

Center for Health, Learning & Achievement

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Parent Questionnaire

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

Who can we thank for this referral? _____

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

Today’s Date: _____

Reason for Referral

(Check all that apply)

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

Demographics

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

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

List all people living in the household:

Name	Age	Education
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

Relative	Involvement (very, occasionally, never)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Health

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

- | | |
|---|----------------------------------|
| Alzheimer's disease _____ | Anemia _____ |
| Or Dementia _____ | Low or overactive Thyroid _____ |
| Pituitary Gland dysfunction _____ | Down's Syndrome _____ |
| Fragile X Chromosome _____ | Double YY Chromosome _____ |
| Cancer _____ | Tourette's Disorder _____ |
| Cystic Fibrosis _____ | Asperger's Syndrome _____ |
| Diabetes _____ | Neurofibromatosis _____ |
| Hypoglycemia _____ | Alcohol/drug abuse _____ |
| Heart disease _____ | Panic Attacks _____ |
| High blood pressure _____ | Atmospheric Allergies _____ |
| Kidney disease _____ | Emotional disturbance _____ |
| Migraine headaches _____ | Attention Deficit Disorder _____ |
| Multiple sclerosis _____ | Depression _____ |
| Muscular dystrophy _____ | Speech or language problem _____ |
| Parkinson's disease _____ | Food allergies _____ |
| Pervasive Development Disorder _____ | Nervousness/ Anxiety _____ |
| Stroke _____ | Seizures or epilepsy _____ |
| Mental Illness (e.g. Bipolar Disorder, Manic Depression, Mania, Schizophrenia, Obsessive Compulsive Disorder) _____ | |

Other: Describe _____

Learning Problems-

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

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

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

Personality and Temperament

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

How would you describe your child’s personality? _____

How does the child show the following feelings:

Love _____

Anger _____

Sadness _____

Happiness _____

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

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

Parental Family System

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

MOTHER:

How were you usually punished as a child? _____

What types of behavior caused punishments? _____

Describe your relationship with your mother _____

Describe your relationship with your father _____

How did you usually express your anger toward your parents _____

FATHER:

How were you usually punished as a child? _____

What types of behavior caused punishments? _____

Describe your relationship with your mother _____

Describe your relationship with your father _____

How did you usually express your anger toward your parents _____

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

_____ Fun	_____ Honesty	_____ Independence
_____ Religion	_____ Ambition	_____ Education
_____ Initiative	_____ Security	_____ Health
_____ Personal Appearance	_____ Generosity	_____ Morality
_____ Manners	_____ Kindness	_____ Listening to others
_____ Warmth& Affection	_____ Politeness	_____ Pride
_____ Quietness	_____ Aggressiveness	_____ Work
_____ Thrift	_____ Assertiveness	_____ Social obligations
_____ Cleanliness	_____ Obedience	_____ Survival
_____ Power & position	_____ Privacy	_____ Other, Specify
_____ Keep Family Secrets		_____
_____ Don't Discuss Them Either		

Preconception

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

How would you describe the child's mother's living situation before pregnancy?

_____ Good _____ Fair _____ Poor

How was the mother getting along with her spouse/partner prior to pregnancy?

_____ Good _____ Fair _____ Poor _____ Not Applicable (no spouse/partner)

Did the mother have any illness/disease(s) or exposure to radiation prior to pregnancy?

_____ No _____ Yes Explain _____

Pregnancy

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty with conception | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> German measles |
| <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Vaginal bleeding |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other (Rh incompatibility, Herpes, Diabetes, etc.) _____ | | |

Hospitalization during pregnancy: Reason _____

X-Ray during pregnancy: What month _____

Alcohol used during pregnancy: Frequency _____

Cigarettes used during pregnancy: Frequency _____

Other drugs used during pregnancy:

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

Was the child very active in utero? Yes No

Birth

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

Was this child born in a hospital? Yes No

Was the baby:

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

Length of labor: _____ Hours

Birth weight _____ lbs. _____ oz.

