

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 circling one number per sentence. For each sentence:

- a) Please circle the number that shows **how often** your child behaved that way in the last week.
- b) Circle 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 circle "NO."

How often does your child...	Never		Sometimes		Always		Change?	
1. Cry at bedtime?	1	2	3	4	5	6	7	YES <input type="checkbox"/> NO <input style="border: 1px solid black; border-radius: 50%; text-align: center;" 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		
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		
2. Have trouble behaving at meal times?	1	2	3	4	5	6	7	YES	NO		
3. Disobey or act defiant?	1	2	3	4	5	6	7	YES	NO		
4. Act angry, or aggressive?	1	2	3	4	5	6	7	YES	NO		
5. Scream and yell when upset and is hard to calm?	1	2	3	4	5	6	7	YES	NO		
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)			

