> Often loses temper |
| <input type="checkbox"/> Breaks things/destructive | <input type="checkbox"/> Poor personal hygiene habits |
| <input type="checkbox"/> Shy and does not assert self | <input type="checkbox"/> Often bullies, threatens, or intimidates |
| <input type="checkbox"/> Has stolen items (shoplifting) | <input type="checkbox"/> Used weapons to cause physical harm to others |
| <input type="checkbox"/> Blames others for their mistakes | <input type="checkbox"/> Reserved, a loner, unusually quiet, or sad |
| <input type="checkbox"/> Argues with adults | <input type="checkbox"/> Has a learning disability or IEP |
| <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Sneaks out to use alcohol/drugs/cigarettes/etc. |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Often has difficulty playing or engaging in leisure activities |
| <input type="checkbox"/> Often leaves seat in classroom | <input type="checkbox"/> Often avoids or dislikes mental effort activities |
| <input type="checkbox"/> Deliberately engaging in fire setting | <input type="checkbox"/> Deliberately destroyed others' property |
| <input type="checkbox"/> Broken into someone's house | <input type="checkbox"/> Runs away from home overnight at least twice |
| <input type="checkbox"/> Truant from school | <input type="checkbox"/> Stays out at night despite parental prohibitions |
| <input type="checkbox"/> Deliberately annoys people | <input type="checkbox"/> Often defies or refuses to comply with adults' rules |
| <input type="checkbox"/> Broken into someone else's house | <input type="checkbox"/> Often initiates physical fights |

Parent Name: _____ Phone Number: _____ DATE: _____