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

Child's condition at birth _____

Mother's condition at birth _____

Check any of the following complications that occurred during birth

Breech birth Labor induced Vacuum Cesarean delivery

Forceps – Position of forceps _____

Other complications during delivery: Describe _____

Neonatal care: Explain _____

Incubator: How long? _____

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

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

Child had illnesses and/or Diseases; Describe _____

Anesthesia used during delivery? Yes No What kind? _____

Length of stay in the hospital: Mother: _____ days Child: _____ days

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

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

<input type="checkbox"/> Happy	<input type="checkbox"/> Excited	<input type="checkbox"/> Fulfilled
<input type="checkbox"/> Unhappy	<input type="checkbox"/> Life disrupted	<input type="checkbox"/> Unprepared
<input type="checkbox"/> Nervous	<input type="checkbox"/> Financially burdened	<input type="checkbox"/> Other, specify _____

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

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

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

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

<input type="checkbox"/> Fun	<input type="checkbox"/> Quiet	<input type="checkbox"/> Sickly
<input type="checkbox"/> Fussy	<input type="checkbox"/> Irritating	<input type="checkbox"/> Overactive

Early Development

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

_____ Sit alone	_____ Walk Alone
_____ Crawl	_____ Speak first words
_____ Stand alone	_____ Speak in sentences
_____ Show first attraction to sound	

When did the child cut his/her first tooth? _____

When did the child have a full set of baby teeth? _____

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

Did bed-wetting occur after toilet training? Yes No If yes, until what age? _____

Did bed-soiling occur after toilet training? Yes No If yes, until what age? _____

-Is either difficulty known to have occurred in either biological parent or other relative? Yes No
If yes, who?

Were there any medical reasons for the bed wetting or soiling Yes No If yes, please describe

Does the child sleep very deeply? Yes No

Does the child have night terrors? Yes No

Is he/she a sleepwalker? Yes No

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

Chronic ear infections No Yes _____

Age of onset _____ Frequency _____

Antibiotic Type(s) _____ Dosage _____

Tubes ? Yes No Still Occurring? Yes No

Walking difficulty No Yes _____

Too Sensitive to Touch No Yes _____

Too Sensitive to Sound No Yes _____

Unclear speech No Yes _____

Eating problems No Yes _____

Underweight problem No Yes _____

Overweight problem No Yes _____

Colic No Yes _____

Sleep problems No Yes _____

Difficulty learning to throw or catch No Yes _____

Difficulty learning to kick or hit No Yes _____

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

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

Has either parent continued to be concerned about the child's development?

(M &F to indicate mother and/or father)

No Yes Explain _____

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

For Eating _____ For Throwing, Catching, etc _____

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

Did/Does the child seem to be confused with right/left? No Yes

Or is he/she comfortable with both and perhaps ambidextrous? No Yes

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

Did/Does the child hold a pencil correctly? No Yes

Has he as yet gotten special assistance in holding a pencil? No Yes

During his/her Preschool/Kindergarten years:

How well did the child cut?

Poor Fair Good Excellent

How well did the child glue?

Poor Fair Good Excellent

How well did the child color in the lines?

Poor Fair Good Excellent

Medical History

Has the child had any of the following:

Serious accidents ___ No ___ Yes At what age? ___ Specify: _____

Serious illnesses ___ No ___ Yes At what age? ___ Specify: _____

Childhood Illnesses/Injuries

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

- | | |
|---|---|
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Encephalitis _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Whooping Cough _____ | <input type="checkbox"/> Fever 104 or above _____ |
| <input type="checkbox"/> Scarlet Fever _____ | |
| <input type="checkbox"/> Head injury: Describe-occurrence and location on skull _____ | |
| <input type="checkbox"/> Coma or loss of consciousness: Describe _____ | |

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

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

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

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

- | | |
|--|---|
| <input type="checkbox"/> Pep pills or uppers | <input type="checkbox"/> Tranquilizers or sedatives |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> LSD or other hallucinogens |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Narcotics |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> None | |

