

## Center for Health, Learning & Achievement

1561 S. Alafaya Trail Suite 200  
 Orlando, FL 32828  
 (407) 382 – 5551  
 Fax- (407) 382 – 5637

7605 Conroy Windermere Rd  
 Orlando, FL 32835  
 (407) 298-8995  
 Fax- (407) 293-2109

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





**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.

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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

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**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 \_\_\_\_\_

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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. \_\_\_\_\_

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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? \_\_\_\_\_

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

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**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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Personality            | <input type="checkbox"/> Habits             | <input type="checkbox"/> Attention     |
| <input type="checkbox"/> Mood                   | <input type="checkbox"/> Level of tenseness | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Attitude toward others | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Memory        |
| <input type="checkbox"/> Dress                  | <input type="checkbox"/> Activity           | <input type="checkbox"/> 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*

<b>Item</b>	<b>Consistently</b>	<b>Inconsistently</b>	<b>Never</b>	<b>N/A</b>
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*

<b>Item</b>	<b>Consistently</b>	<b>Inconsistently</b>	<b>Never</b>	<b>N/A</b>
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:

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**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.<sup>1</sup>
  
- 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).<sup>2</sup>

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):

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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?

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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

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<sup>1</sup>Diagnostic and Statistical Manual of Mental Disorders: DSM-IV, 4<sup>th</sup> edition, American Psychiatric Association, Washington, DC, 1994.  
<sup>2</sup>Ibid.

**SENSORY HISTORY****VESTIBULAR SENSATION**

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

**MODULATION**

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

**COORDINATION**

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

**PROPRIOCEPTION***Does your child:*

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

**TACTILE SENSATION**

- Was your child irritable in infancy, particularly when held?
- Dislikes being cuddled?
- Prefers to touch rather than be touched?
- Dislikes grooming tasks? (*please indicate*)
  - hair washing / combing / brushing
  - face washing / bathing
  - tooth brushing
  - nail trimming
  - hair cutting
- Is irritated by or prefers certain textures of clothing?
- Reacts negatively to the feel of new clothes?
- Prefers tight, well-fitting clothing?
- Prefers loose clothing?
- Prefers multiple layers of clothing?
- Strips off clothing?
- Wraps self in clothing or bedding?
- Frequently adjusts clothing as if it binds or is uncomfortable?
- Prefers to play by themselves (*please indicate*)
  - rather than with another child
  - rather than in groups
- Bumps / pushes other children if standing in line?
- Indicates distress when barefoot?
- Insists on being barefoot?
- Insists on large personal space?
- Prefers to be in 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:

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

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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? \_\_\_\_\_

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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?

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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?

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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

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3

### Category II: Hypochlorhydria

Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

### Category III: Hyperacidity (Ulcer)

Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

### Category IV: Small Intestine (Pancreas)

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

### Category V: Biliary Insufficiency/Status

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		

### Category VI: Hypoglycemia

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

### Category VII: Insulin Resistance

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

### Category VIII: Adrenal Hypofunction

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

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

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

**Category X: Hypothyroid**

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

**Category XI: Thyroid Hyperfunction**

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

**Category XII: Pituitary Hypofunction**

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

**Category XIII: Pituitary Hyperfunction**

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

**Category XIV (Male Only): Prostate**

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

**Category XV (Males Only): Andropause**

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

**Category XVI (Menstruating Females Only)**

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

**Category XVII (Menopausal Females Only)**

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

**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:**

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

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## Center for Health, Learning and Achievement Cancellation Policy

Effective September 1<sup>st</sup> 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**

**CENTER FOR HEALTH, LEARNING & ACHIEVEMENT**  
 1561 S. Alafaya Trail Suite 200  
 Orlando FL 32828  
 (407) 382-5551 Fax (407) 382-5637

**Patient**

Name (Last, First)	Age	Birth Date	Sex
Mailing Address	City	State	Zip Code
Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis	Marital Status

**Responsible Party (Insurance only skip section if Medicaid or Medwaiver)**

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
Employer	Home Phone	Cell Phone		

**Referring Provider**

Name (Last, First)	Phone	Fax
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**Primary Insurance Information**

Primary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code
Phone Number	Co-Insurance %	Co-Pay	Group Number
			Deductible

**Secondary Insurance Information**

Secondary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code
Phone Number	Co-Insurance %	Co-Pay	Group Number
			Deductible

**Patient Release**

I verify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payments of medical claims. I also authorize payment of the medical benefits to the provider. I agree that I am responsible for all deductibles, co pays, and non-covered services.

Signature of insured or authorized person	Date
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