Center for Health, Learning & Achievement

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Autism Spectrum Evaluation Questionnaire

Thank you so much for taking the time to fill out this form. This is a generic form, so some of the information will not apply to your child. However, please fill it out as completely as possible. You play a critical role in your child's life and getting a complete medical and social history is a crucial part in the evaluation process. The pertinent information on this form will be included in the evaluation report, however, this form and the report will be kept confidential and remain in your child's secured clinical file. This information can only be released to others with your written permission.

Who can we thank for this referral? _____

Name:_____ Grade: _____
First Middle Last
Address:_____ School: _____
_____ Date of Eval.:_____
Home Phone:_____ Birthdate: _____
Cell Phone: _____ Age: _____
E-mail Address:_____
Parents/Guardian (Mr., Dr., Mrs., Ms., Miss)_____

Person filling out this form: _____

Today's Date: _____

Reason for Referral

(Check all that apply)

1_____ To fully evaluate all aspects of our/my child's capabilities.
2_____ To determine why our/my child is having trouble learning how to:
(Circle all that apply) Read, Comprehend, Spell, Write, Do Math, Express self
3_____ To evaluate whether or not he/she has an Attention Deficit Disorder.
4_____ To determine why our/my child is misbehaving.
5_____ To gain a better understanding of our child.
6_____ To determine what we/I and the school can do to help our child.
7_____ To develop an individualized treatment plan to improve our/my child's performance and/or growth.

Presenting Problem:

Please explain your primary concerns for referring this child/adult (concerns, difficulties, questions):

How have these difficulties improved or deteriorated? _____

Does anything seem to help alleviate some of the problems or concerns this child experiences?

Is there anything that makes the problems or concerns worse? _____

Demographics

Mother's Name: _____ Age: _____
Occupation: _____Business Phone:_____
Father's Name: _____ Age: _____
Occupation _____Business Phone:_____
Stepparent's or Legal Guardian's Name: _____
Occupation: _____ Business Phone: _____

What is the primary language spoken within the home? _____
Are there any other languages spoken within the home? _____

List all people living in the household:

Name	**Age**	**Education**

If the parents are separated or divorced, how old was the child when the separation occurred?
_____

List all extended family members that are still alive (paternal and maternal grandparents, aunts, uncles, cousins) and how involved they are in this child's life.

Relative	Involvement (very, occasionally, never)

Family System

Circle the statement which most closely describes how the child is getting along with the following persons:

Mother: Very Well Fairly Well Not Very Well Very Poor N/A
Father: Very Well Fairly Well Not Very Well Very Poor N/A

Others in home: Specify
_____ Very Well Fairly Well Not Very Well Very Poor N/A

_____ Very Well Fairly Well Not Very Well Very Poor N/A

_____ Very Well Fairly Well Not Very Well Very Poor N/A

Do you and your spouse disagree about the child? No Yes, explain
_____

In general would you say life in your present family is:
Excellent Good Fair Poor Bad

Describe father's present health _____
_____

Describe mother's present health _____
_____

Is getting away from your child/children (having time for yourself) a problem for you? No Yes

Did anything happen that affected the family shortly before the child's difficulties or behaviors occurred?

Yes No
☐ Job change, explain _____
☐ Divorce, separation _____
☐ Birth or adoption _____
☐ Death _____
☐ Other _____

Family Health

Was this child adopted? _____ If so, at what age? _____
If so, please report history of biological parents if known.

A large majority of learning issues and emotional disturbances are hereditarily based
Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.

Alzheimer's disease
Or Dementia _____
Pituitary Gland dysfunction _____
Fragile X Chromosome _____
Cancer _____
Cystic Fibrosis _____
Diabetes _____
Hypoglycemia _____
Heart disease _____
High blood pressure _____
Kidney disease _____
Migraine headaches _____
Multiple sclerosis _____
Muscular dystrophy _____
Parkinson's disease _____
Pervasive Development Disorder __
Stroke _____

Anemia _____
Low or overactive Thyroid _____
Down's Syndrome _____
Double YY Chromosome _____
Tourette's Disorder _____
Autism Spectrum Disorder_____
Neurofibromatosis_____
Alcohol/drug abuse _____
Panic Attacks _____
Atmospheric Allergies _____
Emotional disturbance _____
Attention Deficit Disorder _____
Depression _____
Speech or language problem_____
Food allergies _____
Nervousness/ Anxiety_____
Seizures or epilepsy _____

Mental Illness (e.g. Bipolar Disorder, Manic Depression, Mania, Schizophrenia, Obsessive Compulsive Disorder) _____
Other: Describe _____
Learning Problems-

Reading of Words _____
Reading Comprehension _____
Spelling _____
Math Computation _____
Math Concepts _____
Handwriting _____
Written Expression _____
Oral Expression _____
Listening Comprehension _____

Has anyone in the family ever been identified for special education services? No Yes
If yes, who? _____What type of class? _____

