Park Cities Child and Family Counseling

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WEEKLY REPORT

Child Name:___________________ Date:____________ Person Completing Form : ____________

1. Any new changes (small and/or larger) since last seen therapist:
    a. Home (parent worked longer hours this week, pet dying....etc.):

    b. School (substitute teacher, didn't eat lunch, fight with peers....etc.):

    c. Physical (new medications, stopped medication, sore throat, lost weight....etc.):

2. New behaviors noticed that concern you:

3. Behavior(s) of Concern (_________________) as compared to last week:

1	2	3	4	5	6	7	8	9	10
Better				Same				Worse	

4. Something positive your child did this week that either surprised you or impressed you:

5. Other Concerns or Questions?

6. I need to talk to you about these questions/concerns:
    ____ At a future parent consultation.
    ____ Additional appointment – Therapist will call to arrange this.