GroupWorks, LLC Wellness and Recovery Services

CHILD INTAKE FORM

Date:_____

Child's Name: : _____ _____ _____ Name Preference: _____
First Name M. I. Last Name

Birth Gender: ☐ Male ☐ Female Gender Identity: _____ Pronoun Preference: _____

Age:_____ Date of Birth:_____ Your name and relationship to child _____

Who has current legal guardianship of child?_____

Race: ☐ White ☐ Black/African American ☐ Native American/Alaskan
☐Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino

Home #:_____ Work #:_____ Cell#_____

Mail Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____County of Residence:_____

Who referred this child to GroupWorks?_____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us

Who _____ Office _____

Child Currently Lives:

- ☐ at home with family
- ☐ at a relative's home (name and relationship of custodial adults in this home): _____
- ☐ in a foster home (name of foster parents)_____
- ☐ at a group home or residential facility (name of facility)_____
- ☐ other (please explain)_____

length of time child has been at current placement?:_____

People residing in the same household with child:

Name	Age	Occupation	Relationship to child

Please list any changes in the family/household in the past year ☐ None

_____

_____

_____

Order for protection and restraining order policy (Please read and sign):

In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with GroupWorks' policy concerning disclosure of restraining orders.

_____ _____

Parent or Legal Guardian Signature **Date**

Is there currently an Order for Protection (OFP) or Harassment Order in place from any state regarding a member of your household?

☐ Yes ☐ No If yes, name of family member _____

Name of other party involved _____

Expiration Date of Order _____

Client name:_____ DOB:_____ Today's Date:_____

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CONCERNS

What are the main concerns you have about the child? _____

_____

_____

How long has this problem been a concern? _____

_____

When did you first notice the problem? _____

Are there any current or pending legal actions against the child? ☐ Yes ☐ No

If yes explain: _____

_____

Is the County Social Services involved with this child or family? ☐ Yes ☐ No

If yes explain: _____

_____

Have there been mental health services involved with this child before? ☐ Yes ☐ No

If yes explain: _____

_____

What evaluations have already been performed? _____

_____

_____

Have there been any inpatient psychiatric hospitalizations? _____

Where? _____

_____

What has already been done to treat this problem (diet, medications, counseling)? _____

_____

What have you done, personally, to address the problem? _____

_____

What seems to help the most? _____

_____

What would you like to see change by coming here? _____

_____

_____

Is there anything additional information you would like us to know? If yes, please list here

_____

_____

_____

_____

_____

CONCERNS	1 never	2 a little	3 sometimes	4 a lot	5 always
1. **Anxiety**	☐	☐	☐	☐	☐
2. **Physical Problems**	☐	☐	☐	☐	☐
3. **Sleep Problems**	☐	☐	☐	☐	☐
4. **Depression**	☐	☐	☐	☐	☐
5. **Alcohol or Substance Abuse**	☐	☐	☐	☐	☐
6. **Parent-Child Conflicts**	☐	☐	☐	☐	☐
7. **Sibling Conflicts**	☐	☐	☐	☐	☐
8. **Social Relationships**	☐	☐	☐	☐	☐
9. **School Problems**	☐	☐	☐	☐	☐
10. **Sexual Problems**	☐	☐	☐	☐	☐
11. **Spiritual/Religious**	☐	☐	☐	☐	☐
12. **Legal Problems**	☐	☐	☐	☐	☐
13. **Eating Disorder**	☐	☐	☐	☐	☐
14. **Abuse (physical, emotional, sexual)**	☐	☐	☐	☐	☐

Please add any other information that would help us help your child: _____

_____

_____

_____

_____

_____

OTHER SERVICES MY CHILD IS RECEIVING : ☐ No other services at this time

Occupational Therapy ☐ Yes Where _____ Provider _____

Physical Therapy ☐ Yes Where _____ Provider _____

Speech Therapy ☐ Yes Where _____ Provider _____

CTSS In-home ☐ Yes Where _____ Provider _____

CTSS School-based ☐ Yes Where _____ Provider _____

Kinship ☐ Yes Where _____ Provider _____

Social Services ☐ Yes Where _____ Provider _____

Other _____ ☐ Yes Where _____ Provider _____

Other _____ ☐ Yes Where _____ Provider _____

Client name: _____ DOB: _____ Today's Date: _____

MARITAL

Are the biological parents of the child ☐ Married ☐ Separated ☐ Divorced ☐ Living together
☐ Never were together ☐ Widowed ☐ Other_____

Are the biological parents now remarried or living with a significant other? ☐ Yes ☐ No

If yes, who:_____

If biological parents are divorced, what are the legal and physical custody arrangements?