Any History if physical or emotional abuse within the family history or with this child?
No Yes If yes, who, when and what kind of abuse _____
_____

Personality and Temperament

Does this child's physical features, personality and/or temperament remind you of anyone in your family? (like yourself, your spouse, other relative) If so, how? _____
_____

How would you describe your child's personality? _____
_____

How does the child show the following feelings:
Love _____
Anger _____
Sadness _____
Happiness _____

Choose those characteristics that apply to the child (Use M & F for Mother and Father's opinion)

____ Lonely	____ Acts young for age	____ Flexible
____ Dependable	____ Acts old for age	____ Bored
____ Proper	____ Easily influenced	____ Hot Tempered
____ Intelligent	____ Enthusiastic	____ Independent
____ Daydreamy	____ Prim	____ Gets along well w/ others
____ Aggressive	____Pessimistic	____ Forgetful
____ Messy	____ Happy	____ Even Tempered
____ Resourceful	____ Bully	____ Detached
____ Antisocial	____ Victim	____ Submissive
____ Assertive	____ Energetic	____ Humorous
____ Optimistic	____ Shy	____ Stubborn
____ Rigid/Compulsive	____ Fearful	____ Compliant
____ Confused	____ Easily hurt feelings	____ Resilient
____ Unusual	____ Neat	____ Sensitive
____ Friendly	____ Underactive	____ Scattered Attention
____ Irritable	____ Overactive	____ Considerate
____ Graceful	____ Impulsive	____ Insecure
____ Lazy	____ Cries easily	____ Secure
____ Show-off	____ Self-conscious	____ Loving
____ Obedient	____ Likes to be alone	____ Jealous
____ Gentle	____ Often sad	____ Physical complainer
____ Drowsy	____ Helpful	____ Clumsy
____ Nervous	____ Disobedient	____ Dependent
____ Different	____ Fidgety	

Birth

At this child's birth, what was the mother's age? _____ Father's age? _____

Was this child born in a hospital? Yes No

Was the baby:

_____ Premature: How premature? _____
_____ Late: How late? _____
_____ Full Term
_____ Don't know

Length of labor: _____ Hours

Birth weight _____lbs. _____oz.

Apgar score at birth _____ at 5 min. _____ at 10 min. _____

Child's condition at birth _____
Mother's condition at birth _____

Check any of the following complications that occurred during birth

☐ Breech birth ☐ Labor induced ☐ Vacuum ☐ Cesarean delivery

☐ Forceps – Position of forceps _____
☐ Other complications during delivery: Describe _____
_____

☐ Neonatal care: Explain _____
_____

☐ Incubator: How long? _____

☐ Jaundiced: Bilirubin Count (Circle One) Very High, High, Just Above Normal
Bilirubin lights? Yes No How long _____

☐ Breathing problems right after birth: Describe _____
Supplemental oxygen? Yes No How long _____

☐ Child had illnesses and/or Diseases; Describe _____

☐ Anesthesia used during delivery? Yes No What kind? _____

Length of stay in the hospital: Mother: _____days Child: _____days

If the baby did not come home from the hospital with the mother, why? _____

_____

Please express how you AND your spouse felt about having this child. Use an M for mother and an F for father to describe how each felt.

_____ Happy	_____ Excited	_____ Fulfilled
_____ Unhappy	_____ Life disrupted	_____ Unprepared
_____ Nervous	_____ Financially burdened	_____ Other, specify_____

How do you feel about the sex of this child? (Use M & F) _____ Just what I wanted
_____ Didn't care _____ Satisfied _____ Disappointed

Was the child: _____ breastfed? _____ bottle fed? What formula? _____
When weaned? _____

Did the child have eating problems? _____ No _____ Yes Explain: _____

Which of the following best describes the child as an infant?

_____ Fun	_____ Quiet	_____ Sickly
_____ Fussy	_____ Irritating	_____ Overactive

Early Development

At what age did this child first do the following? *Please indicate approximate month and/or year of age*

_____Sit alone _____ Walk Alone
_____Crawl _____ Speak first words
_____Stand alone _____Speak in sentences
_____Show first attraction to sound

When did the child cut his/her first tooth? _____
When did the child have a full set of baby teeth? _____

When was this child toilet trained? Days: _____Nights: _____

Did bed-wetting occur after toilet training? Yes No If yes, until what age? _____
Did bed-soiling occur after toilet training? Yes No If yes, until what age? _____
-Is either difficulty known to have occurred in either biological parent or other relative? Yes No
If yes, who?
Were there any medical reasons for the bed wetting or soiling Yes No If yes, please describe
_____

Does the child sleep very deeply? Yes No
Does the child have night terrors? Yes No
Is he/she a sleepwalker? Yes No

Has the child experienced any of the following problems? **If yes, please describe**.

