NeuropsychEd
Neuropsychological and Educational Consultants

Person completing form: _____ Relationship to the Child:_____

Primary Demographic Information

Child's name: _____ Date of birth: _____ Child's age _____
Gender: ☐ Male ☐ Female Child's Race/Ethnicity: _____
Child's Address: _____
Child's Current School and Year:_____
School Address/Telephone: _____
Teacher (s): _____
Languages Spoken at Home: 1st: _____ 2nd _____

Referral Information

Reason for referral? _____
Who recommended the referral?: _____

What are the primary concerns?:	What specific questions would you like answered?
1.)_____	1.)_____
2.)_____	2.)_____
3.)_____	3.)_____

Family Background

Parent Information

Mother's name: _____ Stepmother? ☐ Yes ☐ No
Address (if different from address listed above): _____
Home Phone: _____ Mobile Phone: _____
Occupation: _____

Father's name: _____ Stepfather? ☐ Yes ☐ No
Address (if different from address listed above): _____
Home Phone: _____ Alternate Phone: _____
Occupation: _____

	Biological Mother	Biological Father
Ethnicity	_____	_____
Highest education level	_____	_____
Medical problems	_____	_____
Learning problem (in childhood)	_____	_____
Emotional problems	_____	_____
Substance abuse problems	_____	_____

Was the child adopted? ☐ Yes ☐ No

Does this child have other parent(s)/stepparents(s)? □ Yes □ No

If yes, please provide the following information.
Name_____
Relationship to this child_____ Home Phone _____

Name_____
Relationship to this child_____ Home Phone_____

Has this child ever experienced any parental separations, divorces or death? □ Yes □ No
If yes, when? _____ How old was the child? _____
Please describe the circumstances. _____

If parents are separated or divorced, what is the custody status? _____
Child resides primarily with _____
How often does the other parent see this child? □ Weekly or more □ Once or twice a month
□ Few times year □ Never

Sibling Information

Please list the names, ages, relationship (full-sibling, half-sibling, foster/adoptive), grade/job, and any learning, emotional, or medical problems siblings may have.

Name	Age	Relationship	Grade/Job	Learning/Medical Problems	(✓) Live at home

Family Medical Information

Have any of the child's family members had any of the following? If yes, please specify family member's relationship to this child and the side of the family (maternal or paternal).

□ Cancer _____
□ Cystic fibrosis _____
□ Diabetes _____
□ Heart disease _____
□ High Blood Pressure _____
□ Tuberculosis _____
□ Alzheimer's disease _____
□ Haemophilia _____
□ Huntington's chorea _____
□ Muscular dystrophy _____
□ Cerebral Palsy _____
□ Alcohol/drug abuse _____
□ Behaviour disorder _____
□ Mental illness _____
□ Intellectual Disability _____
□ Nervousness _____
□ Seizures or epilepsy _____
□ Reading problem _____

□ Kidney disease _____
□ Migraine headaches _____
□ Multiple Sclerosis _____
□ Physical handicap _____
□ Stroke _____
□ Parkinson's disease _____
□ Sickle-cell anaemia _____
□ Tay-Sachs disease _____
□ Tourette's syndrome _____
□ Birth defect _____
□ Severe head injury _____
□ Schizophrenia _____
□ Suicide attempt _____
□ Depression _____
□ Thought Problems _____
□ Speech/language _____
□ Food allergies _____
□ Other: _____

Which of the child's biological relatives are left-handed?

☐None ☐ Mother ☐ Father ☐Sibling(s) ☐Grandparent(s) ☐Aunt/Uncle(s) ☐Cousin(s)

Has anyone in the family ever been hospitalized in a psychiatric facility? ☐ Yes ☐ No

If yes, who? _____ When? _____

Has anyone in the family ever completed suicide? ☐ Yes ☐ No

If yes, who? _____ When? _____

Has anyone in your family witnessed or been involved in domestic violence? ☐ Yes ☐ No

If yes, who? _____ When? _____

Please describe the domestic violence: _____

_____

Background Information

Pregnancy

Mother's age at child's birth: _____ Father's age at child's birth _____

How many pregnancies did the mother have prior to this one?

Number of live births: _____ Number of miscarriages: _____

Prior to the pregnancy, what medications (prescribed over-the counter) did the mother take?