_____

_____

If divorced, what is the non-custodial parent's involvement with this evaluation? _____

_____

_____

Is your child adopted? _____ *Does child know?* _____ *If not, do you intend to tell the child?* _____

At what age was the child placed in your home? _____ *At what age when adopted?* _____

If your child was adopted, please answer the following sections as best you can.

FAMILY

Are you satisfied with how your family works? ☐ Yes ☐ No *(please circle any that might apply)*

lack of structure; rules
poor communication
poor division of chores, responsibilities
marital problems
no family "together times"
financial troubles
lack of "breathing space"
resentment of another member

Comments _____

_____

Where and how does this child fit in the family? *(please circle any that apply)*

sibling rivalry (more than expected)
spoiled, always get own way
a rescuer, can't stand upsets
a team player
a manipulator
a helper

Born baby # _____ out of _____ children

Please indicate which types of discipline are used in your family by using M for mother and F for father.

discussion and education _____
encouraging independent thinking _____
contracts/token systems _____
lecturing, nagging, yelling _____
positive reward and praise _____
time out _____
spanking _____
restriction/grounding _____

For what is your child most frequently disciplined? _____

_____

What type of discipline(s) work best with your child? _____

_____

Please circle any of the following stressors which might apply to your family's situation, or to which the child had an extremely strong reaction. Please note how long ago the stressor occurred:

parental separation/divorce
death of a family member/important friend
change in school
financial stress
severe illness
move to a new house
change of job
pregnancy/birth of new child

Comments _____

_____

Are there any "family secrets" or important things we have left out? Please include such things as relationships between divorced parents, involvement of extended family, parental adjustment difficulties, etc

_____

_____

_____

Family psychiatric history (including grandparents, aunts, uncles, cousins, etc)?

Who? _____

_____

Please describe any abuse, chemical dependency or legal difficulties in the child's immediate relatives:_____

_____

_____

_____

Is there any family history of medical, developmental, learning, or legal difficulties?

☐ Yes ☐ No If yes, please list the individual's relationship to the child, the nature of each difficulty, and any treatments received. Please include past generations and extended family if you have such information:

_____

_____

Please describe any psychiatric or psychological treatment this child or any sibling has received:

_____

_____

_____

_____

Please review each of the following lists of characteristics and check any item that applies to your child.

A. Does your child have any of the following attention related troubles?

_____ fidgets
_____ easily distracted
_____ difficulty playing quietly
_____ shifts from one activity to another
_____ often interrupts or intrudes on others
_____ often engages in physically dangerous activities
_____ often blurts answers to questions before completed
_____ difficulty remaining seated
_____ difficulty awaiting turn
_____ difficulty sustaining attention
_____ often does not listen
_____ often loses things
_____ difficulty following instructions
_____ often talks excessively

B. Does your child have any of the following oppositional troubles?

_____ often deliberately acts to annoy others
_____ is often touchy or annoyed by others
_____ often swears/uses obscene language
_____ often blames others for own mistakes
_____ often actively defies or refuses adult request of rules
_____ often takes or touches others' property without asking
_____ often argues with adults
_____ is often angry or resentful
_____ is often spiteful or vindictive
_____ often loses temper

C. Has your child had problems with any of the following?

_____ stolen without confrontation
_____ deliberate fire-setting
_____ breaking and entering
_____ cruel to animals
_____ forced someone else into sexual activity
_____ often initiates physical fights
_____ lies often
_____ often truant from school
_____ destroyed others' property
_____ used a weapon in a fight
_____ stolen with confrontation
_____ physically cruel to people

D. Does your child show any of the following anxiety symptoms?

_____ unrealistic worry about future events
_____ persistent refusal to go to school
_____ bothersome thoughts
_____ unrealistic concerns about competence
_____ repeated nightmares about separation from you
_____ excessive distress when separated from home or you
_____ excessive need for reassurance
_____ unrealistic and persistent worry something will happen to you
_____ avoidance of being alone
_____ physical aches and pains
_____ marked self-consciousness
_____ marked inability to relax
_____ ongoing refusal to sleep alone

E. Does your child show:

_____ diminished pleasure in activities
_____ poor appetite or overeating
_____ trouble sleeping or sleeping too much
_____ poor concentration or difficulty making decisions
_____ depressed or irritable mood most of day, almost daily
_____ feelings of worthlessness or excessive inappropriate guilt
_____ feelings of hopelessness
_____ suicidal thoughts or actions
_____ agitation or sluggishness
_____ low self-esteem
_____ low energy or fatigue