Chronic ear infections No Yes _____
Age of onset _____ Frequency _____
Antibiotic Type(s) _____ Dosage _____
Tubes ? Yes No Still Occurring? Yes No

Walking difficulty No Yes_____
Too Sensitive to Touch No Yes _____
Too Sensitive to Sound No Yes _____
Unclear speech No Yes _____
Eating problems No Yes _____
Underweight problem No Yes _____
Overweight problem No Yes _____
Colic No Yes _____
Sleep problems No Yes_____
Difficulty learning to throw or catch No Yes _____
Difficulty learning to kick or hit No Yes _____

During this child's first 4 years, were any special problems noted in the following areas? If yes, please describe.

Excessive Anger (Rage)	No	Yes _____
Separating from parents.	No	Yes _____
Excessive crying	No	Yes _____
Nail biting	No	Yes _____
Failure to thrive	No	Yes _____
Masturbation	No	Yes _____
Motor skills	No	Yes _____
Head bumping or banging	No	Yes _____

Has either parent continued to be concerned about the child's development?
(M &F to indicate mother and/or father)
No Yes Explain _____

Which hand does this child use for writing or drawing? _____

For Eating _____ For Throwing, Catching, etc_____

If the child used both, which is most preferred? Hand _____ Arm _____

Did/Does the child seem to be confused with right/left? No Yes
Or is he/she comfortable with both and perhaps ambidextrous? No Yes

Did/Does the child become confused when asked to turn right or left? No Yes

Did/Does the child hold a pencil correctly? No Yes
Has he as yet gotten special assistance in holding a pencil? No Yes

During his/her Preschool/Kindergarten years:

How well did the child cut?
Poor Fair Good Excellent

How well did the child glue?
Poor Fair Good Excellent

How well did the child color in the lines?
Poor Fair Good Excellent

Later Development

From the age of 5 to the present time, were/are any special problems noted in the following areas?
If yes, please describe.

Difficulty learning to ride a bike No Yes_____
Difficulty learning to skip No Yes _____
Difficulty following directions No Yes _____
Difficulty following multiple directions No Yes _____
Difficulty articulating sounds, if so which sounds No Yes _____
Difficulty discriminating words that sound similar No Yes _____
Does/Did child often misspeak or substitute similar sounding words? No Yes_____
Difficulties telling a story in sequence No Yes _____

On the child's last visit to his/her physician, at what percentile was his/her physical growth compared to others the same age? _____

If a girl, when did she begin menstruation? _____

If a boy, when did he reach puberty? _____

Did body hair development begin early? No Yes- when?_____

Is this child considered to have excessive hair? No Yes _____

At what age during adolescence did your child begin to show signs of increased desire for independence?
_____

Medical History

Has the child had any of the following:
Serious accidents ____ No ____ Yes At what age? ____ Specify: _____
Serious illnesses ____ No ____ Yes At what age? ____ Specify: _____

Childhood Illnesses/Injuries
Please check the illnesses this child has had and indicate age (year/month)

☐ Measles _____
☐ German Measles _____
☐ Mumps _____
☐ Chicken pox _____
☐ Tuberculosis _____
☐ Whooping Cough _____
☐ Scarlet Fever _____
☐ Rheumatic fever _____
☐ Diphtheria _____
☐ Meningitis _____
☐ Encephalitis _____
☐ Anemia _____
☐ Fever 104 or above _____
☐ Head injury: Describe-occurrence and location on skull _____
☐ Coma or loss of consciousness: Describe _____

☐ Seizure(s) Check behaviors evident during and immediately following seizure (378)
- ☐ Muscle twitches
- ☐ Hallucinations of flashes of light
- ☐ Numbness or tingling reported in a specific body part
- ☐ Image Hallucinations and/or complicated repetitive behavior, e.g. walking in circles
- ☐ Chewing movements/ Lip smacking
- ☐ Intense smell reported (pleasant or unpleasant)

Has this child ever been on long-term prescribed medication (more than 6 months)? No Yes
If yes, when? _____ What kind? _____

Has this child ever taken medication for an Attention Deficit Disorder? No Yes
If yes, what medication? _____ Dosage? _____

To your knowledge, has the child ever used any of the following?

☐ Pep pills or uppers
☐ Alcohol
☐ Marijuana
☐ Diet pills
☐ None
☐ Tranquilizers or sedatives
☐ LSD or other hallucinogens
☐ Narcotics
☐ Other, specify _____

Do you or others think the child now has a problem with any of the substances listed above?
No ____ Yes, specify substance _____

Are there any other factors, which could have caused insult to this child's central nervous system?_____

Please indicate whether this child currently has any of the following problems.
If yes, describe how often.