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

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

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

Frequent colds	No	Yes	_____
Chronic cough	No	Yes	_____
Asthma	No	Yes	_____
Hay fever	No	Yes	_____
Sinus condition	No	Yes	_____
Shortness of breath or dizziness			
With physical exertion	No	Yes	_____
Activity limitation due to:			
Heart condition	No	Yes	_____
Heart murmur	No	Yes	_____
Excessive vomiting	No	Yes	_____
Frequent diarrhea	No	Yes	_____
Constipation	No	Yes	_____
Stomach pain	No	Yes	_____
Nervous stomach	No	Yes	_____
Bingeing and purging	No	Yes	_____
Anorexia	No	Yes	_____
Urination in pants/bed	No	Yes	_____
Pain while urinating	No	Yes	_____
Excessive urination	No	Yes	_____
Muscle pain	No	Yes	_____
	When?	Where?	_____
Clumsy walk	No	Yes	_____
Poor posture	No	Yes	_____
Other muscle problems	No	Yes	_____
Frequent rashes	No	Yes	_____
Bruises easily	No	Yes	_____
Sores	No	Yes	_____
Severe acne	No	Yes	_____
Itchy skin (eczema)	No	Yes	_____
Brain Damage from known trauma	No	Yes	If yes, describe _____
Suspected Brain Trauma	No	Yes	_____
Speech defects	No	Yes	_____
Accident prone	No	Yes	_____
Bites nails	No	Yes	_____
Sucks thumb	No	Yes	_____
Grinds teeth	No	Yes	_____
Has tics/twitches	No	Yes	_____
Bangs head	No	Yes	_____
Rocks back and forth	No	Yes	_____
Autism	No	Yes	
If yes, when was this child diagnosed?			_____

Compulsive behaviors No Yes, describe _____

Pervasive Development Disorder No Yes _____

Nonverbal Learning Disorder No Yes _____

Sensory Integration Dysfunction No Yes _____

Other Neurological Condition No Yes _____

Allergy to medicine No Yes If yes, describe _____

Allergy to food No Yes If yes, describe _____

Other allergies No Yes If yes, describe _____

Ear infections No Yes _____

Hearing problems No Yes _____

Ear tubes No Yes _____

Date of most recent hearing exam _____

Vision problems No Yes _____

Wears glasses/contacts No Yes _____

Date of most recent eye exam _____

Medical Care

Child's physician _____ Telephone _____

Address _____

How often does this child see a doctor? _____ Date of last visit _____

Is this child currently on medication? No Yes

If yes, indicate type and reason

Educational History*List schools your child has attended***Preschool/Day Care** _____

City(s) _____

Ages attended _____

Grade School Name(s) _____

City(s) _____

Grade Level(s) _____

Middle School Name(s) _____

City(s) _____

Grade Level(s) _____

High School Name(s) _____

City(s) _____

Grade Level(s) _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dislikes going to school. No Yes

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

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

Friendships*Please indicate how this child relates to other children*

Has problems relating to or playing with other children? No Yes

If yes, describe _____

Fights frequently with playmates? No Yes _____

Prefers playing with younger children? No Yes _____

Has difficulty making friends? No Yes _____

Prefers to play alone? No Yes _____

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

What role does this child take in peer group games, (i.e., leader, aggressor, follower, etc.)?
_____Does your family have pets? No Yes
If yes, how does the child get along with them? _____**Recreation/Interests**

What activities does this child enjoy?

Sports: _____

Hobbies: _____

Other: _____

Has this child's interest in participating in these activities declined recently? No Yes

If yes, describe _____
_____**Behavior Related to Reason For Referral**

Are you worried that the child may hurt herself/himself or others? No Yes

If yes, explain. _____

Have there been any changes in the child's:

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

Explain _____

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

If yes, psychiatrist or psychologist's name _____

Address _____

Telephone _____

Type of counseling _____

When? _____

Has this child ever had a neurological exam? No Yes

If yes, Neurologist's name _____

Address _____

Telephone _____

Date of exam _____

Reason for exam _____

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

No Yes

Parent or guardian signature _____

Date _____

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

No Yes

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

School Psychologist _____

Guidance Counselor _____

Teacher _____

Principal _____

Other _____

List of Children's Behaviors

Child's Name _____

Informant _____

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

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

Group A

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

Group B

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

Group C

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

Group D

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

Group E

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

Group F

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

Group G

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

Social/Pragmatic Checklist

Please check the appropriate response for each item

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

Social/Pragmatic Checklist(cont.)*Please check the appropriate response for each item*

