PACKET CHECKLIST

Welcome to Touro University Nevada Center for Autism and Developmental Disabilities!

This is a Check List of the items we will need to schedule your appointment.

- Copy of Insurance Card (Front & Back)
- Copy of Driver’s License
- Registration Form
- Notice of Privacy Practice Signature page
- Legal Custody Signature Page
- Observation Room Usage Waiver
- Patient Rights and Responsibilities
- Child Neuropsychological History Packet
- Social Skills Checklist
- Copies of prior therapy reports form therapist or school for the therapy they are being seen for at Touro.
- Copy of most recent IEP

We look forward to working with you and your child. If you have any questions, please feel free to contact us at 702.777.4808.

Sincerely,

Nicole A. Cavenagh, Ph.D.
Welcome to Touro University Nevada Center for Autism and Developmental Disabilities!

Thank you for your interest in clinical services at Touro University’s Center for Autism and Developmental Disabilities. Enclosed you will find the necessary intake paperwork that must be completed prior to your first visit. Please complete all enclosed forms and questionnaires to the best of your ability and return them to the Center at least 24 hours prior to your child’s first appointment*. Additionally, please bring any relevant medical records and/or prior assessment results.

Your first appointment is scheduled with ___________________ at ___________ on ______________.

Prior to your child’s appointments, please make sure that he/she gets plenty of rest and takes any medications as usual (if applicable). If your child wears glasses, has hearing aids, or has any other assistive devices that are used regularly, please bring them to each appointment. You may also bring a snack for your child if you feel that he/she may need one during the appointment. A refrigerator and microwave are available for your convenience.

The following fee schedule represents the fee-for-service rates as of July 1, 2010:

- 
<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>$90/hour</td>
</tr>
<tr>
<td>Speech/Language Therapy</td>
<td>$90/hour</td>
</tr>
<tr>
<td>Applied Behavior Analysis</td>
<td>$50 - $90/hour</td>
</tr>
<tr>
<td>Neuropsychological Assessment</td>
<td>$135/hour</td>
</tr>
<tr>
<td>Group Social Skills Therapy (6-12)</td>
<td>$75/week (90 minutes/week; 12 week program)</td>
</tr>
<tr>
<td>Group Social Skills Therapy (13-18)</td>
<td>$85/week (90 minutes/week; 14 week program)</td>
</tr>
</tbody>
</table>

We look forward to working with you and your child. If you have any questions, please feel free to contact us at 702.777.4808.

Sincerely,

Nicole A. Cavenagh, Ph.D.

* Failure to return packet at least 24 hours prior to first appointment will result in rescheduling of appointment.
REGISTRATION FORM

**Patient Information**

Name: ____________________________________________
Address: ____________________________________________
City: __________________________ State: ___________ Zip: ________
Sex: □ M □ F Age: ______ Birthdate:______________ SSN: ____________
Patient’s School: ____________________________________________
Mother’s Name: ____________________________________________
Father’s Name: ____________________________________________
Parent Marital Status: __ Married    __Divorced   __Separated    Custodial Parent: ______________________________
Whom may we thank for referring you? ____________________________________________ Phone: ____________________
In case of emergency who should be notified? ____________________________________________ Phone: ____________________

**Primary Insurance**

Person Responsible for Account: ____________________________________________
Relation to Patient: ____________________________________________ Birthdate: ____________ SSN: ____________
Address (if different from patient): ____________________________________________ Phone: ____________
City: __________________________ State: ___________ Zip: __________
Person Responsible Employed by: ____________________________________________ Occupation: __________________
Business Address: ____________________________________________ Business Ph: ____________
Insurance Company: ____________________________________________
Insurance Address: ____________________________________________
Insurance Phone: ____________________________________________ Subscriber #: ____________ Group #: ____________
Names of other dependents covered under this plan: ______________________________

**Additional Insurance**

Is the Patient covered by additional Insurance? □ Yes □ No Subscriber Name: ____________________________________________
Relation to Patient: ____________________________________________ Birthdate: ____________ SSN: ____________
Address (if different from patient): ____________________________________________ Phone: ____________
City: __________________________ State: ___________ Zip: __________
Subscriber Employed by: ____________________________________________ Business Ph: ____________
Insurance Company: ____________________________________________
Insurance Address: ____________________________________________
Insurance Phone: ____________________________________________ Subscriber #: ____________ Group #: ____________
Names of other dependents covered under this plan: ______________________________

**Assignment and Release**

I hereby assign all medical benefits to which I am entitled to T.U.N. CADD in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to the collection service fees, attorney’s fees and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of T.U.N. CADD as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Signature of Patient, Parent, Guardian or Personal Representative __________________________ Date ____________

Please print name of Patient, Parent, Guardian or Personal Representative __________________________________________
Relationship to Patient __________________________
UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI):
Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI) we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act, 45CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes contacting you for appointment reminders and follow-up care.

YOUR HEALTH INFORMATION RIGHTS: You have the right to:
- Request a restriction of the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per NRS 629.061, except that you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the request amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The law requires us to:
- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, Craig Seiden, at 874 American Pacific Drive, Henderson, NV 89014, 702-777-4794. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.
We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

**Treatment:** e.g. we will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

**Payment:** e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

**Health Care Operations:** e.g. members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

**Other uses and disclosures not requiring authorization**

- **Business Associates:** There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- **Notification:** We may disclose limited health information to friends or family members identified by you as being involved in your care of assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- **Legally Required Disclosures, Public Health & Law Enforcement:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report births and deaths. We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of a crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- **Information Regarding Decedents:** We may disclose health information regarding a deceased person to: 1) Coroners and Medical Examiners to identify cause of death or other duties; 2) Funeral Directors for their required duties; and 3) to procurement organizations for purposes of organ and tissue donation.
- **Research:** We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
- **Marketing:** We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- **Fund Raising:** We may contact you as part of a fund raising effort.
- **Directory Information:** We may disclose limited information regarding your name and location for directory purposes to those persons who as for you by name or to members of the clergy. You may request that we not include your name in the directory.

**Disclosures requiring authorization**

All other disclosures of protected health information will only be made pursuant to your written authorization; which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.
Acknowledgement of Receipt: Notice of Privacy Practice

Patient Name: ____________________________________________

(Please print)

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). We encourage you to read it in full.

If you have any questions about our Notice of Privacy Practices, please contact our front office at (702)777-4808.

________________________________________________________________________

I acknowledge receipt of the Notice of Privacy Practices of Touro University Nevada, Center for Autism & Developmental Disabilities.

Signature: ______________________________________________________

(Patient, Parent, Legal Representative)

Date: ____________________________________________________________

Print Name: ______________________________________________________

Relationship to Patient: ___________________________________________
Legal Custody

Patient Name: ____________________________________________________________

Patient Date of Birth: ___________________________________________________

I, the undersigned, indicate by my signature below that I have legal custody of my child (named above), and, therefore, the right to seek evaluation and/or treatment for my child. I have been advised by Touro University Nevada Center for Autism and Developmental Disabilities that it is their recommendation that my child’s other parent, if any, be informed of my decision to seek evaluation and/or treatment.

