

WACB – 0 - 2

(Weekly Assessm	ent of C	hild Be	havior –	for 0 –	2 year c	olds)			
Admin Use Only: Check if adminis	stered by	therapist							
ur Name	Relationship to Child Today's Dat								/
ild's Name	Child's Gender					Chi	Child's Age		
Directions: Please fill out the whole form by c									
b) Check either "yes" or "no" to sh	now whe me (once								
STEP 1:]								
n the past week	Not at all			Sort of		Very		Does this need to change?	
How stressful was it to parent this child?	1	2	3	4	5	6	7	YES	NO
<u>STEP 2:</u>								Does tl	his need
How often does your child	Never Sometimes Always				to change?				
1. Have trouble falling asleep?	1	2	3	4	5	6	7	YES	NO
2. Have trouble feeding, or fuss about food?	1	2	3	4	5	6	7	YES	NO
3. Act cranky and get easily upset?	1	2	3	4	5	6	7	YES	NO
4. Have trouble waking up or staying awake?	1	2	3	4	5	6	7	YES	NO
Have intense tantrums, screaming and crying?	1	2	3	4	5	6	7	YES	NO

				Total Score (items 1 through 9 ONLY)			/63	/9 (1 per YES)	
						1			
9. Seem agitated and upset for no reason?	1	2	3	4	5	6	7	YES	NO
8. Show no interest in toys, other children, or animals?	1	2	3	4	5	6	7	YES	NO
7. Act extremely hard to calm or console?	1	2	3	4	5	6	7	YES	NO
6. Stare into space and not respond to efforts to engage?	1	2	3	4	5	6	7	YES	NO