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

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

BEHAVIOR SYMPTOMS OF LEARNING DIFFICULTIES FOR STUDENTS

- ____ 1. Unhappiness with school
- ____ 2. Complains about teacher(s)
- ____ 3. Easily frustrated
- ____ 4. Anxious; or ____4a panics under pressure
- ____ 5. Reluctance to read
- ____ 6. Reluctance to sit and be read to
- ____ 7. Reluctance to study or ____7a do other sedentary tasks, e.g. _____
- ____ 8. Poor study skills
- ____ 9. Slow reading; or ____ poor reading
- ____ 10. Difficulty with sounding out words
- ____ 11. Is primarily a “sight reader”
- ____ 12. Adds words, leaves out words, or substitutes words
- ____ 13. Poor spelling; or ____13a does okay on spelling test but forgets words later
- ____ 14. Poor vocabulary
- ____ 15. Difficulty understanding what is read
- ____ 16. Difficulty remembering what was read
- ____ 17. Difficulty understanding what is heard
- ____ 18. Difficulty remembering what was heard
- ____ 19. Difficulty expressing thoughts ____19a verbally or ____19b in written form
- ____ 20. Learning a foreign language very difficult even after hard study
- ____ 21. Thinks concretely or literally; ____21a Can’t “read between the lines”
- ____ 22. Has difficulty foreseeing consequences
- ____ 23. Trouble telling time or difficulty with minutes, hours, months, etc.
- ____ 24. Difficulty understanding or telling jokes
- ____ 25. Words appear to move, jiggle or dance
- ____ 26. Skips line(s) when reading
- ____ 27. Sees flashes of light or blotches when viewing page or screen
- ____ 28. Words are blurry even though vision is okay or has corrective lenses
- ____ 29. Doesn’t see spaces or enough space between letters and/or words
- ____ 30. Poor memory for what words say (can’t recall what whole word says – not a “sight” reader)
Or, seems to forget “the,” “and,” “when,” “went,” “there,” etc.
- ____ 31. Attempts to use phonetic spelling all of the time
- ____ 32. Cannot write letters of the alphabet or cannot do so without great difficulty
- ____ 33. Can’t keep columns straight in math
- ____ 34. Dislikes or hates math
- ____ 35. Trouble with times tables and basic math facts
- ____ 36. Can’t understand new math concepts
- ____ 37. Can’t remember combinations
- ____ 38. Distractible ____38a Hard to focus attention
- ____ 39. Difficulty in following directions
- ____ 40. Difficulty in getting work done; ____40a Difficulty following through
- ____ 41. When does homework, forgets to turn it in
- ____ 42. Disorganized and/or problems with sequencing and planning
- ____ 43. Inaccurate copying
- ____ 44. Sloppy or illegible writing
- ____ 45. One or more biological family members have problems in (circle appropriate one(s)): reading, spelling, writing, enjoying reading, passing a grade or class
- ____ 46. Has been held back or not passed a grade.
- ____ 47. Had speech and/or language therapy
- ____ 48. Is in or thought to need remedial reading (tutoring or class)
- ____ 49. Is in or thought to need a learning disability (L.D.) class

Attention-Activity Questionnaire

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

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

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

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

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

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

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

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

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

²Ibid.

SENSORY HISTORY**VESTIBULAR SENSATION**

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

MODULATION

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

COORDINATION

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

PROPRIOCEPTION*Does your child:*

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

TACTILE SENSATION

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

MOTOR SKILLS/PLANNING and BODY**AWARENESS**

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

MUSCLE TONE

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

AUDITORY SENSATION

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

VISUAL SENSATION

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

OLFACTORY/GUSTATORY SENSATION

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

VISUAL SYMPTOM CHECKLIST- School-Aged

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

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

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

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

SPEECH & LANGUAGE SCREENING CHECKLIST

AUDITORY DEVELOPMENT CHECKLIST

Does your child have a history of hearing loss? If so, please describe:

Has your child had his/her hearing tested? If yes, when? Please describe the results:

Have you or others ever thought your child was deaf? _____

Has the child had any training with sound stimulation, or auditory processing training in the past? If so, what, when, and where? _____

Please mark those that are a concern to you:

The child:

- Does not listen carefully to directions – often necessary to repeat instructions
- Says “huh?” or “what?” at least five or more times per day
- Cannot attend to auditory stimuli for more than a few seconds
- Has difficulty with phonics
- Experiences problems with sound discrimination
- Has difficulty recalling a sequence that has been heard
- Experiences difficulty following auditory directions
- Frequently misunderstands what is said
- Does not comprehend many words – verbal concepts for age/grade level
- Learns poorly through the auditory channel
- Has a language problem (morphology, syntax, vocabulary, phonology)
- Cannot always relate what is heard to what is seen
- Displays slow or delayed response to verbal stimuli
- Demonstrates below average performance in one or more academic area(s)

Does your child:

- | | |
|----------------|---|
| Yes ___ No ___ | Hear things before you hear them? |
| Yes ___ No ___ | Seem overly sensitive to sound? |
| Yes ___ No ___ | Become frightened by certain sounds, such as certain machinery, toys, voices, or other things? If so, what? _____ |
| Yes ___ No ___ | Miss some sounds? |
| Yes ___ No ___ | Seem confused about the direction of sounds? |
| Yes ___ No ___ | Like to make loud noises or talk loud? |
| Yes ___ No ___ | Complain of ringing in the ear, dizziness, or nausea? |
| Yes ___ No ___ | Need to have instructions repeated frequently? |
| Yes ___ No ___ | Often fail to pay attention when being spoken to? |
| Yes ___ No ___ | Have others who work with the child commented on his/her listening skills? |
| Yes ___ No ___ | Respond inconsistently to sound? |
| Yes ___ No ___ | Appear to be overly careful to watch the speaker's face? |
| Yes ___ No ___ | Turn the head so that one ear is closer to the speaker? Which ear? ___ |

SPEECH AND LANGUAGE DEVELOPMENT CHECKLIST

Has the child ever been evaluated by a speech-language pathologist before? If so, when, and what were the results?

Did your child have problems sucking at birth? _____ By day three? _____

Did/Does your child use a pacifier? _____ If so, for how long? _____

Did/Does your child suck his/her thumb or fingers? ____ If so, for how long? _____

Excluding crying, was the child a quiet, average, or very vocal infant? _____

Were there normal baby sounds in the first year, such as cooing, gurgling, babbling, pitch inflection, and attempts to imitate sounds of parents? Yes ___ No ___

When were the first words, other than "Mommy" and "Daddy" spoken? _____

What were they? _____

Were words added regularly thereafter? Yes ___ No ___

Explain: _____

Were the words easy or difficult to understand? _____

Did struggle behaviors accompany speech efforts? _____

At what age was the child thought to have an articulation or language disorder? _____

Is the child aware of a speech or language difference? If so, how is it shown?

What percentage of the time is the child understood by the family? _____ friends? _____

Does the client currently use an Alternative/Augmentative Communication device? _____

What kind? _____

What sounds can your child currently produce successfully? _____

What is the average number of words your child has in his/her vocabulary? _____

SPEECH & LANGUAGE SCREENING CHECKLIST

Does your child demonstrate difficulty with any of the following:

1. Trouble making specific speech sounds (i.e.: "s", "l", "r")?
If yes, which sounds in particular?
2. Drool or hold an open-mouth resting posture?
3. Demonstrate a tongue-thrust motor pattern when speaking or swallowing? (i.e.: tongue is placed between the teeth when it is not supposed to be)
4. Stutter or have a strange rhythm in his/her voice?
5. Abnormal voice quality (i.e.: hoarse, breathy)?
If yes please explain:
6. Understanding or expressing vocabulary and/or basic language concepts? (i.e.: adjectives, verbs, prepositions)
7. Following or explaining a sequence of 2-3 step directions?
8. Thinking of words to express him/herself?
9. Trouble with phonology (understanding what letters say certain sounds, rhyming, etc.)
10. Trouble with sentence construction and/or comprehension?
11. Trouble explaining past events or sequences?
12. Delete, add, or use inappropriate grammatical structures?
13. Repeating back sentences and phrases verbatim?
14. Constructing correct and meaningful sentences to express him/herself?
15. Understand and/or use figurative language (i.e.: "it's raining cats & dogs")?
16. Initiating or participating in conversations?

