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CHILD'S NAME_____ DATE:_____
ASSESSMENT COMPLETED BY: _____
RELATION TO CHILD: _____ **PHYSICIAN**:_____
CHILD'S DATE OF BIRTH: _____
DIAGNOSIS:_____ **HOSPITALIZATIONS/SURGERIES:**_____
_____
PREVIOUS PSYCHOLOGICAL TESTING:_____
CURRENT CONCERNS:_____

Birth History
Child was born:____fullterm ____premature How many weeks premature?_____
Delivery:____ vaginal _____with forceps _____C-Section
Were there any complications?_____
Was your child placed in the Newborn Intensive Care Unit?__ If so, how long?___
Please describe any other medical problems or complications at birth_____

Developmental History ***Indicate: Delayed (D) or On Time (OT)****

Rolled over:_____ Babbled:_____
Sat alone:_____ Said first word:_____
Crawled:_____ Drank from cup:_____
Pulled to stand:_____ Used a spoon:_____
Stood alone:_____ Toilet trained:_____
Walked alone:_____ Dressed self:_____

Current physical limitations/Equipment used:_____
Comments:_____

FATIGUE:

1. How much does fatigue interfere with daily or school functioning? **(check one below)**

Fatigue is ***not a problem***	Fatigue ***mildly*** **limits activities**	Fatigue ***moderately*** **limits activities**	Fatigue ***severely*** **limits activities**

2. Please indicate number of naps student takes daily:_____
3. Please indicate typical duration of naps:_____
4. Please indicate typical number of hours of sleep student gets each night:_____
5. Does student takes medication to help sleep? YES NO

6. Does student take medication(s) during the day that may cause drowsiness? YES NO
NAME OF ANY MEDICATION(S):_____
ALLERGIES:_____

COGNITIVE-COMMUNICATIVE ABILITIES:
Please check the appropriate boxes below.

Ability	No Problem	Mild Problem	Moderate Problem	Severe Problem
Concentrating for ***short periods*** of time				
Concentrating for ***extended periods*** of time				
Concentrating ***when there is noise or other distractions***				
Concentrating ***on more than one thing at a time***				
Mental endurance to get through the day at home or school				
Feeling overwhelmed or anxious in large crowds or noisy environments – avoid them or leave early				
Feeling overwhelmed or anxious in large or visually stimulating places (i.e., department store, mall)				
Paying attention to what time it is				
Paying attention to what is happening in surrounding environment				

Ability	No Problem	Mild Problem	Moderate Problem	Severe Problem
Initiating to participate in daily activities or interactions				
Putting tasks in order of priority – anticipating own needs				
Following through with tasks to completion				
Being flexible to change plans if other priorities arise				
Being able to transition between activities				
Generating solutions to				

problems				
Anticipating positive & negative consequences of actions				
Considering needs of self and/or others when making decisions				
Avoiding activities that are unsafe or restricted by parents/caregivers				
Remembering daily schedule				
Remembering play time & interactions				
Remembering day to day events				
Recalling familiar names				
Remembering faces				
Self-organizing items needed for school				
Organizes own clothes				
Tolerates loose clothing				
Tolerates form fitting clothing (i.e. socks)				

Ability	No Problem	Mild Problem	Moderate Problem	Severe Problem
Eager to read				
Comprehending when reading				
Comprehending when reading chapters of a book				
Staying focused while reading a book or magazine				
Remembering what was read				
Understanding speech when someone is talking				
Understanding speech when on the phone				
Understanding conversation in a group of people				
Enunciating speech sounds				
Thinking of words to express self				
Organizing thoughts to express ideas clearly and concisely				
Accessing more complex vocabulary to express self				
Spelling/writing for homework needs				
Writing skills are adequate to				

keep up with class activities				
Writing is legible with good letter formation and pressure through pencil				
Writing is a preferred activity for this student.				

BEHAVIOR AND SOCIAL INTERACTION:

Please check the appropriate boxes below.