_________________________________________________________  _______________________
Printed Name – Parent or Legal Guardian                           Date

_________________________________________________________  _______________________
Signature                                                   Date

_________________________________________________________  _______________________
Signature of TUNCADD Witness                                         Date
Observation Room Usage Waiver

Patient Name: ________________________________________________________________

Patient Date of Birth: _________________________________________________________

I, the undersigned, indicate by my signature below that I understand that by using the Observation Room and Multipurpose Room I may be indirectly exposed to the assessment and/or treatment sessions of other patients of Touro University Nevada Center for Autism and Developmental Disabilities and that other families may be indirectly exposed to my child’s assessment and/or treatment sessions. My signature also indicates that I agree to keep confidential any assessment and/or treatment sessions to which I am indirectly exposed.

_________________________________________  ____________________________
Printed Name – Parent or Legal Guardian                   Date

_________________________________________
Signature                                                Date

_________________________________________
Signature of TUNCADD Witness                   Date
PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful care and to be comfortable in the environment where care is delivered.
- Request the services of an interpreter, if needed, at no cost to you.
- Receive information about your child’s treatment status, course of treatment, and outcomes of treatment in terms you can understand.
- Participate actively in decisions regarding your child’s care and to receive as much information about any proposed treatment as you may need in order to give informed consent or to refuse a course of treatment.
- Be advised if the provider proposes to engage in or perform research affecting your child’s care or treatment. You have the right to refuse to participate in such research projects and your decisions will not affect your right to receive care.
- An estimate for the cost of your child’s treatment.
- Reasonable responses to any reasonable requests made for service.
- Have personal privacy respected. Case discussion, consultation, and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. Written authorization shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise required by law. You have the right to access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.
- Receive a written “Notice of Privacy Practices” that explains how your Protected Health Information (PHI) will be used and disclosed.
- Receive care in a safe setting, free from verbal or physical abuse or harassment.
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care.
- Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, or marital status or the source of payment for care.
- Understand and use these rights. If for any reason you do not understand or you need help, Touro University Nevada Center for Autism and Developmental Disabilities will provide appropriate assistance.

You have the responsibility to:

- Follow Touro University Nevada Center for Autism and Developmental Disabilities (TUNCADD) rules and regulations affecting patient care and conduct. This includes the following:
  - Show respect for the rights and privacy of other patients and their families while in the waiting room and other public areas of the center. ALL patients are
entitled to a private, quiet, therapeutic atmosphere. This includes monitoring the behavior of other children that you may bring with you to appointments as well as the behavior of your child who is a patient of TUNCADD while in the waiting room. Please bring a quiet activity for your child(ren) (e.g., a coloring book, etc.) to use while in the waiting room.

- Accompanying your child(ren) should they need to use the restroom.
- Complete any intake paperwork provided to you prior to your first scheduled appointment or the appointment may be rescheduled.
- Unless actively participating in a session or meeting with your child’s clinician, please remain in the waiting room area. Should you require entrance to the clinical areas of the TUNCADD, please explain your need to front office staff and allow them to unlock the door for you. If the front desk is unattended, please ring the bell outside of the front door of the TUNCADD for assistance.
- Use of cellular phones (including text messaging) is prohibited in the TUNCADD. Please turn cellular phones off prior to entering the TUNCADD. Should you choose to use your cellular phone during your child’s session, you will be asked to remain in the waiting room for the remainder of your child’s session. ______
- Comply with the posted rules and regulations regarding usage of the observation room.
- Arrive on time for all appointments. If you are up to 15 minutes late, you will be seen but the appointment will end at the scheduled time. If you are more than 15 minutes late, the appointment will be rescheduled. ______
- Be respectful of your clinician’s time. Please provide 2 business days notice for cancellations. Failure to do so may result in the assessment of fees. ______
- Continuity of care is critical to your child’s success. If you cancel more than 5 appointments in a 2 month period, TUNCADD staff will meet with you to discuss your child’s attendance and make appropriate adjustments to your child’s schedule, which may include a reduction in the number of weekly scheduled appointments. ______
- If you fail to call to cancel an appointment in the TUNCADD (e.g., are a “no show”) more than 2 times, a written notice will be sent and your child will be removed from the schedule. ______
- Payment is expected at the time that services are rendered unless prior arrangements have been made.

- Be considerate of TUNCADD facilities and equipment and to use them in such a manner so as to not abuse them.
- Respect the rights and property of other patients and TUNCADD personnel. Just as you want privacy, a quiet atmosphere, and courteous treatment, so do other patients.
- Report, to the best of your knowledge, accurate and complete information regarding any matters pertaining to your child’s condition to the clinicians who provide care to your child.
- To provide accurate payment information and insurance benefits.
Follow the treatment plan recommended by the clinicians responsible for your child’s care. It is your responsibility to tell your clinician whether or not you can and want to follow the treatment plan recommended for your child. The most effective plan is the one which all participants agree is the best and which is carried out exactly.

Pay bills promptly to assure that your financial obligation to your child’s care are fulfilled. Payment is expected at the time when services are rendered unless other arrangements have been established in advance.

If you should have any questions regarding these Patient Responsibilities, please contact the Center at (702) 777-4808.

Consent:

Audio and video recording are an integral part of the treatment philosophy of Touro University Nevada Center for Autism and Developmental Disabilities. As such, your child’s sessions may be subject to audio and video recording. Your signature, below, indicates that you understand this and consent to having your child’s sessions audio and/or video recorded.

Touro University Nevada Center for Autism and Developmental Disabilities is a teaching facility for advanced students in multiple disciplines, including clinical psychology and neuropsychology, occupational therapy, speech pathology, behavioral therapy, education, nursing, physical therapy, nursing, and medicine. As such, at any given time, your child’s treatment session may be observed by, participated in, or conducted by an advanced student, or multiple advanced students, in one of these disciplines. Students receive substantial supervision by the Clinical Director and other clinical staff of the Touro University Center for Autism and Developmental Disabilities and Touro University Nevada. Your signature, below, indicates that you understand this and agree to consent to the participation of supervised advanced students in my child(ren)’s care.

By signing below I attest that I have read, understood, and agree to comply with the above Patient Rights and Responsibilities. I have been provided a copy of this document for my records.