PEDIATRIC SLEEP QUESTIONNAIRE

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

Where does your child usually sleep? _____

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

How long does it take them to fall asleep? _____

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

How many hours does your child sleep? _____

Does your child wake up frequently at night?

If so, how often and how long does it take them to go back to sleep?

Metabolic Assessment Form Key

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

Category I: Colon				Category V: Biliary Insufficiency/Stasis					
Feeling that bowels do not empty completely	0	1	2	3	Greasy or high fat foods cause distress	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Lower bowel gas and or bloating several hours after eating	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Diarrhea	0	1	2	3	Unexplained itchy skin	0	1	2	3
Constipation	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Hard dry or small stool	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Do you use laxatives frequently	0	1	2	3	Have you had your gallbladder removed	Yes	No		
Category II: Hypochlorhydria				Category VI: Hypoglycemia					
Excessive belching burping or bloating	0	1	2	3	Crave sweets during the day	0	1	2	3
Gas immediately following a meal	0	1	2	3	Irritable if meals are missed	0	1	2	3
Offensive breath	0	1	2	3	Depend on coffee to keep yourself going or started	0	1	2	3
Difficult bowel movements	0	1	2	3	Get lightheaded if meals are missed	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Eating relieves fatigue	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3	Feel shaky, jittery, tremors	0	1	2	3
Category III: Hyperacidity (Ulcer)				Category VII: Insulin Resistance					
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Do you frequently use antacids	0	1	2	3	Crave sweets during the day	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Must have sweets after meals	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Frequent urination	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3	Increased thirst & appetite	0	1	2	3
Category IV: Small Intestine (Pancreas)				Category VIII: Adrenal Hypofunction					
Roughage and fiber cause constipation	0	1	2	3	Cannot stay asleep	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3	Crave salt	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3	Slow starter in the morning	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon fatigue	0	1	2	3
Nausea and/or vomiting	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon headaches	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Frequent urination	0	1	2	3	Weak nails	0	1	2	3
Increased thirst and appetite	0	1	2	3					
Difficulty losing weight	0	1	2	3					

Metabolic Assessment Form Key (cont.)**Category IX: Adrenal Hyperfunction**

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

Category X: Hypothyroid

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

Category XI: Thyroid Hyperfunction

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

Category XII: Pituitary Hypofunction

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

Category XIII: Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male Only): Prostate

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

Category XV (Males Only): Andropause

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

Category XVI (Menstruating Females Only)

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

Category XVII (Menopausal Females Only)

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

Metabolic Assessment Form Key (cont.)

PART II: Foods

How many alcohol beverages they consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week?

_____, _____, _____

List the three healthiest foods you eat during the average week?

_____, _____, _____

Do you smoke?_____ If yes, how many times a day _____ , a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

—

—

—

—

—

Please list any natural supplements you currently take and for what conditions:

—

—

—

—

Center for Health, Learning and Achievement

Cancellation Policy

Effective September 1st 2009, the full fee for speech and language therapy, occupational therapy, behavior therapy, counseling, neurofeedback, and consultation services will be charged for missed appointments. A \$100 cancellation fee will be charged for individuals who do not show for a testing/evaluation appointment. When an initial appointment is booked, the office manager will take credit card information and a deposit will be charged to hold the first appointment. If the appointment is not cancelled 24 hours prior to the scheduled appointment time, the credit card will be charged the above cancellation fee. If the appointment is kept, that fee will be credited toward the cost of the service. This credit card number will be held on file and will be charged if the client does not show for any follow up appointments.

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

Client Signature

Date

Printed Name

Payment Authorization Form

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

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

_____ MasterCard _____ Visa _____ Credit _____ Debit

Account # _____ Exp. Date _____

Card Holder Name _____

Card Holder Address _____

Card Hold Signature _____ Date _____

Additional Comments/Concerns