



Patient Label Here

ACORN Questionnaire

Child age 6-11

Need a letter/paperwork? Tell your provider at the *beginning* of the visit!

Viewpoint of: ☐ Child ☐ Adult

Please circle a number to indicate your answer Over the LAST TWO WEEKS , how often did you	Never	Hardly ever	Sometimes	Often	Very often
1. Annoy other people on purpose?	0	1	2	3	4
2. Worry about a lot of things?	0	1	2	3	4
3. Feel nervous and/or shy around other people?	0	1	2	3	4
4. Argue with adults?	0	1	2	3	4
5. Cry easily?	0	1	2	3	4
6. Get into fights easily with family members or friends?	0	1	2	3	4
7. Feel unhappy or sad?	0	1	2	3	4
8. Think that you don't have any friends?	0	1	2	3	4
9. Get into trouble?	0	1	2	3	4
10. Lie to get things you wanted?	0	1	2	3	4
11. Have a hard time controlling your temper?	0	1	2	3	4
12. Interrupt others?	0	1	2	3	4
13. Have a hard time waiting your turn?	0	1	2	3	4
14. Have a hard time paying attention?	0	1	2	3	4
15. Lose things you need?	0	1	2	3	4
16. Have a hard time sitting still?	0	1	2	3	4
17. Talk about hurting yourself or not wanting to live?	0	1	2	3	4

Feelings about the <i>MOST RECENT VISIT</i> (if any) with this provider	Agree	Somewhat agree	Not sure	Somewhat disagree	Do not agree
We worked well together	0	1	2	3	4
I made progress toward my goals	0	1	2	3	4

Take this page with you to your visit

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