Frequent colds No Yes _____
Chronic cough No Yes _____
Asthma No Yes _____
Hay fever No Yes _____
Sinus condition No Yes _____
Shortness of breath or dizziness
With physical exertion No Yes _____
Activity limitation due to:
Heart condition No Yes _____
Heart murmur No Yes _____
Excessive vomiting No Yes _____
Frequent diarrhea No Yes _____
Constipation No Yes _____
Stomach pain No Yes _____
Nervous stomach No Yes _____
Bingeing and purging No Yes _____
Anorexia No Yes _____

Urination in pants/bed No Yes_____
Pain while urinating No Yes _____
Excessive urination No Yes _____

Muscle pain No Yes _____
When? _____ Where? _____
Clumsy walk No Yes _____
Poor posture No Yes _____
Other muscle problems No Yes _____
Frequent rashes No Yes _____
Bruises easily No Yes _____
Sores No Yes _____
Severe acne No Yes _____
Itchy skin (eczema) No Yes _____
Brain Damage from known trauma No Yes If yes, describe _____
_____
Suspected Brain Trauma No Yes _____
Speech defects No Yes _____
Accident prone No Yes _____
Bites nails No Yes _____
Sucks thumb No Yes _____
Grinds teeth No Yes _____
Has tics/twitches No Yes _____
Bangs head No Yes _____
Rocks back and forth No Yes _____
Autism No Yes
If yes, when was this child diagnosed? _____

Compulsive behaviors No Yes, describe _____
_____

Pervasive Development Disorder No Yes _____
Nonverbal Learning Disorder No Yes _____
Sensory Integration Dysfunction No Yes _____
Other Neurological Condition No Yes _____

Allergy to medicine No Yes If yes, describe _____
_____

Allergy to food No Yes If yes, describe _____
_____

Other allergies No Yes If yes, describe _____
_____

Ear infections No Yes _____
Hearing problems No Yes _____
Ear tubes No Yes _____
Date of most recent hearing exam _____

Vision problems No Yes _____
Wears glasses/contacts No Yes _____
Date of most recent eye exam _____

Medical Care

Child's physician _____ Telephone _____
Address _____
How often does this child see a doctor? _____ Date of last visit _____
Is this child currently on medication? No Yes
If yes, indicate type and reason
_____

_____

_____

_____

Educational History

List schools your child has attended

Preschool/Day Care _____

City(s) _____

Ages attended _____

Grade School Name(s) _____

City(s) _____

Grade Level(s) _____

Middle School Name(s) _____

City(s) _____

Grade Level(s) _____

High School Name(s) _____

City(s) _____

Grade Level(s) _____

Please indicate if this child has had any of the following school experiences

If your child attended preschool/daycare: At what age? _____
Amount of time per day _____ Days per week _____
Any problems in preschool? No Yes If yes, describe _____
_____

Did this child attend Kindergarten? No Yes
Any problems in Kindergarten? No Yes If yes, describe _____
_____

Has this child changed schools for reasons other than normal academic progression? No Yes
If yes, explain _____

Has been retained a grade in school? No Yes If yes, when and why? _____
_____

Has skipped a grade in school? No Yes If yes, when and why? _____
_____

In grade school (K-5) does/did this child have difficulty with reading? No Yes
If yes, describe _____

In middle school (6-8) does/did this child have difficulty with reading? No Yes
If yes, describe _____

In High School (9-12)? No Yes If yes, describe _____
_____

In grade school (K-5) does/did this child have difficulty with math? No Yes
If yes, describe _____

In middle school (6-8) does/did this child have difficulty with math? No Yes
If yes, describe _____

In high school (9-12) does/did this child have difficulty with math? No Yes
If yes, describe _____

In grade school (K-5) does/did this child have difficulty with written expression? No Yes
If yes, describe _____

In middle school (6-8) does/did this child have difficulty with written expression? No Yes
If yes, describe _____

In high school (9-12) does/did this child have difficulty with written expression? No Yes
If yes, describe _____

Gets poor grades? No Yes Describe most recent report card results. _____
_____

Has been tested for special education services in the past. No Yes When _____

Is presently receiving some special services or accommodations. No Yes
If yes, describe _____

Dislikes going to school. No Yes

Is absent from school frequently. No Yes If yes, why? _____
_____

Do you have any concerns about the quality of this child's school or teachers? No Yes
If yes, describe _____

_____

Friendships

Please indicate how this child relates to other children
Has problems relating to or playing with other children? No Yes
If yes, describe _____

_____

_____

Fights frequently with playmates? No Yes _____
Prefers playing with younger children? No Yes _____
Has difficulty making friends? No Yes _____
Prefers to play alone? No Yes _____

Are there children in the neighborhood with whom this child could play? No Yes

What role does this child take in peer group games, (i.e., leader, aggressor, follower, etc.)?
_____

Does your family have pets? No Yes
If yes, how does the child get along with them? _____

Recreation/Interests

What activities does this child enjoy?
Sports: _____
Hobbies: _____
Other: _____

Has this child's interest in participating in these activities declined recently? No Yes
If yes, describe _____

