6430

Centers for Family Change

Brief Child Outcome Questionnaire

Version 11

Completed by: ○ Child ○ Adult who knows the child well

Below is a list of things young people might do, or feel. Please fill in the circle that best tells how often you did, or felt these things in the last 2 weeks. Think about the different places you may have done or felt these things, like at school, at home, or with friends (or at work, if you have a job).

In the past 2 weeks how often did you...	Never	Hardly ever	Some-times	Often	Very often
Feel threatened or bullied by others?	○	○	○	○	○
Feel worthless?	○	○	○	○	○
Have a hard time having fun?	○	○	○	○	○
Sleep a lot more than you normally do?	○	○	○	○	○
Eat a lot more or a lot less than usual?	○	○	○	○	○
Feel nervous and/or shy around other people?	○	○	○	○	○
Get into fights with family members and/or friends?	○	○	○	○	○
Have a hard time sleeping because you were worried?	○	○	○	○	○
Feel unhappy or sad?	○	○	○	○	○
Think that you don't have any friends?	○	○	○	○	○
Get into trouble?	○	○	○	○	○
Have little or no energy?	○	○	○	○	○
Avoid going to school?	○	○	○	○	○
Think about hurting yourself?	○	○	○	○	○
Disobey adults? (not do what adults told you to do)	○	○	○	○	○

If this is not your first session, please take a moment to give feedback on your most recent session to help us better serve your needs.	Not at all	Only a little	Some-what	Quite a bit	Totally
This counselor and I are working toward the same goals.	○	○	○	○	○
Did the last session head in the direction that you wanted?	○	○	○	○	○
Did you feel the counselor understood and respected you during the last session?	○	○	○	○	○

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Date Completed: ☐☐ / ☐☐ / ☐☐ Org ID: **980** Site ID: ☐☐☐ Session #: ☐☐

Client ID: ☐☐☐☐☐☐☐☐☐☐ Clinician ID: ☐☐☐☐☐☐☐☐☐☐

Clinician NPI: ☐☐☐☐☐☐☐☐☐☐

For more information on this and other questionnaires visit www.psychoutcomes.org

Fax completed forms to: 800-961-1224