List all medications used: _____

The mother's general physical health during the pregnancy was: ☐ Good ☐ Poor

If poor, explain: _____

How often did the mother see her doctor during the pregnancy (prenatal care)?

☐ Regularly (as scheduled by doctor) ☐ Rarely ☐ Not at all

During the pregnancy, the mother's diet was: ☐ Good ☐ Poor

If poor, explain: _____)_____

During the pregnancy, did the mother use any of the following?

☐ Alcohol ☐ Recreational Drugs (marijuana, cocaine, heroin, etc) ☐ Caffeine ☐ Tobacco

☐ Other drugs used during pregnancy:

	Type	Frequency	Prescription
	_____	_____	□ Yes □ No
	_____	_____	□ Yes □ No

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

☐Toxaemia	☐Abnormal weight gain	☐ Measles
☐Excessive vomiting	☐German measles	☐Excessive swelling
☐Vaginal bleeding	☐Anaemia	☐Flu
☐Emotion problems	☐Diabetes	☐High blood pressure
☐Surgery	☐Preeclampsia or eclampsia	☐Rh factor

☐Maternal injury: Describe _____

☐Hospitalization during pregnancy: Reason _____

☐X –rays during pregnancy: What month? _____

Birth History

Was this child born:

☐Early -- How early? _____wks ☐On time (38-42 wks) ☐Late -- How late? _____ wks

How much did the baby weigh at birth? ____lbs. ____oz. OR ____ grams.

The labour was: ☐ Easy ☐Moderately difficult ☐Very difficult
- AND - ☐ Induced ☐ Non-induced

What type of medication was the mother given to help with delivery?

☐ Demerol ☐ Gas ☐ Regional nerve (spinal) block
☐ Tranquilizer ☐ Epidural ☐None

Type of delivery: ☐Natural/Vaginal ☐Caesarean section ☐Vacuum extraction

Were forceps used during delivery? ☐Yes ☐No

Was the baby born:

☐Head first ☐Transverse (crosswise) ☐Posterior first
☐Breech ☐Other: _____

Did baby experience any of these problems <u>after birth</u>:

☐Foetal distress ☐Low placenta (Placenta previa) ☐Cord wrapped around neck
☐Prolapsed cord ☐Jaundice ☐Premature separation of placenta

Describe any other special problems the mother or child had during delivery:

_____

At birth, did the baby:

Have difficulty breathing? ☐Yes ☐No Appear inactive? ☐Yes ☐No
Fail to cry? ☐Yes ☐No List baby's Apgar Scores 1st _____ 2nd _____

How long did the baby stay in the hospital? _____

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

_____

Describe any special problems that the baby had in the first days following birth (e.g., cardiac or respiratory problems):_____

_____

Describe any special care, treatment, or equipment the child was given after birth (e.g., phototherapy, oxygen):

_____

_____

Developmental History

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 (i.e. walking occurs approx. 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.

Motor Skills

Sat without support	☐ Early	☐ Average (3-4 mo)	☐ Late	☐ Not yet
Crawled forward	☐ Early	☐ Average (6-9 mo)	☐ Late	☐ Not yet
Walked with hands held	☐ Early	☐ Average (9-12 mo)	☐ Late	☐ Not yet
Walked alone (2-3 steps)	☐ Early	☐ Average (9-18 mo)	☐ Late	☐ Not yet
Showed clear hand preference	☐ Early	☐ Average (7 years)	☐ Late	☐ Not yet
Buttoned Clothing	☐ Early	☐ Average	☐ Late	☐ Not yet
Tied Shoelaces	☐ Early	☐ Average	☐ Late	☐ Not yet
Rode Bicycle	☐ Early	☐ Average	☐ Late	☐ Not yet

Language Skills

Said "dada" or "mama"	☐ Early	☐ Average (12-15 mo)	☐ Late	☐ Not yet
Said other single words	☐ Early	☐ Average (12-24 mo)	☐ Late	☐ Not yet
Said phrases/2-3 word sentences	☐ Early	☐ Average (18-24 mo)	☐ Late	☐ Not yet
Spoke sentences of 3 or more words	☐ Early	☐ Average (30-42 mo)	☐ Late	☐ Not yet
Spoke clearly	☐ Early	☐ Average	☐ Late	☐ Not yet