F. Does your child have any of the following?

_____ repeated unusual movements
_____ compulsive rituals
_____ vocal tics
_____ excessive reaction to noise or failing to react to loud noises
_____ odd postures
_____ motor tics
_____ overreacts to touch

G. Has your child exhibited any symptoms of thought disturbance, including any of the following?

_____ can't get to the point, loses train of thought
_____ bizarre ideas (odd fascinations, strange ideas, hallucinations)
_____ disoriented, confused, staring or "spacey"
_____ incoherent speech (mumbles, uses words only the child understands)

H. Has your child exhibited symptoms of affective mood disturbance, including any of these?

_____ explosive temper with little provocation
_____ excessively monotonous or bland affect
_____ situationally inappropriate emotions
_____ excessive reaction to changes in routine
_____ unusual fears
_____ panic attacks
_____ excessive mood swings

I. Has your child exhibited any of the following? Check and circle which ones fit your child

_____ melt down for 30 minutes or longer
_____ want to control his family and friends
_____ like to be held tight (calms behavior)
_____ dislike tags, pants, long-sleeve shirts
socks with lining across toes (circle any that apply)
_____ prefer short-sleeve shirts, shorts, no socks,
dresses, big clothes
_____ hear background noise or other noises
that may disturb their attention
_____ hair brushing may "hurt", doesn't like hair,
fingernails or toenails cut
_____ certain smells are bothersome or no smell at all
_____ transitioning to places, people, or objects is difficult
_____ likes crashing, bashing, jumping, and rough-housing
_____ constantly touches objects, touches and intrudes on people
_____ often licks, sucks, or chews on non-food items, hair, hands, pencils, clothing
_____ clumsy
_____ falling
_____ slouching
_____ stiff
_____ uncoordinated
_____ toe walking (past or current)
_____ ascending and descending stairs
_____ slap feet when walking
_____ does not like gentle touches
_____ only eats certain foods
_____ difficulty tolerating bright light
_____ poor spatial relationships
_____ doesn't like being held upside down

Comments regarding any of the above items which you checked _____

Has your child ever experienced anything that has been difficult for him/her to cope with? ☐ Yes ☐ No

If yes, please describe _____

Does your child	**Frequently**	**Sometimes**	**Rarely**	**Never**
Bully, threaten, or intimidate other people	☐	☐	☐	☐
Behave in a manner physically cruel to animals or people	☐	☐	☐	☐
Seem to experience truancy from school	☐	☐	☐	☐
Stay out at night despite your rules	☐	☐	☐	☐
Run away from home	☐	☐	☐	☐
Force people into sexual activity	☐	☐	☐	☐
Engage in fire setting behavior	☐	☐	☐	☐
Destroy other people's property	☐	☐	☐	☐
Lie to get things from other people or avoid responsibility	☐	☐	☐	☐

Would you consider your child to be depressed? ☐ Yes ☐ No

If yes, what are your concerns _____

Has your child ever made a suicide plan or any attempt on his/her life? ☐ Yes ☐ No

If yes, please explain with # of attempts _____

Please describe your child's sleeping habits _____

Would you consider your child to be anxious or worried? ☐ Yes ☐ No

If yes, what are your concerns _____

Does your child have difficulty when he/she is separated from the family or home? ☐ Yes ☐ No
If yes, please explain _____

Does your child have excessive fears about bad things happening? ☐ Yes ☐ No
If yes, please explain _____

Does your child report physical syptoms when he/she are trying to avoid something? ☐ Yes ☐ No
If yes, please explain _____

STRENGTHS
Please tell us about your child's most outstanding characteristics, hobbies, achievements, abilities, etc.

_____
_____
_____
_____
_____
_____
_____

HEALTH **Current physician:** _____ **Location:** _____
When was your child's last physical examination? _____ Results: _____
Is your child allergic to any drugs? ☐ Yes ☐ No
If Yes, please list _____
Does your have child any other allergies? ☐ Yes ☐ No
For example, foods, air borne, etc. If Yes, please list _____
Is your child a pregnant teen? ☐ Yes ☐ No
Does your child have any problems that might interfere with receiving services here? ☐ Yes ☐ No
If Yes, please list _____
Has your child had any of the following? *(please circle all that apply)*

Measles	Mumps	Chicken pox	Whooping cough
Pneumonia	Encephalitis	Meningitis	Ear infections
Lead poisoning	Allergies	Vision problems	Hearing problems
Unexplained high fevers			

Please explain any circled items _____
_____

Does your child have any of the following? (*please circle any that apply*):