Printed Name of Patient (or Patient’s Representative if patient is a minor)

________________________________________________________

Signature of Patient (or Patient’s Representative if patient is a minor)

________________________________________________________

Signature of Touro Center for Autism and Developmental Disabilities

____________________________

Staff Witness

____________________________

Date
Authorization to Release Patient Health Information

Patient Name: ___________________________ DOB: ___________________________

I request and authorize the release of healthcare information of the patient named above:

Send Records ☐ TO / ☐ FROM:
T.U.N. Center for Autism & Developmental Disabilities
874 American Pacific Drive
Henderson, NV 89014
(702) 777-4808 phone * (702) 777-4818 fax

Send Records ☐ TO / ☐ FROM:
Facility/Attn:
Address: ___________________________
Phone: ___________________________ Fax: ___________________________

Type of Information to be released (limited to 2 years of information, unless otherwise stated):
1. General Release: ☐ TO: ___________________________
   ☐ Entire Records ☐ Provider Notes ☐ Diagnostic Tests ☐ Lab Results ☐ Immunizations ☐ Other
   Notes: __________________________________________

2. Information Protected by State / Federal Law:
   ☐ Diagnosis ☐ Treatment OF: ___________________________
   ☐ STD(includes HIV/AIDS) ☐ Substance Abuse/Addiction ☐ Mental Health /Psychiatric
   ☐ Genetic Tests ☐ Child & Domestic Abuse History ☐ Other: ___________________________
   Notes: __________________________________________

3. Patients Right to Revoke: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ___________________________
   IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS.

4. Redisclosure: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health Information Management Department and obtain a copy of the Privacy Notes.

The recipient may use the health information authorized on this form for the following purposes:
☐ Patient is transferring care ☐ Insurance Obligations ☐ Personal
☐ Needed for Medical Care ☐ Legal Purposes ☐ Other: ___________________________

**NOTE: There is a charge of 60 cents per page unless information is being disclosed to a medical facility. PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING.

_____________________________ ___________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

__________________________________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient
CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name: ______________________________________  Date: ______________________________________

Address (Street, City, State, Zip): ________________________________________________________________

Parent’s or guardian phone: (H) ______________________ (W) ______________________

Age ______  Birthdate ______________________  Religion______________________________

Sex ______  Ethnic or racial background ________________________________________________

Grade and school _________________________________________________________________

Special Placement (if any) ________________________________________________________________

Hand child uses for writing or drawing:  Right _____  Left _____  Switches between them ____

Primary language ______________________  Secondary language ______________________

Medical diagnosis (if any) (1) ______________________________________________________________

(2) _________________________________________________________________

(3) _________________________________________________________________

(4) _________________________________________________________________

Who referred the child for this testing? _____________________________________________________

Briefly describe the problem(s)

(1) _________________________________________________________________

(2) _________________________________________________________________

(3) _________________________________________________________________

(4) _________________________________________________________________

What specific questions would you like answered by this evaluation?

(1) _________________________________________________________________

(2) _________________________________________________________________

(3) _________________________________________________________________

(4) _________________________________________________________________

______________________________

THIS FORM HAS BEEN COMPLETED BY:

Name ___________________________________  Relationship to child ______________________

Address _______________________________________________________________________

Phone (H) ______________________ (W) ______________________
**SYMPTOM SURVEY**

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after the injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) **PROBLEM SOLVING**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Old</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Difficulty figuring out how to do new things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty making decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty planning ahead</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty solving problems a younger child can do</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorganized in his/her approach to problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty understanding explanations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty doing things in the right order (sequencing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty verbally describing the steps involved in doing something</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty completing an activity in a reasonable period of time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty changing a plan or activity when necessary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is slow to learn new things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty switching from one activity to another activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easily frustrated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other problem solving difficulties</td>
<td></td>
</tr>
</tbody>
</table>

2) **SPEECH, LANGUAGE, AND MATH SKILLS**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Old</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Difficulty speaking clearly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty finding the right word to say</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not talking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rambles on and on without saying much</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jumps from topic to topic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Odd or unusual language or vocal sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty understanding what others are saying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty understanding what he/she is reading</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty writing letters or words</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty reading letters or words</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty with spelling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty with math</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other speech, language, or math problems:</td>
<td></td>
</tr>
</tbody>
</table>

3) **SPATIAL SKILLS**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Old</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confusion telling right from left</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has difficulty with puzzles, Legos, blocks, or similar games</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems drawing or copying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doesn’t know his/her colors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty dressing (not due to physical disability)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems finding his/her way around places he/she has been to before</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty recognizing objects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seems unable to recognize facial or body expressions of disapproval or emotions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gets lost easily</td>
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<td>Other spatial problems:</td>
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</table>
### 4) AWARENESS AND CONCENTRATION

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<th>New</th>
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</table>

- Easily distracted by: Sounds: ___ Sights: ___ Physical Sensations: ___
- Mind appears to go blank at time: ____________________________________________________________________________
- Loses train of thought: _________________________________________________________________________________________
- Difficulty concentrating on what others say, but can sit in front of a TV for long periods: _____________________________
- Attention starts out OK but can’t keep it up: ___________________________________________________________________
- Other attention or concentration problems: _______________________________________________________________________

### 5) MEMORY

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</table>

- Forgets where he/she leaves things: __________________________________________________________________________
- Forgets things that happened recently (e.g., last meal): _________________________________________________________________
- Forgets things that happened days/weeks ago: ___________________________________________________________________
- Forgets what he/she is supposed to be doing: ___________________________________________________________________
- Forgets names more than most people do: _________________________________________________________________________
- Forgets school assignments: ____________________________________________________________________________________
- Forgets instructions: __________________________________________________________________________________________
- Other memory problems: _________________________________________________________________________________________

### 6) MOTOR AND COORDINATION

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</table>

- Poor fine motor skills (e.g., using a pencil or crayon): _______________________________________________________________________
- Clumsy: _______________________________________________________________________
- Weakness: _______________________________________________________________________
- Tremor: _______________________________________________________________________
- Muscles are tight or spastic: _______________________________________________________________________
- Odd movements (posturing, peculiar hand movements, etc.): _______________________________________________________________________
- Drops things more than most children: _______________________________________________________________________
- Has an unusual walk: _______________________________________________________________________
- Problems running: __________________________________________________________________________
- Balance problems: __________________________________________________________________________
- Other motor or coordination problems: _______________________________________________________________________

### 7) SENSORY

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- Needs to squint or move closer to page to read: _______________________________________________________________________
- Problems seeing objects: __________________________________________________________________________
- Loss of feeling: _______________________________________________________________________________________
- Problems hearing sounds: ____________________________________________________________________________
- Difficulty telling hot from cold: _______________________________________________________________________ 
- Difficulty smelling odors: __________________________________________________________________________
- Difficulty tasting food: _____________________________________________________________________________
- Overly sensitive to: Touch: ___ Light: ___ Noise: ___
- Other sensory problems: ____________________________________________________________________________

### 8) PHYSICAL

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<th>How often?</th>
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<td>4</td>
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</tbody>
</table>

- Frequently complains of headaches or nausea: _______________________________________________________________________
- Overly sensitive to: Touch: ___ Light: ___ Noise: ___
- Other sensory problems: ____________________________________________________________________________

Other concentrations or problems: ________________________________________________________________________________

Check the side this occurs on: Right: _____ Left: _____ Both Sides: _____
Has dizzy spells
Has pains in joints. Where?
Excessive tiredness
Frequent urination or drinking
Other physical problems:

9) BEHAVIOR

√ New Old
Aggressive
Attached to things, not people
Bedwetting
Bizarre behavior
Bowel movements in underwear
Dependent
Depressed
Eating habits are poor
Emotional
Fearful
Immature
Nervous
Nightmares, night terrors, sleepwalks
Quiet
Resists change
Risk-taking
Self-mutilates
Self-stimulates
Shy and withdrawn
Sleeping habits are poor
Swears a lot
Unmotivated
Other unusual behavior

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than in other children of the same age.