Self Help

Toilet trained	☐ Early	☐ Average (20-36 mo)	☐ Late	☐ Not yet
Was toilet training:	☐ Easy	☐ Difficult		

After toilet training did the child have:

Accidents during the day?	☐ Yes ☐ No	If yes, until what age? _____	
Bed wetting?	☐ Yes ☐ No	If yes, until what age? _____	
Bed soiling?	☐ Yes ☐ No	If yes, until what age? _____	

Were there any medical reasons for daytime accidents, bed-wetting or soiling? ☐ Yes ☐ No
If yes, please describe: _____

Overall, the child's development was: ☐ Early ☐ Average ☐ Late

Has your child's speech and language development been different from siblings? How?:
_____

Adaptive Skills

Please indicate whether this child has the following skills.

	Yes	**No**		**Yes**	**No**
Dresses self	☐	☐	Knows how to get help/find home if lost	☐	☐
Helps with household chores	☐	☐	Says "please" & "thank you"	☐	☐
Tells time accurately	☐	☐	Bathes self	☐	☐

Current Performance:

How well does your child function in the following areas compared with age peers? Tick appropriate box and comment if appropriate.

	Similar to peers	Better than peers	Worse than peers
Walking			
Running			
Throwing			
Catching			
Athletic Abilities			
Understanding Directions			
Behaviour			

Does your child ever use jargon excessively (i.e. non-words or words with no meaning)?: ☐ Yes ☐ No

Does your child ever frequently echo what you said, without seeming to understand what the word(s) meant?: ☐ Yes ☐ No

Does your child usually get the intended message across when talking?: ☐ Yes ☐ No

Does your child rely excessively on nonverbal communications skills Such as gestures, facial expressions?: ☐ Yes ☐ No

Infant / Toddler Temperament

During the first three years of life, in comparison to other children of the same age, was your child:

Difficult to feed	☐ Less Often	☐ About the same	☐ More
Difficult to get to sleep	☐ Less Often	☐ About the same	☐ More
Colicky	☐ Less Often	☐ About the same	☐ More
Difficult to put on a schedule	☐ Less Often	☐ About the same	☐ More
Alert	☐ Less Often	☐ About the same	☐ More
Cheerful	☐ Less Often	☐ About the same	☐ More
Affectionate	☐ Less Often	☐ About the same	☐ More
Sociable(eye contact, smiling)	☐ Less Often	☐ About the same	☐ More
Easy to comfort	☐ Less Often	☐ About the same	☐ More
Able to self-soothe	☐ Less Often	☐ About the same	☐ More
Overactive, in constant motion	☐ Less Often	☐ About the same	☐ More
Very stubborn, challenging	☐ Less Often	☐ About the same	☐ More
Apt to cry excessively	☐ Less Often	☐ About the same	☐ More
Emotionally responsive	☐ Less Often	☐ About the same	☐ More
Easy to discipline	☐ Less Often	☐ About the same	☐ More

As an infant and toddler, was your child interested in social contact (eye contact, smiling, showing things, sharing experiences)? ☐ Yes ☐ No

If no, please describe _____

Current Medical History

Please indicate whether this child currently has any of the following problems and how often they occur. N=never, O=once, D=daily, M=monthly and Y=yearly.

Cardiovascular

Heart murmur	☐ N	☐ O	☐ D	☐ M	☐ Y
Shortness of breath/ dizziness w/ physical exertion	☐ N	☐ O	☐ D	☐ M	☐ Y
Activity limitation due to heart condition	☐ N	☐ O	☐ D	☐ M	☐ Y

Respiratory

Frequent colds	☐ N	☐ O	☐ D	☐ M	☐ Y
Chronic cough	☐ N	☐ O	☐ D	☐ M	☐ Y
Asthma	☐ N	☐ O	☐ D	☐ M	☐ Y
Hay fever	☐ N	☐ O	☐ D	☐ M	☐ Y
Sinus Condition	☐ N	☐ O	☐ D	☐ M	☐ Y

Musculoskeletal

Muscle pain	☐ N	☐ O	☐ D	☐ M	☐ Y
Clumsy walk	☐ N	☐ O	☐ D	☐ M	☐ Y
Poor posture	☐ N	☐ O	☐ D	☐ M	☐ Y

