

Child & Family Counseling Clinic

411 S. Prieur St, Room 307

New Orleans, LA 70112

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Weekly Feedback Form

Date: _____

Child's Name/age: _____

Therapist: _____

Caregiver's name: _____

I. Note significant and/or new happenings in child's life since last session (positive and/or negative). If more space needed, use back to write additional information.

At school: new teacher, received honor, low grades, behavior problems/detention, fight with friend, friend moved, etc:

At home: parent working extra long hours, shared toys, completed chores, birthday, pet dying, friend moving away, etc.:

Environmental Changes: sleep patterns, appetite, change in support system, moved to new home, grandma visiting, etc:

Physical changes: complaints, loss/gain of weight, head or stomachache, started menstruating, signs of puberty, etc

II. Medication: New: _____

Discontinued: _____

III. Assessment of Changes in Child: Rate 2 target behaviors of concern using the scale as indicated below.

1	2	3	4	5	6	7	8	9	10
<i>worse</i>			<i>same</i>				<i>better</i>		

Child's overall behavior, compared to last week:

1 2 3 4 5 6 7 8 9 10

Child's behavior of concern (_____), compared to last week:

1 2 3 4 5 6 7 8 9 10

Child's behavior of concern (_____), compared to last week:

1 2 3 4 5 6 7 8 9 10

Child's mood/attitude toward life, compared to last week:

1 2 3 4 5 6 7 8 9 10

My experience caring for child (stressful vs. enjoyment of child, felt in control, etc) compared to last week:

1 2 3 4 5 6 7 8 9 10

I would like to: talk with you as soon as possible talk with you before next session schedule a face-to-face consultation

Issue of concern: _____