**The Amelia Center**

Reactions – Child & Teen

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Child:** |  | | | **Date of Birth:** | /      / | | |
| **Parent/Guardian:** |  | | | **Today’s Date:** | /      / | | |
| **School Attending:** |  | | | **Grade:** |  | | |
| **School System:** |  | | |
| **Ethnic Background** | |
| African American  Caucasian  Hispanic/Latino  Other: | | | | | | |
| **How is this child related to the person who died?** | | | | | | | |
| Son/Daughter  Grandchild  Sibling  Friend  Other (specify) | | | | | | | |
| **If your child is taking medications prescribed for mood or psychiatric needs, please list. Please specify if medication began before or after the death.** | | | | | |
|  | | | | | |
|  | | | | | |
| **Is your child currently seeing or has seen another mental health professional in the past year?** (Please specify) | | | | | |
|  | | | | | |
| * **Did the child witness the death?** | | | Yes  No | | |
| * **Did the child attend the funeral?** | | | Yes  No | | |
| * **How close was the child to the person who died?** | | | Very close  Average  Not very close | | |
| **What is your primary concern for this child?** | | | | | |
|  | | | | | |
| ***Please continue to the next page for the Behavior/Reaction Checklist.*** | | | | | |

|  |  |  |
| --- | --- | --- |
| Behavior/Reaction Checklist • Please check the box if it applies to the child. | | |
| **Before the death** | **After the death** | School |
|  |  | Not paying attention in class |
|  |  | Grades dropping |
|  |  | Absence from school |
|  |  | Poor behavior in school |
|  |  | Skipping school |
|  |  | Dropping out of school |
|  |  | Friends |
|  |  | Not getting along with friends |
|  |  | Lack of interest in friends |
|  |  | Can’t be separated from friends |
|  |  | Home |
|  |  | Fights/argues with parents or siblings |
|  |  | Clings to parents |
|  |  | Frequent mood changes |
|  |  | Regressive behaviors, such as bed wetting, thumb sucking, etc. |
|  |  | Lack of interest in family activities |
|  |  | Behaving more mature than normal |
|  |  | Physical |
|  |  | Sleeping problems |
|  |  | Eating problems |
|  |  | Anxiety or nervousness |
|  |  | Headaches or stomachaches |
|  |  | Lack of energy/lack of enthusiasm |
|  |  | **Death/Illness Related** |
|  |  | Guilt related to the circumstances |
|  |  | Lack of understanding regarding the facts of the illness/death |
|  |  | Preoccupation with death/dying |
|  |  | Unable to talk about the person who is ill/died |
|  |  | Dreams of a deceased loved one |
|  |  | Acts as if the person is not sick/is still alive |
|  |  | **Fears (My child is afraid…)** |
|  |  | Of the dark |
|  |  | That he or she will die |
|  |  | That someone else will die |
|  |  | New experiences |
|  |  | Of being alone or sleeping alone |
|  |  | **Coping with Loss** |
|  |  | Expresses anger in inappropriate ways |
|  |  | Generally holds feelings inside |
|  |  | Feels that others do not understand |
|  |  | Avoids discussing the illness/death |
|  |  | Increased crying/overly sensitive |
|  |  | Self-harming behaviors or making statements about harming self |