Gastrointestinal

Excessive Vomiting	☐ N	☐ O	☐ D	☐ M	☐ Y
Frequent diarrhea	☐ N	☐ O	☐ D	☐ M	☐ Y
Constipation	☐ N	☐ O	☐ D	☐ M	☐ Y
Stomach Pain	☐ N	☐ O	☐ D	☐ M	☐ Y

Genitourinary

Urination in pants/bed	☐ N	☐ O	☐ D	☐ M	☐ Y
Pain while urinating	☐ N	☐ O	☐ D	☐ M	☐ Y
Excessive urination	☐ N	☐ O	☐ D	☐ M	☐ Y
Strong odor to urine	☐ N	☐ O	☐ D	☐ M	☐ Y

Skin

Sores	☐ N	☐ O	☐ D	☐ M	☐ Y
Frequent rashes	☐ N	☐ O	☐ D	☐ M	☐ Y
Severe acne	☐ N	☐ O	☐ D	☐ M	☐ Y
Bruises easily	☐ N	☐ O	☐ D	☐ M	☐ Y
Itchy skin	☐ N	☐ O	☐ D	☐ M	☐ Y

Neurological

Seizures/convulsions	☐ N	☐ O	☐ D	☐ M	☐ Y
Speech defects	☐ N	☐ O	☐ D	☐ M	☐ Y
Accident prone	☐ N	☐ O	☐ D	☐ M	☐ Y
Bite nails	☐ N	☐ O	☐ D	☐ M	☐ Y
Sucks thumb	☐ N	☐ O	☐ D	☐ M	☐ Y
Grinds teeth	☐ N	☐ O	☐ D	☐ M	☐ Y
Has tics/twitches	☐ N	☐ O	☐ D	☐ M	☐ Y
Bowel movement in pants	☐ N	☐ O	☐ D	☐ M	☐ Y

Medications (please list current first)

Name	Reason	Prescribed By	Dosage	Start Date	Stop Date

Allergies

Medicine	☐ Yes	☐ No	If yes, describe_____
Food	☐ Yes	☐ No	If yes, describe_____
Other	☐ Yes	☐ No	If yes, describe_____

Hearing

Date of most recent hearing exam_____ Results _____

Ear infections	☐ Yes	☐ No	How many_____
Hearing problems	☐ Yes	☐ No	Describe_____
Ear tube placement	☐ Yes	☐ No	How many times_____

Vision

Date of most recent vision exam_____ Results _____
Vision Problems ☐ Yes ☐ No _____
Wears glasses or contacts ☐ Yes ☐ No _____

Eating Habits

Please rate your child's eating: ☐ Not enough ☐ Adequate ☐ Good ☐Too much
Has your child ever had problems eating objects not meant to be eaten? ☐ Yes ☐ No
If yes, has this problem been resolved? ☐ Yes ☐ No
Does your child have eating difficulty? ☐ Yes ☐ No
If yes, what are your specific concerns?_____
_____

Sleeping Habits

Please rate your child's sleep: ☐ Not enough ☐ Adequate ☐ Good ☐Too much
Has your child any problems sleeping related to: ☐ Night terrors ☐ Sleep apnoea ☐ Sleep walking
If yes, has this problem been resolved? ☐ Yes ☐ No
Does your child have any other sleeping difficulty? ☐ Yes ☐ No
If yes, what are your specific concerns?_____
_____

Medical Care

Child's physician _____ Telephone_____
Address _____

Has this child ever had a neurological exam? ☐ Yes ☐ No
If yes, neurologist's name _____
City _____ Date of exam_____
Reason for exam _____

Has this child ever had a psychological/psychiatric exam? ☐ Yes ☐ No
If yes, doctor's name _____
City _____ Date of exam _____
Reason for exam _____

Has this child ever had psychological counselling or therapy? ☐ Yes ☐ No
If yes, counsellor's name _____ City _____
Type of counselling _____
_____
When/Frequency? _____

Has your child ever experienced any type of abuse or trauma (e.g. physical, emotional, sexual, or neglect?
☐Yes ☐ No If yes, what type(s)? _____When?_____
Please describe: _____
_____

Child's Medical History (check all that apply)