A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts)
C. lung problems (shortness of breath, asthma, coughing, etc.)
D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc)
E. blood disorder (anemia, bleeding, bruising, etc)
F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc)
G. sexual problems (birth control, promiscuity, excessive masturbation, etc)
H. kidney problems (bedwetting, infections, etc)
I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc)
J. history of poisoning (lead, chemicals, other)
K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc)
L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, lack of bladder control, etc)
M. genetic disorders (birth defects, inherited traits, chromosome abnormalities)

Please explain any items _____
_____

Biological mother's name _____ Age _____

Has biological mother had any of the following? (*please circle any that apply*):

A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts)
C. lung problems (shortness of breath, asthma, coughing, etc.)
D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc)
E. blood disorder (anemia, bleeding, bruising, etc)
F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc)
G. sexual problems (birth control, promiscuity, excessive masturbation, etc)
H. kidney problems (bedwetting, infections, etc)
I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc)
J. history of poisoning (lead, chemicals, other)
K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc)
L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, lack of bladder control, etc)
M. genetic disorders (birth defects, inherited traits, chromosome abnormalities)

Please explain any items _____

Biological father's name _____ Age _____

Has biological father had any of the following? (*please circle any that apply*):

A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts)
C. lung problems (shortness of breath, asthma, coughing, etc.)
D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc)
E. blood disorder (anemia, bleeding, bruising, etc)
F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc)
G. sexual problems (birth control, promiscuity, excessive masturbation, etc)
H. kidney problems (bedwetting, infections, etc)
I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc)
J. history of poisoning (lead, chemicals, other)
K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc)
L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, lack of bladder control, etc)
M. genetic disorders (birth defects, inherited traits, chromosome abnormalities)

Please explain any items _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, complete the following

Age	Reason for stay	Length of stay	Where

Has your child ever taken medication to help with behavior or emotional problems?

Age	Medicine	Doctor	Reason	When/Why stopped

Does your child take ANY medication on a regular basis for chronic or recurring conditions?

Medicine	Doctor	Reason	Start date

Has your child had any special diagnostic tests (x-rays, EEG, MRI, CT scan, blood tests, etc) or hospitalizations?

Age	Test	Reason	Results

Have you ever suspected that this child might have been physically or sexually abused?

☐ Yes ☐ No *If yes, please explain* _____

Has your child ever been treated or experienced any of the following?

- ☐ Abnormal movements
- ☐ Birth or developmental problems
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ ADHD / Hyperactivity
- ☐ Anxiety
- ☐ Fears
- ☐ Failure to complete tasks
- ☐ Depression
- ☐ Eating problems ☐ Too Much ☐ Too Little
- ☐ Head injury / concussion / loss of consciousness
- ☐ Other serious injury or accident
- ☐ Seizure
- ☐ Suspension / expulsion / truancy - school
- ☐ Yelling / swearing
- ☐ Hearing voices, seeing something others don't
- ☐ Sleep disturbance or difficulty
- ☐ Hospitalizations
- ☐ Chronic pain
- ☐ Irritable
- ☐ Headaches, migraines
- ☐ Fights / stealing /lying
- ☐ Fear of germs
- ☐ Legal problems
- ☐ Destroying property
- ☐ Bedwetting / Incontinence
- ☐ Menses
- ☐ Decreased interest in friends / activities
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Speech
- ☐ Setting fires
- ☐ Sexually transmitted disease
- ☐ Other _____

If any of the above boxes are checked, please comment on severity and duration of problem _____

_____

_____

_____

_____

PREGNANCY AND BIRTH

Was the pregnancy

a) planned? ☐ Yes ☐ No b) welcomed? ☐ Yes ☐ No c) stressful? ☐ Yes ☐ No

How many weeks into the pregnancy was it diagnosed? _____

For the three months prior to the pregnancy and the first two months of pregnancy, did the mother use

- Prescribed medications ☐ Yes ☐ No How much? _____
- Recreational drugs ☐ Yes ☐ No How much? _____
- Alcohol ☐ Yes ☐ No How much? _____
- Tobacco ☐ Yes ☐ No How much? _____

During the following seven months of pregnancy, did the mother use

- Prescribed medications ☐ Yes ☐ No How much? _____
- Recreational drugs ☐ Yes ☐ No How much? _____
- Alcohol ☐ Yes ☐ No How much? _____
- Tobacco ☐ Yes ☐ No How much? _____

Were there any medical concerns or other issues during this pregnancy regarding mother and/or baby?