Careless
Is easily distracted
Has a hard time concentrating for long periods
Rarely follows others’ instructions
Doesn’t listen to other people
Goes from one activity to another without finishing anything
Seems like he/she frequently is losing things that are needed for school
Forgetful in daily activities
Seems disorganized
Is very fidgety
Can’t remain seated
Can’t wait for his/her turn when playing with others
Answers before he/she hears the whole question
Frequently makes noise when playing
Seems like he/she is always talking
- Is often rude or interrupts others
- Seems like driven by a motor
- Can’t seem to play quietly
- Frequently does dangerous things without considering the consequences
- Loses temper easily
- Refuses to comply with requests
- Easily blames others for mistakes and problems
- Easily annoyed or irritated
- Seems angry and resentful
- Steals things without people knowing on several occasions
- Often runs away from his parents’ home and stays away overnight
- Easily lies to others
- Fire setting
- Doesn’t go to school
- Breaks into other people’s property
- Destroys other people’s property in some manner other than by fire
- Is cruel to animals
- Has forcible sexual relations with others
- When fighting, has used a weapon on more than one occasion
- Starts fights with others
- Will steal directly from people
- Is cruel to other people

10) Overall, the child’s symptoms have developed:  _____ Slowly  _____ Quickly

11) The symptoms occur:  _____ Occasionally  _____ Often

12) Over the past 6 months the symptoms have:  _____ Stayed about the same  _____ Worsened

**PREGNANCY**

13) Mother’s age at birth: ________  Father’s age at birth: ________

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?  
List all medications used:
__________________________________________________________________________________________

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?  
List all medications used:
__________________________________________________________________________________________

16) How often did the mother see her doctor during the pregnancy?  
Regularly (as scheduled by the doctor) _____  Rarely _____  Not at all _____

17) During the pregnancy, which of the following did the mother use?  

<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount and Daily Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Caffeine (coffee, colas, etc.)</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Recreational drugs (cocaine, heroin, etc.)</td>
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<tr>
<td>Tobacco</td>
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</tbody>
</table>
18) During pregnancy, the mother's diet was: Good ___ Poor ____
   If poor, explain: __________________________________________________________________________

19) The mother's general physical health during the pregnancy was: Good ____ Poor ____
   If poor, explain: _________________________________________________________________________

20) About how much weight did the mother gain while she was pregnant? _____ lbs.

21) During this pregnancy, check all the mother had:
   ______ Accident
   ______ Anemia
   ______ Bleeding (severe or frequent spotting)
   ______ Diabetes
   ______ High blood pressure
   ______ Illnesses or infections
   ______ Preeclampsia, eclampsia, or toxemia
   ______ Psychological problems
   ______ Surgery
   ______ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
   Number of live births: ______
   Number of miscarriages: ______
   Number of abortions ______

BIRTH
23) Was the child born:
   Early _____ How early? _____ weeks
   On time _____ (38-42 weeks)
   Late _____ How late? _____ weeks

24) How much did the baby weight at birth? _____ lbs. _____ oz. OR _____ gms

25) How long did the labor last? __________________________________________________________________

26) The labor was: Easy _____ Moderately difficulty _____ Very difficult _____

27) What type of medication was the mother given to help with delivery? None _____
   Demerol ____ Gas ____ Regional nerve (spinal) block ____ Tranquilizer ____ Epidural ____

28) Were forceps used during delivery? Yes ____ No ____

29) Was the baby born:
   Head first _____ Transverse (crosswise) _____ Posterior first _____
   Breech birth _____ Caesarean section _____ Vacuum extraction _____
   Other: _____________________________________________________________________________

30) Did the baby experience any of these problems:
   Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
   Premature separation of the placenta (Abruptio placenta) _____
31) Describe any other special problems the mother or child had during delivery:
_________________________________________________________________________________
_________________________________________________________________________________

32) At birth, did the baby:
   Have difficulty breathing? Yes ___ No ___ Fail to cry? Yes ___ No ___
   Appear Inactive? Yes ___ No ___

33) List the baby’s Apgar scores:  1st  2nd  ___

34) If the father or mother noticed anything unusual when they first saw the baby, describe:
_________________________________________________________________________________
_________________________________________________________________________________

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe:
_________________________________________________________________________________

36) Describe any special problems that the baby had in the first few days or weeks following birth:
_________________________________________________________________________________
_________________________________________________________________________________

37) Describe any special care, treatment, or equipment the child was given after birth:
_________________________________________________________________________________

38) How long did the baby stay in the hospital? ______________________________________________

DEVELOPMENTAL HISTORY

39) For each area, indicate the child’s development by circling one description. The “Average” period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle “Early” or “Late” only if you are sure the child’s development was different from that of most other children.

GROSS MOTOR SKILLS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Early</th>
<th>Average (6-9 months)</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawled</td>
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<tr>
<td>Walked alone (2-3 steps)</td>
<td>Early</td>
<td>Average (9-18 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Pedals a tricycle</td>
<td>Early</td>
<td>Average (32-26 months)</td>
<td>Late</td>
</tr>
</tbody>
</table>

LANGUAGE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Early</th>
<th>Average (12-18 months)</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Followed simple commands</td>
<td>Early</td>
<td>Average (12-18 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Used single-word</td>
<td>Early</td>
<td>Average (12-24 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Said phrases</td>
<td>Early</td>
<td>Average (24-36 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Names primary colors</td>
<td>Early</td>
<td>Average (36 to 48 months)</td>
<td>Late</td>
</tr>
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</table>

ADAPTIVE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Early</th>
<th>Average (13-36 months)</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet trained</td>
<td>Early</td>
<td>Average (13-36 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Feeds self with spoon</td>
<td>Early</td>
<td>Average (21-24 months)</td>
<td>Late</td>
</tr>
<tr>
<td>Takes off open shirt/coat</td>
<td>Early</td>
<td>Average (18-24 months)</td>
<td>Late</td>
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</table>
40) List any other significant developmental problems:
_________________________________________________________________________________
_________________________________________________________________________________

41) Overall, the child’s development was:
Early ____   Average ____   Late ____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:
   Neck ____   Trunk ____   Legs ____   Arms ____

43) As an infant or toddler, did the child’s muscles seem to be unusually tight or stiff?
   Yes ___   No ____   If yes, describe: __________________________________________

44) Toilet training was:               Easy ____   Difficult ____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?
   Did not enjoy cuddling         ____
   Was not calmed by being held or stroked ____
   Difficult to comfort         ____
   Colic                          ____
   Excessive restlessness        ____
   Poor sleep                    ____
   Head banging                  ____
   Difficult nursing             ____

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:
   Activity Level – How active has your child been from an early age?
   ________________________________________________________________
   Distractibility – How well did your child pay attention? ____________________________________
   Adaptability – How well did your child deal with transition and change? ______________________
   Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)?
   ________________________________________________________________
   Mood – What was your child’s basic mood? _________________________________________________
   Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? _______

HEALTH HISTORY
47) Did the child have a good appetite as a baby?                Yes ___   No ___
48) Did the child fail to gain weight steadily as a baby?       Yes ___   No ___
49) List the baby’s illnesses or physical problems during the first year:
50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?  
   Yes ___  No ___  If yes, what age(s)? ___________ and how long did it last? _______________

51) Has the child ever been hit hard on the head or suffered a head injury?  
   Yes ___  No ___  If yes, what age(s)? ________________ Did the child lose consciousness?  
   Yes ___  No ___  How did it happen? ___________________________________________________________________
   What problems did the child have (physical or mental) afterwards?