Illness/Condition	Age(s)	Illness/Condition	Age(s)
☐Measles	_____	☐Frequent/severe headaches	_____
☐German Measles	_____	☐Difficulty concentrating	_____
☐Mumps	_____	☐Memory Problems	_____
☐Chicken Pox	_____	☐Extreme tiredness/weakness	_____
☐Whooping Cough	_____	☐Rheumatic fever	_____
☐Diphtheria	_____	☐Epilepsy	_____
☐Scarlet Fever	_____	☐Tuberculosis	_____
☐Meningitis	_____	☐Bone or joint disease	_____
☐Encephalitis	_____	☐Gonorrhoea or syphilis	_____
☐High Fever (over 40^0)	_____	☐Anaemia	_____
☐Convulsions	_____	☐Jaundice/hepatitis	_____
☐Allergy	_____	☐Diabetes	_____
☐Hay Fever	_____	☐Cancer	_____
☐PE Tubes (how many)	_____	☐High Blood Pressure	_____
☐Broken bones	_____	☐Heart Disease	_____
☐Hospitalizations	_____	☐Asthma	_____
☐Operations	_____	☐Bleeding Problems	_____
☐Ear Problems	_____	☐Eczema or hives	_____
☐Visual Problems	_____	☐Suicide Attempt	_____
☐Fainting Spell	_____	☐Pregnancy	_____
☐Loss of Consciousness	_____	☐Paralysis	_____
☐Head Injury	_____	☐Other	_____
☐Dizziness	_____		

If your child had a head injury, please the associated symptoms (e.g., loss of consciousness, nausea or vomiting, concussion)._____

Any Surgeries ☐ Y ☐ N ☐ Unknown If yes, for what? _____

Hospitalizations ☐ Y ☐ N ☐ Unknown If yes, at what age? _____

Reason: _____

Exposure to Toxins (e.g., Lead, pesticides etc) in blood testing ☐Y ☐ N ☐ Unknown Date(s) _____

List any other health problems:

1. _____
2. _____
3. _____

Educational History

Please fill in the following table. Grades can be combined if your child received similar supports within the same school.

Grade(s)	**School Attended**	**Classroom Type** (for example regular, inclusion class, special education class)	**Supports provided** (such as aides, speech therapy, occupational therapy, academic & class supports)

Has your child been seen by a school psychologist? If so, please append/attach reports, Individual Education Plans (IEP), Individual Behaviour Plan (IBP), or other relevant documents.

Has this child changed schools for reasons other than normal academic progression (e.g., bullying) □ Yes □ No
If yes, when and why?_____

Has this child repeated a grade in school or started pre-primary late □ Yes□ No
If yes, when and why? _____

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

What kind of grades has this 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

Are these grades a change from previous years? □ Yes □ No

Place a tick next to the following categories indicating whether you see this area as **a strength** or as an area of concern for this child:

Reading	□ Strength	□ Concern
Reading comprehension	□ Strength	□ Concern
Arithmetic	□ Strength	□ Concern
Spelling	□ Strength	□ Concern
Writing	□ Strength	□ Concern
Oral Language	□ Strength	□ Concern
Relationship with teacher(s)	□ Strength	□ Concern
Other subjects: _____	□ Strength	□ Concern
_____	□ Strength	□ Concern

Describe (if any) the teacher's concerns about the child's schoolwork or behavior: _____
_____

Is this child in special education? □ Yes □ No Beginning when_____

If yes, please tick the educational classification:

□ Speech/Language Disorder
□ Mental Retardation
□ Traumatic Brain Injury
□ Emotional/Behavior Disorder
□ Other Health Impaired (e.g., ADHD)
□ Visually Impaired (legal blindness)
□ Autism/PDD/Asperger's Syndrome
□ Deaf/ Hearing Impaired
□ Learning disabilities, area of disability:_____

What therapies have been provided to this child to assist with learning?

□ No therapies
□Occupational therapy hr(s)/wk(s)_____
□Physical therapy hr(s)/wk(s)_____
□Speech therapy hr(s)/wk(s)_____
□Psychotherapy/counseling hr(s)/wk(s)_____
□Other _____ hr(s)/wk(s)_____

In the past year, how much school has this child missed due to illness or injury?

□ Less than 2 weeks □ 2 to 4 weeks □ 5 to 8 weeks □ More than 8 weeks

Briefly describe the reason this child has missed a lot of school: _____
_____

Social Functioning

What are some of your child's favourite activities?

