Center for Health, Learning & Achievement

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Parent 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 _____
Asperger's Syndrome_____
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	

Parental Family System

	Mother	Father
Were you raised by your natural parents?	_____	_____
If no, specify by whom?	_____	_____
Was your home life a happy one?	_____	_____
Do you feel YOUR parents treated you well when your were a child?	_____	_____

MOTHER:
How were you usually punished as a child? _____
What types of behavior caused punishments? _____
Describe your relationship with your mother _____
Describe your relationship with your father _____
How did you usually express your anger toward your parents _____

FATHER:
How were you usually punished as a child? _____
What types of behavior caused punishments? _____
Describe your relationship with your mother _____
Describe your relationship with your father _____
How did you usually express your anger toward your parents _____

Carefully read the following list, then check up to five traits that were stressed in **YOUR** home during **YOUR** childhood. (Indicate M for Mother and F for Father)

_____Fun	_____Honesty	_____Independence
_____Religion	_____Ambition	_____Education
_____Initiative	_____Security	_____Health
_____Personal Appearance	_____Generosity	_____Morality
_____Manners	_____Kindness	_____Listening to others
_____Warmth& Affection	_____Politeness	_____Pride
_____Quietness	_____Aggressiveness	_____Work
_____Thrift	_____Assertiveness	_____Social obligations
_____Cleanliness	_____Obedience	_____Survival
_____Power & position	_____Privacy	_____Other, Specify
_____ Keep Family Secrets		_____
_____Don't Discuss Them Either		

Preconception

Prior to conception, were any substances (prescription medication and/or non-prescription drugs (including illicit drugs) used by the mother or father? If reluctant to write this down, please share them verbally with the evaluator.

_____
_____
_____

How would you describe the child's mother's living situation before pregnancy?
_____ Good _____ Fair _____ Poor

How was the mother getting along with her spouse/partner prior to pregnancy?
_____ Good _____ Fair _____ Poor _____ Not Applicable (no spouse/partner)

Did the mother have any illness/disease(s) or exposure to radiation prior to pregnancy?
_____ No _____ Yes Explain _____

Pregnancy

Check any of the following complications that occurred during the pregnancy.

☐ Difficulty with conception	☐ Toxemia	☐ Abnormal weight gain
☐ Measles	☐ Excessive vomiting	☐ German measles
☐ Excessive swelling	☐ Emotional problems	☐ Vaginal bleeding
☐ Flu	☐ Anemia	☐ High blood pressure

☐ Other (Rh incompatibility, Herpes, Diabetes, etc.) _____

Hospitalization during pregnancy: Reason_____

X-Ray during pregnancy: What month _____

Alcohol used during pregnancy: Frequency _____

Cigarettes used during pregnancy: Frequency _____

Other drugs used during pregnancy:

Type and Frequency	Prescription	
_____	Yes	No
_____	Yes	No
_____	Yes	No

Was the child very active inutero? Yes No

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/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:

_____

_____

_____

_____

_____

_____

BEHAVIOR SYMPTOMS OF LEARNING DIFFICULTIES FOR STUDENTS

_____1. Unhappiness with school
_____2. Complains about teacher(s)
_____3. Easily frustrated
_____4. Anxious; or _____4a panics under pressure
_____5. Reluctance to read
_____6. Reluctance to sit and be read to
_____7. Reluctance to study or _____7a do other sedentary tasks, e.g. _____
_____8. Poor study skills
_____9. Slow reading; or _____ poor reading
_____10. Difficulty with sounding out words
_____11. Is primarily a "sight reader"
_____12. Adds words, leaves out words, or substitutes words
_____13. Poor spelling; or _____13a does okay on spelling test <u>but</u> forgets words later
_____14. Poor vocabulary
_____15. Difficulty understanding what is read
_____16. Difficulty remembering what was read
_____17. Difficulty understanding what is heard
_____18. Difficulty remembering what was heard
_____19. Difficulty expressing thoughts _____19a verbally or _____19b in written form
_____20. Learning a foreign language very difficult even after hard study
_____21. Thinks concretely or literally; _____21a Can't "read between the lines"
_____22. Has difficulty foreseeing consequences
_____23. Trouble telling time or difficulty with minutes, hours, months, etc.
_____24. Difficulty understanding or telling jokes
_____25. Words appear to move, jiggle or dance
_____26. Skips line(s) when reading
_____27. Sees flashes of light or blotches when viewing page or screen
_____28. Words are blurry even though vision is okay or has corrective lenses
_____29. Doesn't see spaces or enough space between letters and/or words
_____30. Poor memory for what words say (can't recall what whole word says – not a "sight" reader)
Or, seems to forget "the," "and," "when," "went," "there," etc.
_____31. Attempts to use phonetic spelling all of the time
_____32. Cannot write letters of the alphabet or cannot do so without great difficulty
_____33. Can't keep columns straight in math
_____34. Dislikes or hates math
_____35. Trouble with times tables and basic math facts
_____36. Can't understand new math concepts
_____37. Can't remember combinations
_____38. Distractible _____38a Hard to focus attention
_____39. Difficulty in following directions
_____40. Difficulty in getting work done; _____40a Difficulty following through
_____41. When does homework, forgets to turn it in
_____42. Disorganized and/or problems with sequencing and planning
_____43. Inaccurate copying
_____44. Sloppy or illegible writing
_____45. One or more biological family members have problems in (circle appropriate one(s)): reading, spelling, writing, enjoying reading, passing a grade or class
_____46. Has been held back or not passed a grade.
_____47. Had speech and/or language therapy
_____48. Is in or thought to need remedial reading (tutoring or class)
_____49. Is in or thought to need a learning disability (L.D.) class

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?

VISUAL SYMPTOM CHECKLIST- School-Aged

Please indicate 0 - occasionally or F - frequently. Leave blank if does not apply. Add notes as needed.

__ Blur in NEAR vision after reading or near visual task
__ Blur in DISTANCE vision after reading or near visual task
__ Letters or words appear to float around or ____ move on page
__ Double or split vision when looking at Distance (may then return to single)
__ Double or split vision when looking at Near (may then return to single)

Ask your child each question in the section above. They often think these symptoms are "normal"!

__ Eyes get tired or __ child gets tired, after reading or near visual task
__ Eyes look Red, __ Water, __ Burn or Itch
__ Headaches, __ Nausea or __ other Discomfort with reading or near visual task
__ Blinks, __ Squints, or __ Rubs eyes, especially during or after reading
__ Uses finger as marker when reading or copying __ Loss of place when reading
__ Unintentional skipping of words when reading
__ Re-reads or __ Skips lines during reading
__ Confuses letters or Similar words during reading
__ Omits small words when reading
__ Moves head when reading
__ Gets very close to reading or near visual activities
__ Tilts head or ___Unusual paper position when reading or writing
__ Covers or Closes one eye when reading or writing
__ Loss of place when copying material from one place to another
__ Errors copying from blackboard to paper
__ Reverses or Transposes letters, numbers or words (was for saw, etc.)
__ Vocalizes when reading silently
__ Reads slowly
__ Lack of comprehension when reading
__ Short attention span for reading
__ Easily distracted while reading
__ Difficulty sustaining near visual tasks, such as reading or writing
__ Dislikes or avoids school-related reading or near visual tasks
__ Dislikes or avoids ALL reading or near tasks
__ Writes or prints poorly
__ Frequently knocks things over at dinner table
__ Frequently bumps into things or __ trips
__ Difficulty hitting or __ catching a ball
__ Difficulty using binoculars, telescope or microscope
__ Car or motion sickness, especially when reading in car
__ Below average sports performance
__ School performance not at grade level expected for age.
__ School performance below average but within grade level

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?

_____

Metabolic Assessment Form Key

PART I **Please circle the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I: Colon				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard dry or small stool	**0**	**1**	**2**	**3**
Coated tongue of "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Do you use laxatives frequently	**0**	**1**	**2**	**3**
Category II: Hypochlorydia				
Excessive belching burping or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**
Category III: Hyperacidity (Ulcer)				
Stomach pain, burning or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Do you frequently use antacids	**0**	**1**	**2**	**3**
Feeling hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	**0**	**1**	**2**	**3**
Category IV: Small Intestine (Pancreas)				
Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage bloated	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category V: Biliary Insufficiency/Statis				
Greasy or high fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed	**Yes**		**No**	
Category VI: Hypoglycemia				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get lightheaded if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory, forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**
Category VII: Insulin Resistance				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst & appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Category VIII: Adrenal Hypofunction				
Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Metabolic Assessment Form Key (cont.)