52) Has the child been diagnosed with seizures or epilepsy?  
   If yes, which type?  Partial seizure ___  Generalized seizure ___  Unclassified type ___  
   If medication is used, what medication(s)? _______________________________________________
   Has the child ever had a bad reaction to this medicine?  
   Yes ___  No ___  If yes, describe: _______________________________________________________
   Did the child ever have a seizure due to a fever or unknown cause?  
   Yes ___  No ___  If yes, describe (age, nature of seizure): ____________________________

53) Was the child ever in the hospital for an accident, injury, or operation?  
   Yes ___  No ___  If yes, what age(s)? ___________ What happened? ________________________________

54) Has the child ever swallowed any poison, non-food, or drug accidentally?  
   Yes ___  No ___  If yes, what age(s)? ________ _______ What happened? ________________________________

55) Did the child have frequent ear infections?  
   Yes ___  No ___  If yes, what age(s)? ___________ How often and severe? ________________________________
   What treatment was provided? __________________________________________________________

56) Please check all the following diseases or conditions the child has ever had:
   ___  Allergies  ___  Cerebral Palsy  ___  Jaundice  ___  Mumps  
   ___  Anemia  ___  Chicken Pox  ___  Kidney Disorder  ___  Oxygen deprivation  
   ___  Asthma  ___  Colds (excessive)  ___  Leukemia  ___  Pneumonia  
   ___  Bleeding disorder  ___  Diabetes  ___  Liver disorder  ___  Rheumatic fever  
   ___  Blood disorder  ___  Encephalitis  ___  Lung Disorder  ___  Scarlet fever  
   ___  Brain disorder  ___  Enzyme deficiency  ___  Measles  ___  Tuberculosis  
   ___  Broken bones  ___  Genetic disorder  ___  Meningitis  ___  Venereal disease  
   ___  Cancer  ___  Heart disorder  ___  Metabolic disorder  ___  Whooping cough  
   ___  Eye problems  ___  Tics (eye blinking, sniffing, and repetitive movement)  
   ___  Other problems _________________________________________________________________

57) As the child has been growing up, he/she has been sick:
   Much of the time _____  An average amount _____  Not much at all _____

58) List all the medications the child takes now:
   Medication  Dosage  How often?  What for?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
59) Does the child?
    Wear glasses? Yes ___ No ___ (Farsighted ___ Nearsighted ___ Other ___)
    Use a hearing aid? Yes ___ No ___

60) Within the past year has the child had: RESULTS
    A vision test? Yes ___ No ___ ____________________________________________
    A hearing test? Yes ___ No ___ ____________________________________________

61) What is the child's: Height: _____ ft. _____ in. Weight: _____ lbs.

62) When was the child's last medical checkup? ________________________________

63) What therapies have been provided to the child? ______ No therapies
    ______ Occupational therapy
    ______ Physical therapy
    ______ Psychological therapy, counseling, or cognitive rehabilitation
    ______ Speech therapy
    ______ Other therapy _________________________________________________

FAMILY HISTORY

64) The child lives with:
    ___ Biological parent(s) only ___ Relatives ___ Foster parents
    ___ Biological parent and other ___ Adoptive parents ___ Institutional care
    ___ Other placement _________________________________________________

Please list all the people currently living in the home with the child and their relation to the child
(include family and nonfamily members)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

65) The family's income is:
    under $10,000 ___ $10,000-29,999 ___ $30,000-50,000 ___ over $50,000 ___

66) What is the name of the child's biological mother? _______________________
    a. Is she living? Yes ___ No ___ If deceased, explain: ______________________
    b. Her age? __________
    c. What is her level of education? _________________________________________
    d. Her occupation? _______________________________________________________
       If mother works outside the home, how may hours and what days
    e. Does she live in the same house as the child? Yes ___ No ___
    f. How often does she see the child? _______________________________________
    g. How involved is the mother in the child's upbringing? Very ___ Somewhat ___ Not at all ___
    h. During school, did the mother have: Learning problems ________________________
Attention problems ____________________________________________________________

Behavior problems ____________________________________________________________

Medical problems ____________________________________________________________

i. What are the mother’s hobbies? ________________________________________________

j. What is mother’s primary language __________________      Secondary language _______________________

67) What is the name of the child’s biological father? __________________________________
   a. Is he living? Yes ___ No ___      If deceased, explain:______________________________
   b. His age? ______________________
   c. What is his level of education? ________________________________________________
   d. His occupation? __________________________________________________________________
      If father works outside the home, how many hours and what days ______________________
   e. Does he live in the same house as the child? Yes ____        No _____
   f. How often does he see the child? ________________________________________________
   g. How involved is the father in the child’s upbringing?  Very ___   Somewhat ___   Not at all ___
   h. During school, did the father have:
      Learning problems ____________________________________________________________
      Attention problems ____________________________________________________________
      Behavior problems ____________________________________________________________
      Medical problems ____________________________________________________________
   i. What are the father’s? _________________________________________________________
   j. What is father’s primary language __________________      Secondary language _______________________

68) Please list the names, ages, and grade (or job) of the child’s brothers and sisters:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Grade or job</th>
<th>Medical, Social, School Problems</th>
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69) Has anyone in the child’s biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

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<tr>
<th></th>
<th>Which relative?</th>
<th>Describe the problem briefly</th>
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<tbody>
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<td></td>
<td>Brain disease</td>
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<td>Developmental Delay</td>
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<td>Epilepsy or seizures</td>
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<td>Learning disability</td>
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<td></td>
<td>Mental retardation</td>
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<td></td>
<td>Neurologic disease</td>
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<td>Psychological problems</td>
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<td></td>
<td>Reading/spelling difficulties</td>
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<td></td>
<td>Speech/language problems</td>
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</table>

70) Which of the child’s biological relatives are left-handed?   No one _____
Mother ____  Father ____  Sibling(s) ____  Grandparents ____

71) What languages are spoken in the home? (List in order of most frequent first)
   (1) ___________________________________   (2) ______________________________________