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have problems with:

Getting along with other children in class?	☐ Yes	☐ No
Making friends in school?	☐ Yes	☐ No
Getting along with teachers?	☐ Yes	☐ No

Does s/he belong to any teams, clubs or participate in group activities? ☐ Yes ☐ No

If yes, which? _____

_____

How many friends does your child have? _____

Approximately how often does your child get together with friends? _____

How does your child get along with

Siblings (if applicable):

_____

_____

Peers:

_____

_____

Parents:

_____

_____

Other adults:

_____

_____

Problem Symptom Checklist

Read each symptom and tick current if this a symptom that is currently present (within the six months). Please tick Old if the symptom was present before the six-month period but is no longer present or problematic. *If this child has not exhibited the symptom; do not check anything*.

Speech and Language	**Current**	**Old**
Difficulty speaking clearly	☐	☐
Difficulty finding the right word to say	☐	☐
Rambles on and on without saying much	☐	☐
Jumps from topic to topic	☐	☐
Odd or unusual language or vocal sounds	☐	☐
Difficulty understanding what others are saying	☐	☐

Motor and Coordination	**Current**	**Old**
Poor fine motor skills (i.e., using a pencil or crayon)	☐	☐
Messy/slow handwriting	☐	☐
Clumsy/Muscle weakness	☐	☐
Muscles spastic or tremor	☐	☐
Odd movements (posturing, peculiar hand movements, etc.)	☐	☐
Drops things more than most children	☐	☐
Has an unusual walk	☐	☐
Balance problems	☐	☐
Difficulty with tying shoes, buttons, buckles, zippers	☐	☐

Sensory	**Current**	**Old**
Problems hearing sounds	☐	☐
Difficulty smelling odours	☐	☐
Difficulty tasting food	☐	☐
Overly sensitive to: ☐Touch ☐Light ☐Noise	☐	☐

Visual Spatial skills	**Current**	**Old**
Confusion telling right from left	☐	☐
Has difficulty with puzzles, Legos, blocks or similar games	☐	☐
Problems drawing or copying	☐	☐
Doesn't know his/her colours	☐	☐
Difficulty recognizing objects	☐	☐
Seems unable to recognize facial or body expressions or emotions	☐	☐

Awareness and Concentration	**Current**	**Old**
Poor attention	☐	☐
Easily distracted by: ☐Sounds ☐Sights ☐Physical sensations	☐	☐
Loses train of thought	☐	☐
Difficulty concentrating on what others say, but can sit in front of TV for long periods	☐	☐
Requires prompts to get started	☐	

Memory	**Current**	**Old**
Forgets where he/she leaves things	☐	☐
Forgets things that happened recently (i.e., last meal)	☐	☐
Forgets what he/she is supposed to be doing	☐	☐
Forgets school assignments	☐	☐
Repetitive/Repeats self	☐	☐

Problem Solving/Organization	**Current**	**Old**
Difficulty figuring out how to do new things……	☐	☐
Difficulty making decisions ……..	☐	☐
Difficulty planning ahead ……..	☐	☐
Disorganized in his/her approach to problems ……..	☐	☐
Difficulty doing things in the right order (sequencing) ……. ……..	☐	☐
Difficulty verbally describing the steps involved in doing something……	☐	☐
Difficulty completing an activity in a reasonable period of time……	☐	☐
Difficulty switching from one activity to another activity……..	☐	☐

Behaviour	**Current**	**Old**
Aggressive……..	☐	☐
Attached to things, not people……	☐	☐
Dependent……	☐	☐
Depressed ……..,……..	☐	☐
Emotional ……	☐	☐
Fearful ……	☐	☐
Immature ……	☐	☐
Nervous ……..	☐	☐
Quiet ……..	☐	☐
Resists change ……	☐	☐
Risk-taking……..	☐	☐
Self-mutilates …….	☐	☐
Repetitive movements (rocking, banging head, finger play, hand flapping, wringing)……	☐	☐
Shy and withdrawn……..	☐	☐
Curses or swears a lot ……	☐	☐
Unmotivated ……..	☐	☐
Has suicidal ideations or has thoughts of hurting one self ……..	☐	☐

Purpose of the Evaluation (please include additional pages if necessary):

What are you hoping to gain from this evaluation?

_____
_____
_____

What specific questions do you have?

_____
_____
_____

Additional Comments?

_____
_____
_____
_____
_____
_____