_____

Behavior Related to Reason For Referral

Are you worried that the child may hurt herself/himself or others? No Yes
If yes, explain. _____

_____

Have there been any changes in the child's:

☐ Personality	☐ Habits	☐ Attention
☐ Mood	☐ Level of tenseness	☐ Concentration
☐ Attitude toward others	☐ Irritability	☐ Memory
☐ Dress	☐ Activity	☐ Speech

Explain _____

Has this child ever had psychological counseling and/or exam? No Yes

If yes, psychiatrist or psychologist's name _____
Address _____
Telephone _____
Type of counseling _____
_____
_____
When? _____

Has this child ever had a neurological exam? No Yes

If yes, Neurologist's name _____
Address _____
Telephone _____
Date of exam _____
Reason for exam _____
_____

Will you give us consent to speak with these practitioners and exchange information?

No Yes
Parent or guardian signature _____
Date _____

Will you give us consent to exchange information with this child's school?

No Yes

If yes, who do you give consent for us to speak with and/or exchange information with at the school?

School Psychologist _____

Guidance Counselor _____

Teacher _____

Principal _____

Other _____

List of Children's Behaviors

Child's Name _____ Informant _____

Please read the following list and rate the child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior. Please use the following scale:

1	2	3	4	5
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**

Group A

1 2 3 4 5 Doesn't trust self
1 2 3 4 5 Frequently puts self down
1 2 3 4 5 Refuses to try new things
1 2 3 4 5 Poor performance even when they have the ability
1 2 3 4 5 Sees the worst in self
1 2 3 4 5 Often shy around others
1 2 3 4 5 Easily embarrassed
1 2 3 4 5 Seems satisfied with poor performance
1 2 3 4 5 Gives up easily/expects failure
1 2 3 4 5 Shows no self confidence

Group B

1 2 3 4 5 Difficulty meeting and making friends
1 2 3 4 5 Difficulty keeping friends
1 2 3 4 5 Difficulty being assertive
1 2 3 4 5 Difficulty initiating and maintaining appropriate communication
1 2 3 4 5 Difficulty staying on topic of discussion
1 2 3 4 5 Difficulty with voice modulation and pragmatics (social language)
1 2 3 4 5 Difficulty managing anger and/or stress
1 2 3 4 5 Uses inappropriate conflict resolution strategies
1 2 3 4 5 Exhibits socially unacceptable behaviors
1 2 3 4 5 Trouble picking up nonverbal social cues

Group C

1 2 3 4 5 Always on the go
1 2 3 4 5 Can't sit still
1 2 3 4 5 Doesn't seem to listen
1 2 3 4 5 Often fails to finish things
1 2 3 4 5 Has poor concentration and attention for school work
1 2 3 4 5 Often fidgets with hand/feet or squirms in seat
1 2 3 4 5 Easily distracted
1 2 3 4 5 Has a hard time playing quietly
1 2 3 4 5 Talks excessively
1 2 3 4 5 Often interrupts or "butts in" to others' conversations and games
1 2 3 4 5 Seems disorganized and looses things they need for school
1 2 3 4 5 Takes risks without considering the danger involved
1 2 3 4 5 Blurts out answers to questions before they are completed

Group D

1 2 3 4 5 Has trouble sleeping
1 2 3 4 5 Has a poor appetite
1 2 3 4 5 Seems sad or unhappy
1 2 3 4 5 Talks about feeling stupid or worthless
1 2 3 4 5 Looses interest in having fun
1 2 3 4 5 Seems irritable
1 2 3 4 5 Moody
1 2 3 4 5 Plays alone
1 2 3 4 5 Cries Easily
1 2 3 4 5 Seems tired

Group E

1 2 3 4 5 Complains of physical problems, like headaches or stomachaches
1 2 3 4 5 Worries excessively
1 2 3 4 5 Bites fingernails
1 2 3 4 5 Needs lots of reassurance
1 2 3 4 5 Fearful of losing control
1 2 3 4 5 Fearful of specific object or event
1 2 3 4 5 Exaggerated startled response
1 2 3 4 5 Difficulty with separation
1 2 3 4 5 Tense muscles
1 2 3 4 5 Repetitive behaviors (hand washing, counting, etc)

Group F

1 2 3 4 5 Refuses to follow rules or do chores
1 2 3 4 5 Looses temper
1 2 3 4 5 Argues with parents or teachers
1 2 3 4 5 Blames other for their mistakes
1 2 3 4 5 Swears
1 2 3 4 5 Deliberately does things to annoy other people
1 2 3 4 5 Is often angry or resentful
1 2 3 4 5 Carries a grudge. Seems to have a “chip on their shoulder”
1 2 3 4 5 Easily annoyed by others
1 2 3 4 5 Displays excessive stubbornness or oppositional behavior

Group G

1 2 3 4 5 Delayed physical development
1 2 3 4 5 Delayed language development
1 2 3 4 5 Prefers to be with younger people
1 2 3 4 5 Immature responses to situations
1 2 3 4 5 Whining and clinging behavior
1 2 3 4 5 Buys and plays with things below age level
1 2 3 4 5 Behavior resembles that of a younger child

Social Behavioral Questionnaire

Circle Yes, No, or Sometimes for each question and describe with examples.