72) How is the child disciplined? _____________________________________________________________

Is the discipline effective? _________________________________________________________________

73) List the child’s usual recreational activities and hobbies: ________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

74) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes ___  No ___
   If yes, explain: ______________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

How much stress has these changes caused the child?  (circle one)
   None    Mild    Moderate    Severe

75) Does the child attend day care outside the home or does someone come into the home to provide the service?
   ___________________________________________________________________________________
   Does day care provide any type of formal program of play, developmental, or academic activities?
   ___________________________________________________________________________________
   ___________________________________________________________________________________

PEER RELATIONSHIPS
76) Does your child seek friendships with peers? ____________________________________________

_____________________________________________________________________________________

77) Is your child sought by peers for friendship? ____________________________________________

_____________________________________________________________________________________

78) Does your child play with children primarily his or her own age? __________________________
   Younger? ______  Older? _______________________  

79) Describe any problems your child may have with peers ____________________________________

_____________________________________________________________________________________

SCHOOL HISTORY
80) The child’s present school is:  Name ____________________________________________________
   Address _______________________________________________________________________________
   Phone ______________________________  Contact person __________________________
81) Was the child ever held back to repeat a grade?  
Yes ___  No ___
If yes, which grade? __________  Why? ______________________________________________________________________

82) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.)  
Yes ___  No ___
If yes, describe the special class ______________________________________________________________________________
Is the child in this class or receiving special services now?  
Yes ___  No ___
If yes, describe the present class placement ______________________________________________________________________

83) Does the child like school?  
Most of the time ___  Sometimes ___  Almost never ___

84) Does the child:
   Have problems with other children in class?  
Yes ___  No ___
   Have problems making friends in school?  
Yes ___  No ___
   Have problems getting along with teachers?  
Yes ___  No ___
   Tend to get sick in the morning before school?  
Yes ___  No ___

85) Describe the teacher’s concerns about the child’s schoolwork or behavior:
________________________________________________________________________________
________________________________________________________________________________

86) What kind of grades has the child received in the past year?
   A’s & B’s _____  B’s & C’s _____  C’s & D’s _____  D’s & F’s _____
   Or
   Outstanding ___  Good ___  Satisfactory ___  Improvement needed ___  Unsatisfactory ___
   Or
   Other grading system
Are these grades a change from previous years?  
Yes ___  No ___
If yes, describe ______________________________________________________________________________________________
________________________________________________________________________________

87) In which subject(s) does the child do best?  
_______________________________________________________________________________________________
_______________________________________________________________________________________________

88) Which subject(s) are the most difficult?  
_______________________________________________________________________________________________
_______________________________________________________________________________________________

89) In the past year, how much school has the child missed due to illness or injury?
   Less than 2 weeks _____  2-4 weeks _____  5-8 weeks _____  Over 8 weeks _____
   Briefly describe the reasons if the child has missed a lot of school:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

90) Does the child seem to have a “school phobia?”  
Yes ___  No ___
If yes, explain: _______________________________________________________________________________

91) Do you consider your child to understand directions and situations as well as other children his or her age?
92) How would you rate your child’s overall intelligence compared to other children?
Below average _____ Above average _____ Average _____

PREVIOUS EVALUATIONS
93) Which of these tests or procedures has recently been done? Note if normal or abnormal

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood work</td>
<td></td>
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<tr>
<td>Family physician or pediatrician office visit</td>
<td></td>
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<tr>
<td>Hearing testing</td>
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<td>Lead level check</td>
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<tr>
<td>Lumbar puncture or spinal tap</td>
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<tr>
<td>Neurological examination or testing (CT scan, EEG)</td>
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<tr>
<td>Psychological or Neuropsychological testing</td>
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<tr>
<td>School testing</td>
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<tr>
<td>Speech &amp; Language testing</td>
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<tr>
<td>Vision testing</td>
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<tr>
<td>X-rays</td>
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<tr>
<td>Other tests:</td>
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</tbody>
</table>

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child’s problems?

Name ____________________________________________ Name ____________________________________________
Address _________________________________________ Address _________________________________________
Phone ___________________________________________ Phone ___________________________________________
Profession ______________________________________ Profession _______________________________________

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________


THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.
## Food Preferences Chart

**Child's Name:**

**Age:**

**Weight:**

**Height:**

List foods your child is allergic to:

Any current dietary restrictions?