Category IX: Adrenal Hyperfunction

Cannot fall asleep	**0**	**1**	**2**	**3**
Perspire easily	**0**	**1**	**2**	**3**
Under high amounts of stress	**0**	**1**	**2**	**3**
Weight gain when under stress	**0**	**1**	**2**	**3**
Wake up tired even after 6 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**

Category X: Hypothyroid

Tired, sluggish	**0**	**1**	**2**	**3**
Feel cold – hands, feet, all over .	**0**	**1**	**2**	**3**
Require excessive amounts of sleep to function properly	**0**	**1**	**2**	**3**
Increase in weight gain even with low-calorie diet	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficult, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression, lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the day progresses	**0**	**1**	**2**	**3**
Outer third of eyebrow thins	**0**	**1**	**2**	**3**
Thinning of hair on scalp, face or genitals or excessive falling hair	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Mental sluggishness	**0**	**1**	**2**	**3**

Category XI: Thyroid Hyperfunction

Heart palpations	**0**	**1**	**2**	**3**
Inward trembling	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous and emotional	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**

Category XII: Pituitary Hypofunction

Diminished sex drive	**0**	**1**	**2**	**3**
Menstrual disorders or lack of menstruation	**0**	**1**	**2**	**3**
Increased ability to eat sugars without symptoms	**0**	**1**	**2**	**3**

Category XIII: Pituitary Hyperfunction

Increased sex drive	**0**	**1**	**2**	**3**
Tolerance to sugars reduced	**0**	**1**	**2**	**3**
"Splitting" type headaches	**0**	**1**	**2**	**3**

Category XIV (Male Only): Prostate

Urination difficulty or dribbling	**0**	**1**	**2**	**3**
Urination frequent	**0**	**1**	**2**	**3**
Pain inside of legs or heels	**0**	**1**	**2**	**3**
Feeling of incomplete bowel evacuation	**0**	**1**	**2**	**3**
Leg nervousness at night	**0**	**1**	**2**	**3**

Category XV (Males Only): Andropause

Decrease in libido	**0**	**1**	**2**	**3**
Decrease in spontaneous morning erections	**0**	**1**	**2**	**3**
Decrease in fullness of erections	**0**	**1**	**2**	**3**
Difficulty in maintain morning erections	**0**	**1**	**2**	**3**
Spells of mental fatigue	**0**	**1**	**2**	**3**
Inability to concentrate	**0**	**1**	**2**	**3**
Episodes of depression	**0**	**1**	**2**	**3**
Muscle soreness	**0**	**1**	**2**	**3**
Decrease in physical stamina	**0**	**1**	**2**	**3**
Unexplained weight gain	**0**	**1**	**2**	**3**
Increase in fat distribution around chest and hips	**0**	**1**	**2**	**3**
Sweating attacks	**0**	**1**	**2**	**3**
More emotional then in the past	**0**	**1**	**2**	**3**

Category XVI (Menstruating Females Only)

Are you perimenopausal	**Yes**		**No**	
Alternating menstrual cycle lengths	**Yes**		**No**	
Extended menstrual cycle, greater than 32 days	**Yes**		**No**	
Shortened menses, less than every 24 days	**Yes**		**No**	
Pain and cramping during periods	**0**	**1**	**2**	**3**
Scanty blood flow	**0**	**1**	**2**	**3**
Heavy blood flow	**0**	**1**	**2**	**3**
Breast pain and swelling during menses	**0**	**1**	**2**	**3**
Pelvic pain during menses	**0**	**1**	**2**	**3**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne break outs	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Hair loss/thinning	**0**	**1**	**2**	**3**

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

Do you ever have uterine bleeding since menopause?	Yes		**No**	
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Mood swings	**0**	**1**	**2**	**3**
Depression	**0**	**1**	**2**	**3**
Painful intercourse	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Increased vaginal pain, dryness or itching	**0**	**1**	**2**	**3**

Center for Health, Learning and Achievement
Cancellation Policy

Effective September 1st 2009, the full fee for speech and language therapy, occupational therapy, behavior therapy, counseling, neurofeedback, and consultation services will be charged for missed appointments. A $100 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