1. Does your child imitate sounds, words and movements of others?

   Yes No Sometimes

2. Does your child respond to facial expressions, gestures, and different tones of voice used by others?

   Yes No Sometimes

3. Does your child respond to his or her name being called by turning and looking at you?

   Yes No Sometimes

4. Does your child direct facial expressions to others to show how he or she is feeling?

   Yes No Sometimes

5. Does your child repeat words and phrases over and over again?

   Yes No Sometimes

6. Does your child have an unusual tone, rhythm, volume or rate of speech?

   Yes No Sometimes

7. Does your child carry on conversations with another person that flows back and forth, at a level you would expect for someone their age?

   Yes No Sometimes

8. Does your child make eye when speaking with or listening to another person?

   Yes No Sometimes

9. Does your child point to and share things of interest with others?

   Yes No Sometimes

10. Does your child follow another person's gaze or point to an object that is out of reach?

    Yes No Sometimes

11. Does your child initiate social interactions with adults and peers?

    Yes No Sometimes

12. Does your child make and maintain friendships with peers of the same developmental level?

    Yes No Sometimes

13. Does your child show a range of emotional expressions that match the situation?

    Yes No Sometimes

14. Does your child understand or responds to how another person is feeling?

    Yes No Sometimes

15. Does your child have unusual ways of moving fingers, hands, arms, legs, or spins or rock body?

    Yes No Sometimes

16. Does your child engage in any behavior that causes self-injury such as biting, scratching or banging their head?

    Yes No Sometimes

17. Does your child have delays in motor skills like shoe tying or handwriting?

    Yes No Sometimes

18. Does your child show worry about the same thing over and over again?

    Yes No Sometimes

19. Does your child cope well with changes in routine or the environment?

    Yes No Sometimes

20. Does your child get easily frustrated that results in a tantrum or meltdown?

    Yes No Sometimes

21. Is your child overly sensitive to some sounds, smells, or textures?

    Yes No Sometimes

22. Does your child have specific routines or specific ways things must be done by self or others?

    Yes No Sometimes

23. Does your child have any special interests or topics that he or she continues to think and talk about?

    Yes No Sometimes

24. Does your child have any extremely unusual mathematical, reading or artistic abilities?

    Yes No If yes, explain –

25. Are there other unusual behaviors or concerns that you have notices that you would like to share with us?

    _____

    _____

    _____

Social/Pragmatic Checklist

Please check the appropriate response for each item

Item	Consistently	Inconsistently	Never	N/A
Uses appropriate eye contact				
Uses socialized greeting				
Displays impulsivity				
Easily distracted				
Has difficulty with transitions				
Inappropriate response to environmental change				
Respects personal space of self and others				
Displays self stimulatory behaviors				
Behavior is socially acceptable				
Displays turn taking skills				
Interrupts frequently				
Is polite				
Initiates conversations with peers				
Maintains interaction for more than 3 turns				
Terminates conversations appropriately				

Social/Pragmatic Checklist(cont.)

Please check the appropriate response for each item

Item	Consistently	Inconsistently	Never	N/A
Uses age appropriate conversational topics				
Can maintain a topic				
Becomes tangential				
Follows topic change throughout interactions				
Changes topic using Markers ("By the way")				
Perseverates on an idea				
Comments on environment				
Uses age appropriate humor				
Comprehends age appropriate humor				
Displays ability to negotiate compromise				
Completes tasks independently				
Tolerates multiple environmental stimuli				

Please explain further the most significant areas of concern in Social Skills:

_____

_____

_____

_____

_____

_____

Attention-Activity Questionnaire

Please circle any of the following of I, II or IM, that have persisted for at least six months and are considered maladaptive and inconsistent with the person's developmental level.

I. 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has difficulty sustaining attention in tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has difficulty organizing tasks and activities.
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
8. Is often easily distracted by extraneous stimuli.
9. Is often forgetful in daily activities.[1]

II. 1. Often fidgets with hands or feet or squirms in seat.
2. Often leaves seat in classroom or in other situations in which remaining seated is expected.
3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
4. Often has difficulty playing or engaging in leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".
6. Often talks excessively.

IM. 7. Often blurts out answers before questions have been completed.
8. Often has difficulty awaiting turn.
9. Often interrupts or intrudes on others (e.g., butts into conversations or games).[2]

1. Which of the above circled symptoms were present prior to age seven? (list by letter(s) and number (i.e., I. #3, II. #5, and IM. #9):

_____
_____

2. Indicate the setting(s) where there is some impairment from the symptoms noted above: (please circle) home, school, work, social group, play, organized sport, other (specify)

_____

3. What clear evidence is there to demonstrate that there is significant impairment in social, academic, or occupational functioning?