Circle each food your child will typically eat

<table>
<thead>
<tr>
<th>Grains /Carbohydrates</th>
<th>Dairy</th>
<th>Meat /Protein</th>
<th>Fruits</th>
<th>Vegetables</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animal Crackers</td>
<td>Milk</td>
<td>Chicken:</td>
<td>Apples</td>
<td>Artichoke</td>
<td>Butter or Margarine</td>
</tr>
<tr>
<td></td>
<td>Type:</td>
<td>Fried</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Baked</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Grilled Nuggets</td>
<td></td>
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</tr>
<tr>
<td>Bagels</td>
<td>Yogurt</td>
<td>Fish/Seafood</td>
<td>Apricots</td>
<td>Asparagus</td>
<td>Salad dressings:</td>
</tr>
<tr>
<td></td>
<td>Types:</td>
<td>Fish Types:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bread:</td>
<td>Cheese</td>
<td>Beef:</td>
<td>Berries Types;</td>
<td>Bean Sprouts</td>
<td>Nut Types:</td>
</tr>
<tr>
<td>White</td>
<td>Types:</td>
<td>Ground</td>
<td></td>
<td></td>
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<tr>
<td>Sour dough</td>
<td>American</td>
<td>Roast</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wheat</td>
<td>Provolone</td>
<td>Hamburger</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Biscuits</td>
<td>Cheddar</td>
<td></td>
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<tr>
<td>Rolls</td>
<td>mexican</td>
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<tr>
<td>Bread Sticks</td>
<td>Cream Cheese</td>
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<tr>
<td>Pita</td>
<td>Monterey</td>
<td>Ham</td>
<td>Banana</td>
<td>Beets</td>
<td>Mayonnaise</td>
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<tr>
<td>Tortilla</td>
<td>Jack</td>
<td>Pork</td>
<td>Cantaloupe</td>
<td>Bell Pepper</td>
<td>Relish</td>
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<td></td>
<td></td>
<td>Bacon</td>
<td>Cherries</td>
<td>Broccoli</td>
<td>Ketchup</td>
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<tr>
<td>Croutons</td>
<td>Sour Cream</td>
<td>Fruit juice</td>
<td>Cranberry</td>
<td>Brussels</td>
<td>Mustard</td>
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<tr>
<td></td>
<td>Ice Cream</td>
<td>Types:</td>
<td>Sprouts</td>
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<td></td>
<td>Pudding</td>
<td>Peanut Butter</td>
<td>Cabbage</td>
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<td>Grits</td>
<td>Kashi</td>
<td></td>
<td>Oil</td>
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<tr>
<td>Pancakes</td>
<td>Other:</td>
<td>Lamb</td>
<td>Dates</td>
<td>Carrots</td>
<td>Jellies</td>
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<tr>
<td>Orzo</td>
<td></td>
<td>Figs</td>
<td>Cauliflower</td>
<td>Celery</td>
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<tr>
<td>Pretzels</td>
<td></td>
<td>Grapefruit</td>
<td>Cherry or grape tomatoes</td>
<td>Celery</td>
<td></td>
</tr>
<tr>
<td>Waffles</td>
<td></td>
<td>Grapes</td>
<td></td>
<td>Syrups:</td>
<td></td>
</tr>
<tr>
<td>Crackers</td>
<td>Type:</td>
<td>Venison</td>
<td>Honeydew</td>
<td>Cookies:</td>
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<td></td>
<td></td>
<td>Melon</td>
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<td>Greens</td>
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<tr>
<td><strong>Grains /Carbohydrates</strong></td>
<td><strong>Dairy</strong></td>
<td><strong>Meat /Protein</strong></td>
<td><strong>Fruits</strong></td>
<td><strong>Vegetables</strong></td>
<td><strong>Other</strong></td>
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<tr>
<td>Muffin Types:</td>
<td></td>
<td></td>
<td>Mango</td>
<td>Green Beans</td>
<td>Cakes:</td>
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<tr>
<td>Pasta Type:</td>
<td></td>
<td></td>
<td>Melon balls</td>
<td>Mushrooms</td>
<td></td>
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<tr>
<td>Vegetable Types/Styles:</td>
<td></td>
<td></td>
<td>Mixed Fruits</td>
<td>Okra</td>
<td></td>
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<tr>
<td>Rice Type/Style:</td>
<td></td>
<td></td>
<td>Nectarines</td>
<td>Onions</td>
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<td></td>
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<td></td>
<td>Mandarin</td>
<td>Peas</td>
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<td>Oranges</td>
<td>Salsa</td>
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<td></td>
<td>Papaya</td>
<td>Spinach</td>
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<td>Peach</td>
<td>Squash</td>
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<td></td>
<td></td>
<td>Pear</td>
<td>Sweet Potatoes</td>
<td>Other:</td>
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<td></td>
<td></td>
<td>Pineapple</td>
<td>Yams</td>
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<td></td>
<td></td>
<td>Plums</td>
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<td></td>
<td>Prunes</td>
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<td></td>
<td></td>
<td></td>
<td>Raisins</td>
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<td></td>
<td>Satsuma</td>
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<td></td>
<td></td>
<td></td>
<td>Tangerine</td>
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<td></td>
<td></td>
<td></td>
<td>Tomato</td>
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<td></td>
<td></td>
<td></td>
<td>Watermelon</td>
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<tr>
<td>Estimated 1 ounce servings per day:</td>
<td>Estimated 1 ounce servings per day:</td>
<td>Estimated 1 ounce servings per day:</td>
<td>Estimated 1 ounce servings per day:</td>
<td>Estimated 1 ounce servings per day:</td>
<td>Estimated 1 ounce servings per day:</td>
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</tbody>
</table>
Social Skills Checklist

Name of Child: __________________ Date Completed: ________________
Birth date: ______ Teacher or Family Member Completing Form:

Based on your observations, in a variety of situations, rate the child’s following skill level. Put a check mark in the box that best represents the child’s current level (see rating scale).

Write additional information in the comments section.

After completing the checklist, place a check in the far right column, a priority next to skills which are to target for instruction.

Rating Scale

Almost Always: The child consistently displays this skill in many occasions, settings and with a variety of people.
Often: The child displays this skill on a few occasions, settings and with a few people.
Sometimes: The child may demonstrate this skill however they seldom display this skill.
Almost Never: The child has never or rarely displays this skill. In their daily routine, is uncommon to see the child demonstrate this skill.

Section 1: Social Play and Emotional Development

<table>
<thead>
<tr>
<th>Does the Child....</th>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Almost Never</th>
<th>Comments</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Beginning Play Behaviors</td>
<td></td>
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<tr>
<td>a. Maintain Proximity to peers within 1 foot.</td>
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<tr>
<td>b. Observe peers in play vicinity within 3 feet.</td>
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<tr>
<td>c. Parallel play near peers using the same or similar materials (e.g., building with blocks next to peer who is also playing with blocks).</td>
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<tr>
<td>d. Imitate peer (physical or verbal).</td>
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<tr>
<td>e. Take turns during simple games (e.g., rolling ball back and forth).</td>
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<tr>
<td>Does the Child...</td>
<td>Almost Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Almost Never</td>
<td>Comments</td>
<td>Priority</td>
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<tr>
<td><strong>1.2 Intermediate Play Behaviors</strong></td>
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<tr>
<td>a. Play associatively with other children (e.g., sharing toys and talking about the play activity, even though the play agenda of the other child (ren) may be different).</td>
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<tr>
<td>b. Respond to interactions from peers (e.g., Physically accept toy from a peer; answer questions).</td>
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<tr>
<td>c. Return and initiate greetings with peers (e.g., wave or say “hello”).</td>
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<tr>
<td>d. Know acceptable ways of joining in an activity with others (e.g., offering a toy to a peer or observe play and ask to join in).</td>
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<tr>
<td>e. Invite others to play.</td>
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<tr>
<td>f. Take turns during structured games/activities (e.g., social or board games).</td>
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<tr>
<td>g. Ask peers for toys, food, and materials.</td>
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<tr>
<td><strong>1.3 Advanced Play Behavior</strong></td>
<td></td>
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<tr>
<td>a. Play cooperatively with peers (e.g., take on pretend role during dramatic play, lead the play, and follow game with rules).</td>
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<tr>
<td>b. Make comments about what he/she is playing to peers (e.g., “I am making a tall tower.”)</td>
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<tr>
<td>c. Organize play by suggesting play plan (e.g., “Let’s make a train track and then drive the trains.”)</td>
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<tr>
<td>d. Follow another peers play ideas.</td>
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<tr>
<td>e. Take turns during unstructured activities (e.g., with toys/materials that are limited, roles during dramatic play).</td>
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<tr>
<td>f. Give up toys, food and materials to peers.</td>
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<tr>
<td>g. Offer toys, food, and materials to peers.</td>
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</tbody>
</table>
## Section 2: Emotional Regulation

<table>
<thead>
<tr>
<th>Does the Child....</th>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Almost Never</th>
<th>Comments</th>
<th>Priority</th>
</tr>
</thead>
</table>

### 2.1 Understanding Emotions

- a. Identify Likes and dislikes.
- b. Identify emotions in self.
- c. Label emotions in self.
- d. Identify emotions in others.
- e. Label emotions in others.
- f. Justify an emotion once identified/labeled (e.g., if a girl is crying the child can say she is crying because she fell down and is hurt).
- g. Demonstrate affection toward peers (e.g., gives peers hugs).
- h. Demonstrate empathy toward peers (e.g., if a peer’s toy breaks, the child may feel sad for them).
- i. Demonstrate aggressive behavior toward others.
- j. Demonstrate aggressive behavior toward self.
- k. Demonstrate intense fears (e.g., the child will not go near dogs and becomes upset when a dog is near).

