

# Daily Life Test for Children (DLTC)

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Child's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Does your child live in a safe environment,  
is it safe??

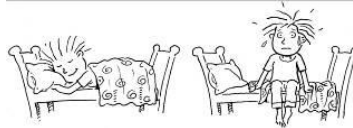


often    rare    never

## How is it's day-to-day life?

Restful sleep?  
(sleeping problems, nightmares?)



Personal hygiene/selfcare ok?



Adequate nutrition and good appetite?



Adequate exercise, sports,  
age-appropriate play?



## Relationships

Family members/caregivers available?  
Does the child have friends, peers?

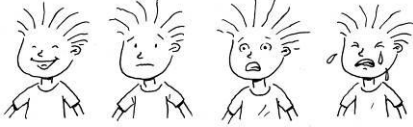


Does the child attend a kindergarten  
or school?



**Please describe your child's emotional state:**

		<b>Often</b>	<b>rare</b>	<b>never</b>
Balanced		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Restless		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scared		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sad		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tensed		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Happy		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aggressive		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Withdrawn		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**Does your child show unusual behavior?  
Developmental regression or halt?**



For example: lost skills which were available before like talking, sleeping alone, going to the toilet self-sufficient etc.? Please describe:

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**How do you deal with that??**