_____
_____

4. Are there other possible reasons for the symptoms circled? Underline possible reason(s): e.g., depression, anxiety, manic-depression, loosely associated, post-traumatic stress, environmental factors such as loose or polar parenting styles, physical and/or sexual abuse, excessive guilt, fear from unknown sources, other

_____
_____

[1]Diagnostic and Statistical Manual of Mental Disorders: DSM-IV, 4th edition, American Psychiatric Association, Washington, DC, 1994.
[2]Ibid.

SENSORY HISTORY

VESTIBULAR SENSATION

__ Seems fearful in space? *(using stairs, riding rides)*
__ Trips or falls often?
__ Prefers fast or spinning rides?
__ Appears to be in "perpetual motion"?
__ Has difficulty sitting still for schoolwork or table activities?
__ Frequently gets up from table while eating?
__ Leans when sitting or standing?
__ Loses balance easily?
__ Does not attempt to catch themselves when falling?
__ Prefers to sit rather than stand, or lay down rather than sit?
__ Stands or sits 'with a seemingly wide base?
__ Avoids participating in sports or movement activities?
__ Rocks body when sitting or standing?
__ Likes to spin body or be spun?
__ Has difficulty walking without bouncing or running?

MODULATION

__Shuts down or has meltdowns?
__ Has difficulty transitioning from one activity to another?
__ Has unpredictable emotional outbursts?
__ Slow to recover or hard to calm when upset?
__ Shows hypersensitivity to sensation *(pain, touch, sound, smell, light)*
__ Seems to be emotionally "up and down"?
__ Has a low frustration tolerance?
__ Rocks, bangs head or hits easily when frustrated?
___ Seems distractible, short attention to task?

COORDINATION

__ Uses mainly one hand at a time in activities requiring two hands?
__ Turns body to avoid reaching across midline of body?
__ Has poor timing for activities such as jumping jacks or jump rope?
__ Has difficulty manipulating small objects?
__Seems clumsy or accident prone?
(frequent scrapes or bruises)
__ Eats in a sloppy manner?
__ Has difficulty with pencil activities?
__ Has difficulty dressing and/or fastening clothes?
__ Has poor spatial awareness? ***please indicate:***
__ bumps into objects
__ knocks things over at dinner table
__ bumps into furniture or people
__ bumps into doorways when walking through
__ Descends or ascends stairs/ramps without alternating feet?
__ Has not established hand dominance
__ Often confuses right and left?
__ Has difficulty throwing/catching a ball?

PROPRIOCEPTION

Does your child:
__ Collapses or flops down onto furniture?
__ Chews on sleeve, collar, or other object?
__ Is physically rough with people and objects?
__ Toe walks?
__ Likes to stomp or jump excessively?
__ Likes to climb excessively?
__ Pushes or leans heavily against people or furniture?

TACTILE SENSATION

__ Was your child irritable in infancy, particularly when held?
__ Dislikes being cuddled?
__ Prefers to touch rather than be touched?
__ Dislikes grooming tasks? *(please indicate)*
  __ hair washing / combing / brushing
  __ face washing / bathing
  __ tooth brushing
  __ nail trimming
  __ hair cutting
__ Is irritated by or prefers certain textures of clothing?
__ Reacts negatively to the feel of new clothes?
__ Prefers tight, well-fitting clothing?
__ Prefers loose clothing?
__ Prefers multiple layers of clothing?
__ Strips off clothing?
__ Wraps self in clothing or bedding?
__ Frequently adjusts clothing as if it binds or is uncomfortable?
__ Prefers to play by themselves *(please indicate)*
  __ rather than with another child
  __ rather than in groups
__ Bumps / pushes other children if standing in line?
__ Indicates distress when barefoot?
__ Insists on being barefoot?
__ Insists on large personal space?
__ Prefers to be in comer, under table, behind furniture?
__ Rubs spot after being touched?
__ Tries to handle or touch everything?
__ Avoids having hand held?
__ Constantly puts hand or other object in mouth?
__ Constantly puts hand in pants or pants pocket?
__ Sits on hands/feet?

MOTOR SKILLS/PLANNING and BODY AWARENESS

__ Has difficulty positioning self squarely on furniture or playground equipment?
__ Is awkward when getting on or off furniture or playground equipment?
__ Resists shaping hand to hold objects or another's hand?
__ Oversteps or understeps obstacles?

MUSCLE TONE

__Tires easily?
__ Prefers passive activities over active activities?
__ Demonstrates a weak grip?
__ Drools or makes "bubbles" when concentrating?