### 2.2 Self-Regulation

- a. Allow others to comfort him/her if upset or agitated (e.g., allows caregiver to give them a hug or peers to pat their back).
- b. Self-regulate when tense or upset (e.g., calms self by counting to 10 or taking a breath).
- c. Self-regulate when energy level is high (e.g., Counts to 10 or runs around the playground to release energy).
### 2.2 Self-Regulation Continued

<table>
<thead>
<tr>
<th></th>
<th>Almost Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>d.</td>
<td>Use acceptable ways to express anger or frustration (e.g., states they are upset or asks to take a break).</td>
<td></td>
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<tr>
<td>e.</td>
<td>Deal with being teased in acceptable ways (e.g., ignore, walk away, tell adult).</td>
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<tr>
<td>f.</td>
<td>Deals with being left out of group.</td>
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<tr>
<td>g.</td>
<td>Request a &quot;break&quot; or to be all done when upset.</td>
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<td>h.</td>
<td>Accept not being first at a game or activity.</td>
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<tr>
<td>i.</td>
<td>Say “no” in an acceptable way to things s/he doesn’t want to do.</td>
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<td>j.</td>
<td>Accept losing at a game without becoming upset/angry.</td>
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<tr>
<td>k.</td>
<td>Deals with winning appropriately (e.g., the child may say, &quot;maybe next time&quot; or congratulate the winner.&quot;).</td>
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<tr>
<td>l.</td>
<td>Accept being told “no” without becoming upset/angry.</td>
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<tr>
<td>m.</td>
<td>Able to say “I don’t know.”</td>
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### 2.3 Flexibility

<table>
<thead>
<tr>
<th></th>
<th>Almost Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Accept making mistakes without becoming upset/angry.</td>
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<tr>
<td>b.</td>
<td>Accept consequences of his/her behaviors without becoming upset/angry.</td>
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<td>c.</td>
<td>Ignore others or situations when it is desirable to do so.</td>
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<tr>
<td>d.</td>
<td>Accept unexpected changes.</td>
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<tr>
<td>e.</td>
<td>Accept changes in routine.</td>
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<tr>
<td>f.</td>
<td>Continue to try when something is difficult.</td>
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### 2.4 Problem Solving

<table>
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<tr>
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<th>Almost Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
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<tbody>
<tr>
<td>a.</td>
<td>Claim and defend possessions.</td>
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<tr>
<td>b.</td>
<td>Identify/define problems.</td>
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<td>c.</td>
<td>Generate solutions (e.g., if juice spills the child can suggest getting a sponge and cleaning it up).</td>
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<td>d.</td>
<td>Carry out solutions by negotiating or compromising</td>
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</table>
### Section 3: Group Skills

<table>
<thead>
<tr>
<th>Does the Child...</th>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Almost Never</th>
<th>Comments</th>
<th>Priority</th>
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</thead>
<tbody>
<tr>
<td><strong>3.1 Seeking Assistance</strong></td>
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</table>
a. Seek assistance from adults. | | | | | | |
b. Seek assistance from peers. | | | | | | |
c. Give assistance to peers. | | | | | | |
| **3.2 Participate in Group** |               |       |           |              |          |          |
a. Respond/participate when one other child is present. | | | | | | |
b. Respond/participate when more than one other child is present. | | | | | | |
c. Use appropriate attention seeking behaviors (e.g., calling name, tapping shoulder). | | | | | | |
| **3.3 Follow Group** |               |       |           |              |          |          |
a. Remain with group. | | | | | | |
b. Follow the group routine. | | | | | | |
c. Follow directions. | | | | | | |
d. Make transition to next activity when directed. | | | | | | |
e. Accept interruptions/unexpected change. | | | | | | |
### Section 4: Communications Skills

<table>
<thead>
<tr>
<th>Does the Child….</th>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Almost Never</th>
<th>Comments</th>
<th>Priority</th>
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</thead>
</table>

#### 4.1 Conversational Skills

- **a.** Initiate a conversation around specified topics (e.g., says to peers, "Guess what I did yesterday?")
- **b.** Initiate conversations when it is appropriate to do so (e.g., at recess and not during a time for quiet independent work at school).
- **c.** Ask "wh" questions for information (e.g., child will ask "Where are my shoes?" or "Who is that girl?").
- **d.** Respond to "Wh" questions.
- **e.** Respond appropriately to changes in topic (e.g., if peer changes the topic from skiing to swimming, the child will talk about the new topic).
- **f.** Make a variety of comments, related to the topic, during conversations (e.g., if a friend says, "I have blue truck." The child responds, "I have a green truck/").
- **g.** Ask questions to gain more information.
- **h.** Introduce him/herself to someone new.
- **i.** Introduce people to each other.
- **j.** Demonstrate the difference between telling information and asking for more information.

#### 4.2 Nonverbal Conversational Skills

- **a.** Maintain appropriate proximity to conversation partner (e.g., does not stand too close or touch other person).
- **b.** Orient body to speaker.
- **c.** Maintain appropriate eye contact.
- **d.** Use an appropriate voice volume.
<table>
<thead>
<tr>
<th>Does the Child….</th>
<th>Almost Always</th>
<th>Often</th>
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<th>Almost Never</th>
<th>Comments</th>
<th>Priority</th>
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<tbody>
<tr>
<td><strong>4.2 Nonverbal Conversational Continued</strong></td>
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<td>e. Pay attention to a person's nonverbal language and understand what is being communicated (e.g., if someone shakes their head that means no and nodding your head means yes).</td>
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<td>f. Wait to interject (e.g., waits until there is a pause before they begin talking).</td>
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<td>g. Appropriately interject (e.g., “guess what” or “do you know what I did”).</td>
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<td>h. End the conversation appropriately (e.g., when the conversation is over says, “I have to go now” or “see you later”).</td>
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<td><strong>4.3 Questions</strong></td>
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<tr>
<td>a. Answer Yes/No questions.</td>
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<td>b. Answer simple social questions (e.g., name, age, hair color, address).</td>
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<td>c. Answer subjective questions such as “what do you like to eat/drink?” or “what is your favorite color/video?”).</td>
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<td>d. Respond Simple “Wh” questions (e.g., “what color is that ball?” “Where are your shoes?”).</td>
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<td>e. Ask questions to gain more information.</td>
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<td>f. Answer questions about past events (e.g., “What did you have for lunch?” or “where did you go for vacation?”).</td>
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<td>g. Stay on topic by making comments or asking questions related to the topic.</td>
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<td>h. Use “please” and “thank you” at appropriate times.</td>
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<td><strong>4.4 Compliments</strong></td>
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<tr>
<td>a. Give compliments to peers.</td>
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<td>b. Appropriately receive compliments (e.g., thank you, reciprocate).</td>
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After completing the checklist, place a check in the far right column, next to skills which are a priority to target for instruction.