

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 selecting one number per sentence. For each sentence:

- a) Please select the number that shows **how often** your child behaved that way in the past week.
- b) Select 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 select "2" and "NO."

How often does your child... *Never* *Sometimes* *Always* *Need to Change?*

1. Cry at bedtime? 1 2 3 4 5 6 7 YES NO

STEP 1:									
In the past week...	Sort of							Does this need to change?	
	Not at all						Very	YES	NO
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)