_____

Name and address of hospital where the child was born _____

List any types of pain medications/anesthesia used during delivery _____

_____

At the time of birth

How long did the pregnancy last? _____ weeks How long was the labor? _____ hours

What was the baby's birth weight? _____ lbs _____ ozs birth length? _____ inches

Head circumference? _____ inches

Was the baby born vaginally _____ or caesarean _____

Was the baby born head first _____ breech _____ or other (*explain*)_____

Did the baby have? *(please circle all that apply)*:

Trouble breathing	Yellow jaundice	Blood transfusion
Resuscitation	Jitteriness	Physical injuries
Twin	Seizures/fits	Trouble sucking
Birth defects	Cord around neck	Intensive care
Fevers or low temperature		

Was the baby breast-fed? _____ How long? _____ Bottle-fed? _____ Formula name _____

Did the baby have any early feeding problem? _____ Describe _____

_____

Please describe any other concerns or problems noted by either the doctors or parents _____

_____

DEVELOPMENTAL HISTORY

Early development

A. At about what age did your child first	age	Not sure of age, but: Early	On Time	Late
Smile, goo and coo	_____	_____	_____	_____
Sit up	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Stand alone	_____	_____	_____	_____
Speak real words	_____	_____	_____	_____
Walk by self	_____	_____	_____	_____
Feed self	_____	_____	_____	_____
Use two word sentences	_____	_____	_____	_____
Dress self (except buttoning and tying)	_____	_____	_____	_____
Speak so that strangers understood	_____	_____	_____	_____
Ride a tricycle	_____	_____	_____	_____
Ride a bicycle	_____	_____	_____	_____
Tie own shoe	_____	_____	_____	_____

Do you have any concerns about your child's motor or muscle development?

_____

Do any of the following concern you regarding your child's language development? *Please circle*.

trouble finding the right words	too few words
unconnected thoughts	repeats words/phrases over and over
has seen a speech therapist	speech clarity
following directions	seems confused when spoken to
stuttering	missing sounds (like r or k)

Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his/her peers? _____

_____

Did your child seem to learn pre-academic skills such as numbers, colors, shapes, etc, at the same time as other children his/her age? _____ *If no, please explain* _____

_____

SCHOOL

Current school: _____ Grade: _____ Teacher: _____

What is your impression of your child's learning potential? *Please circle*

Low Average Above-average Gifted

Do you feel that your child is performing up to his/her potential in school? ☐ Yes ☐ No

Do you feel that your child has any difficulties with *(circle any that apply and explain)*

Reading _____

Writing _____

Arithmetic _____

Social studies _____

Science _____

Languages _____

Is homework a problem? ☐ Yes ☐ No *If yes, please circle all that apply*

can't get started	no place to work
forgets to bring home materials	forgets assignments
doesn't understand the work	doesn't anticipate deadlines
distracted by radio, tv, or anything	takes too long
battles or argues about doing work	the most stressful time of day
needs you there constantly	doesn't care/no motivation

Is your child's work made more difficult by problems with	Not at all	Somewhat	A lot
poor concentration	_____	_____	_____
giving up too easily	_____	_____	_____
inconsistent performance	_____	_____	_____
poor motivation	_____	_____	_____
disorganization	_____	_____	_____
spacing out or daydreaming	_____	_____	_____
not finishing things	_____	_____	_____
having low frustration tolerance	_____	_____	_____
anxiety/sadness	_____	_____	_____
poor handwriting	_____	_____	_____
rapidly shifting from one thing to another	_____	_____	_____
being easily distracted	_____	_____	_____
impulsiveness	_____	_____	_____
anxious	_____	_____	_____

Has your child even been retained? ☐ Yes ☐ No advanced a grade? ☐ Yes ☐ No

suspended? ☐ Yes ☐ No expelled? ☐ Yes ☐ No

Please list all the schools your child has attended

Name of School	Address of School	Grade (s) atttended

SOCIAL

Does your child get along well with others? ☐ Yes ☐ No

In what areas do you notice difficulties	Yes	No	Sometimes
makes friends easily	_____	_____	_____
has a best friend	_____	_____	_____
plays well with others	_____	_____	_____
shares easily	_____	_____	_____
follow rules	_____	_____	_____
enjoys team sports	_____	_____	_____
leads other children	_____	_____	_____
helps others	_____	_____	_____
easily influenced	_____	_____	_____
prefers to be alone	_____	_____	_____
is a party animal	_____	_____	_____
bullies others	_____	_____	_____
fights others	_____	_____	_____
insists on having his own way	_____	_____	_____

Comments _____

_____

SELF-ESTEEM

Does your child *(please circle)*

have an "I can do it" attitude?	Yes	No	give up easily?	Yes	No
recover from upsets?	Yes	No	stand up for self?	Yes	No
recognize strengths?	Yes	No	lack confidence?	Yes	No
			act adventuresome?	Yes	No