AUDITORY SENSATION

__Seems overly sensitive to sound?
__ Seems to miss some sounds?
__ Seems confused about the direction a sound is coming from?
__ Uses excessively loud voice to talk?
__ Makes excessive or inappropriate loud noises?

VISUAL SENSATION

__ Appears sensitive to light?
__ Becomes excited when confronted with a variety of visual stimuli?
__ Resists having one or both eyes covered?

OLFACTORY/GUSTATORY SENSATION

__Seems very sensitive to odors?
__ Seems to not notice odors?
__ Has difficulty discriminating odors?
__ Acts as if all foods taste the same?
__ Explores by mouthing or tasting objects?

SPEECH & LANGUAGE SCREENING CHECKLIST

Does your child demonstrate difficulty with any of the following:

1. Trouble making specific speech sounds (i.e.: "s", "l", "r")?
   If yes, which sounds in particular?

2. Drool or hold an open-mouth resting posture?

3. Demonstrate a tongue-thrust motor pattern when speaking or swallowing? (i.e.: tongue is placed between the teeth when it is not supposed to be)

4. Stutter or have a strange rhythm in his/her voice?

5. Abnormal voice quality (i.e.: hoarse, breathy)?
   If yes please explain:

6. Understanding or expressing vocabulary and/or basic language concepts? (i.e.: adjectives, verbs, prepositions)

7. Following or explaining a sequence of 2-3 step directions?

8. Thinking of words to express him/herself?

9. Trouble with phonology (understanding what letters say certain sounds, rhyming, etc.)

10. Trouble with sentence construction and/or comprehension?

11. Trouble explaining past events or sequences?

12. Delete, add, or use inappropriate grammatical structures?

13. Repeating back sentences and phrases verbatim?

14. Constructing correct and meaningful sentences to express him/herself?

15. Understand and/or use figurative language (i.e.: "it's raining cats & dogs")?

16. Initiating or participating in conversations?

PEDIATRIC SLEEP QUESTIONNAIRE

Does Your Child ……..	NO	YES
1. Snore more than half the time?		
2. Have heavy or loud breathing?		
3. Always snore?		
4. Snore loudly?		
5. Have trouble breathing or struggle to breath		
6. Stop breathing during the night?		
7. Tend to breath through the mouth during the day?		
8. Have a dry mouth on waking up in the morning?		
9. Occasionally wet the bed?		
10. Wake up un-refreshed in the morning?		
11. Have a problem with sleepiness during the day?		
12. Has a teacher or other supervisor said your child appears sleepy during the day?		
13. Is it hard to wake your child up in the morning?		
14. Does your child wake up with headaches in the morning?		
15. Did your child stop growing at a normal rate at any time since birth?		
16. Is your child overweight?		
17. Does your child complain of restless/achy legs when asleep?		
18. Does your child have repetitive "twitching" of the arms or legs during sleep?		
19. Does your child have frequent nightmares (more than once a week) that disturb him/her during the day?		

Where does your child usually sleep?_____

How long does it typically take to get your child to go to sleep? _____

How long does it take them to fall asleep? _____

Do you have a bedtime routine for your child? If so, what is it? _____

How many hours does your child sleep? _____

Does your child wake up frequently at night?
If so, how often and how long does it take them to go back to sleep?

_____

Center for Health, Learning and Achievement
Cancellation Policy

Effective August 1st 2019, the full fee for speech and language therapy, occupational therapy, behavior therapy, counseling, neurofeedback, and consultation services will be charged for missed appointments. A $200 cancellation fee will be charged for individuals who do not show for a testing/evaluation appointment. When an initial appointment is booked, the office manager will take credit card information and a deposit will be charged to hold the first appointment. If the appointment is not cancelled 24 hours prior to the scheduled appointment time, the credit card will be charged the above cancellation fee. If the appointment is kept, that fee will be credited toward the cost of the service. This credit card number will be held on file and will be charged if the client does not show for any follow up appointments.

I have read the above cancellation policy and acknowledge that I, as the client, will be charged for all missed or cancelled appointments without at least 24 hours notice.

_____ _____
Client Signature Date

_____
Printed Name

Payment Authorization Form

I authorize Center for Health, Learning & Achievement to keep my signature on file and to charge my credit card for any missed appointments or recurring charges (ongoing treatment)

I understand that this form is valid unless I cancel the authorization through written notice to Center for Health, Learning & Achievement.

_____ MasterCard _____ Visa _____ Credit _____ Debit

Account # _____ Exp. Date _____

CVC Code _____

Card Holder Name _____

Card Holder Address _____

Card Hold Signature _____ Date _____

Additional Comments/Concerns

Initial:

_____ I acknowledge that I have read the HIPPA Privacy Practices and do not need a paper copy.

_____ I acknowledge that I was informed that I can receive free evaluations through the public schools and have chosen to get these evaluations services privately with the Center for Health, Learning and Achievement.

_____ _____

Signature of Client/Parent Date of Signature