

WACB – N

(Weekly Assessment of Child Behavior – N)

Admin Use Only:	Check if administered by therapist <input type="checkbox"/>	Session # _____
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Your Name _____ Relationship to Child _____ Today's Date ___/___/___

Child's Name _____ Child's Gender _____ Child's Age _____

Directions: Please fill out the whole form by checking one number per sentence. For each sentence:

- a) Please check the number that shows **how often** your child behaved that way in the last week.
- b) Check either "yes" or "no" to show whether you need that behavior to change.

For example: If your child rarely cried at bedtime (once or twice) last week, you might choose 2 and check "NO."

How often does your child...	Never	Sometimes	Always		Change?				
1. Cry at bedtime?	1	2	3	4	5	6	7	YES	NO
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STEP 1:													
In 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				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
STEP 2:													
How often does your child....	Never			Sometimes				Always		Does this need to change?			
1. Dawdle, linger, stall, or delay?	1	2	3	4	5	6	7	YES	NO				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Have trouble behaving at meal times?	1	2	3	4	5	6	7	YES	NO				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Disobey or act defiant?	1	2	3	4	5	6	7	YES	NO				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Act angry, or aggressive?	1	2	3	4	5	6	7	YES	NO				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Scream and yell when upset and is hard to calm?	1	2	3	4	5	6	7	YES	NO				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

6. Destroy or act careless with others' things?	1	2	3	4	5	6	7	YES	NO
7. Provoke others or pick fights?	1	2	3	4	5	6	7	YES	NO
8. Interrupt or seek attention?	1	2	3	4	5	6	7	YES	NO
9. Have trouble paying attention or is overactive?	1	2	3	4	5	6	7	YES	NO
						Total Score (items 1 through 9 ONLY)		/63	
								/9 (1 per YES)	