BEHAVIORS, FEELINGS, AND INTERACTIONS	No Problem	Mild Problem	Moderate Problem	Severe Problem
Gets frustrated easily				
Yelling at others				
Hitting others				
Hitting walls or objects				
Acting dangerously				
Overreacting to situations				
Crying more than usual – particularly at times when stressed or overwhelmed				
Laughing more than usual or at the wrong time – particularly at times when stressed or overwhelmed				

BEHAVIORS, FEELINGS, AND INTERACTIONS	No Problem	Mild Problem	Moderate Problem	Severe Problem
Withdrawing from others when overwhelmed				
Appropriate use of personal space				
Withdraws from activities that are perceived to be too hard				
Tolerates loud or unexpected noise stimulus				
Initiating to talk to others – to start conversations				
Talking too much – rambles on….				
Jumping from one topic to another while talking – forgetting the original topic at times				
Interrupting others when they are in the middle of speaking				
Forgetting to make eye contact when talking to others or being talked to				
Tolerates light/deep touch				
Tolerates warm/cold temperatures				

Causes harm to self				
Causes harm to others				
Damages property				

ACTIVITIES OF DAILY LIVING:

Please check the appropriate boxes below.

ACTIVITY	No Problem	Mild Problem	Moderate Problem	Severe Problem
Tying shoelaces independently				
Grooming independently				
Dressing upper body				
Dressing lower body				
Paying attention to the ***left*** side of body/space				
Paying attention to the ***right*** side of body/space				
Getting on & off the toilet				
Initiating to use the toilet				
Bladder continence				
Bowel continence				

ACTIVITY	No Problem	Mild Problem	Moderate Problem	Severe Problem
Packs/unpacks backpack or lunch box without help				
Using feeding utensils				
Able to manipulate straw into juice pouch/box				
Limited repertoire of foods (please list on back of sheet)				
Avoids certain textures (please list on back of sheet)				
Prefers to snacking through the day to sit down meals				
Opening food containers				
Pouring self a drink				
Helping with household chores as directed				
Initiate play activities with sibling or peer group				
Walking on even surfaces				
Trips frequently in familiar environments				
Walking on grass, sand, or other uneven surface				
Walking up and down stairs				
Maintaining balance to walk within the home				

Keeps up with peers in physical activities				
Physical endurance to get around the community				
Running/jogging/sports				

ACTIVITY	No Problem	Mild Problem	Moderate Problem	Severe Problem
Frequent runny nose				
Presents with allergies?				
Often chews on non-food items (i.e. pencil tops/shirt collars)				
Responds to verbal discipline				
Responds to time out				
Responds to cause and effect				

FUNCTIONAL ASSESSMENT ACADEMIC SKILLS

ACADEMIC SKILL	No Problem	Mild Problem	Moderate Problem	Severe Problem
Understanding classes				
Understanding teacher instructions for assignments				
Paying attention in class				
Concentrating when reading				
Frequently loses place when reading				
Skips words when reading				
Sounding out words when reading				
Identifying meaning of words when reading				
Remembering content of what is read				
Understanding more abstract language when reading				
Keeping homework and class notes organized				
Remembering ***to complete*** homework assignments				
Remembering ***to turn in*** homework and projects				
Self-initiating to complete homework, projects, or prepare for tests/quizzes				
Learning and retaining what is learned to take tests/quizzes				
Motivation toward school				

Does student have a history of:
Dyslexia? ___ YES ___ NO
Nonverbal Learning Disorder? ___ YES ___ NO
Specified Learning Disorder (SLD)? ___ YES ___ NO
Learning Delay? ___ YES ___ NO
Concussion During Sports? ___ YES ___ NO
Prematurity? ___ YES ___ NO
Has student had a recent eye exam? ____ YES ____ NO Name of Eye Doctor: _____
Has student had a recent hearing exam? ____ YES ____ NO Name of Ear Doctor: _____
Has student participated in any specific therapeutic program/therapies or learning programs (i.e.: OT, PT, ST, tutor, etc.)?

_____
_____
_____
_____

List current classes and grades for each: (optional unless an outstanding concern)

Class:	Grade:	Class:	Grade:
Class:	Grade:	Class:	Grade:
Class:	Grade:	Class:	Grade:

List extracurricular activities (sports, clubs, playtime, etc.)

_____
_____
_____

Thank you so much for taking the time to fill out this questionnaire. This information will help me become more familiar with your child so that I can provide the best service possible to you and your child. If you have any additional comments, please list them below.

Signature:_____ Date:_____