

## Welcome to the Autism Spectrum Center at Boston Children's Hospital

Thank you for your interest in the Autism Spectrum Center (ASC). We provide:

- Comprehensive, family-centered diagnostic and care services for children with autism spectrum disorder
- Initial appointment may be with **one** of the following providers:
  - Developmental Pediatrician
  - Neurologist
  - Nurse Practitioner
  - Psychologist
- Resource Specialists: dedicated staff who provide outreach and education

The below steps will need to be completed prior to adding your child to the waitlist:

1. **Complete and return all** attached forms to our office by mail, email or fax. **Please do not send your original forms. We encourage you to make copies of all information for your records.**

Mail: Boston Children's Hospital  
Autism Spectrum Center BCH3433  
Attn.: Intake Coordinators  
300 Longwood Avenue  
Boston, MA 02115

Email: [AutismCenter@childrens.harvard.edu](mailto:AutismCenter@childrens.harvard.edu)

Fax: 617-730-4823

2. Please include copies of any recent documents from early intervention, school or outside providers such as:
  - **IFSP** (Individualized Family Service Plan-report from early intervention services)
  - **IEP** (Individualized Education Program)/**504 Accommodation Plan**
  - School district based **CORE/TEAM evaluations** (educational testing, psychological testing, OT, PT, and/or speech and language evaluations).
  - Any **private or clinic-based testing** (psychological testing, neuropsychological evaluation, OT, PT and/or speech and language evaluations).
3. Once all of this information has been received, **we will call to confirm and provide an estimate of your current wait time** for your initial visit.

The Autism Spectrum Center does not provide evaluations for child abuse and neglect, custody determination, immediate suicidality, IQ testing for gifted placement, or assessment for acute psychiatric conditions. If you need any of the above services, please let us know and we can direct you to an appropriate provider.

If you need further information or have any additional questions, please feel free to contact the Center by phone at 617-355-7493 or by email at [AutismCenter@childrens.harvard.edu](mailto:AutismCenter@childrens.harvard.edu). You can also visit our website: [www.bostonchildrens.org/autismspectrumcenter](http://www.bostonchildrens.org/autismspectrumcenter)

# Family Education Sheet

## Preparing for a Medical Appointment or Autism Spectrum Disorder (ASD) Evaluation



Boston Children's Hospital  
Autism Spectrum Center

[childrenshospital.org/  
autismspectrumcenter](http://childrenshospital.org/autismspectrumcenter)

Whether you are coming to Boston Children's Hospital for an outpatient appointment, evaluation, a surgical procedure or an emergency visit, there are steps you can take to create a more positive experience for your child.

### What should I bring?

#### Communication systems and devices

- **Bring your child's communication system or device** (for example: Dynavox, picture communication board, or iPad/tablet) to the appointment.
  - Even if your child can speak, the stress of a hospital visit can make it hard to communicate. Having these systems with you helps to make sure that your child can communicate with their medical team.

#### Distraction tools

Distraction items can help your child cope with a medical appointment.

- **Bring a favorite toy, sensory item, book or electronic device** (iPad or tablet)
- **Bring a set of headphones.** Headphones may be good for your child to wear if you are going to talk about sensitive issues with the health care provider.

#### Rewards or reinforcers

- **Bring items that you often use as rewards for your child in your home.** For example, if your child struggles with blood draws, it can be helpful to say "First blood draw, then a sticker."

#### Comfort items

If your child has favorite stuffed animal, blanket, or object, you can bring it. It may help to make the visit or stay more comfortable.

### How can I prepare my child?

#### My Hospital Stories

- These are visual tools that give your child a sense of what may happen, what the hospital area may look like and what to expect.

- You can find My Hospital Stories here: <http://www.childrenshospital.org/patient-resources/family-resources/child-life-specialists/preparing-your-child-and-family-for-a-visit/my-hospital-story>.

#### Medication

Please give your child their medication as you normally would unless you are told otherwise by your provider's team.

#### Behavior support plan

- If your child often has a hard time with medical visits, you can **work with our team to develop a behavior support plan.** Call the Autism Spectrum Center at 617-355-7493 for help creating this plan.
- This plan will alert staff to your child's unique needs and preferences, including help with getting to a clinic, limiting the number of people in the room or providing distraction tools.

#### Child Life specialists

- Child Life Specialists use developmentally appropriate strategies and play to help support your child through medical procedures. The Autism Spectrum Center's Child Life Specialist can work with you to plan ahead for your visits, prepare for appointments and provide support on the day of the appointment.
- For more information, contact the Autism Spectrum Center's Child Life Specialist at 617-919-6390 or by e-mail at [kristin.coffey@childrens.harvard.edu](mailto:kristin.coffey@childrens.harvard.edu).

### How can I prepare?

- Write down your questions and concerns **before** the visit to share with your child's provider.
- Give yourself more time than you think you need to get to the appointment.
- Ask for help if your child is having a difficult time—many departments or areas are able to offer accommodations.
- If possible, bring someone with you for support

*This Family Education Sheet is available in [Spanish](#).*

**Insurance Information**

Please fill out the below form with accurate information regarding your child’s insurance plan(s). This information can be found on the insurance card, or by contacting your insurance company’s member service number.

Most insurance companies require prior authorization for neuropsychological or psychological testing and/or mental health visits. Prior authorization is not a guarantee of payment coverage. Many insurers contract with a specific “carve-out” company to administer behavioral/mental health benefits and claims. If your insurer has such a “carve-out,” the process for coverage determination and prior approval may be different from those processes used for your medical insurance benefits.

**Please call your insurance company to inquire about coverage/benefits under your plan and your required out-of-pocket payments.** Coverage policies for individual carriers differ greatly and change frequently.

**Parent Name:** \_\_\_\_\_

**Primary Insurance Carrier:** \_\_\_\_\_

Group name & number (if applicable): \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Child’s identification number: \_\_\_\_\_

Effective from \_\_\_\_\_ to \_\_\_\_\_ (mm/dd/yyyy)

Subscriber’s name & date of birth: \_\_\_\_\_

Subscriber’s address (if different than child’s address): \_\_\_\_\_

**\*Important\*** Member service phone number for mental health benefits (usually located on back of insurance card): \_\_\_\_\_

**Secondary Insurance Carrier** (if applicable): \_\_\_\_\_

Group name & number (if applicable): \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Child’s identification number: \_\_\_\_\_

Effective from \_\_\_\_\_ to \_\_\_\_\_ (mm/dd/yyyy)

Subscriber’s name & date of birth: \_\_\_\_\_

Subscriber’s address (if different than child’s address): \_\_\_\_\_

**\*Important\*** Member service phone number for mental health benefits (usually located on back of insurance card): \_\_\_\_\_

Your signature below indicates that you have been advised that you may be responsible for paying all charges associated with the visit.

I acknowledge that is any of the above referenced items or services is not considered medically necessary by my insurance company or is a non-covered service, I am financially responsible for the full amount should the claim be denied. If I am denied insurance coverage for any service, discounts may be available.

**Guarantor Name:** \_\_\_\_\_

**Parent/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**A. GENERAL INFORMATION**

Child's Name:     \*Last \_\_\_\_\_     \*First \_\_\_\_\_  
 \*Date of Birth: \_\_\_\_\_     \*Gender:  M    F    Other  
 Current Grade & School Name (if applicable): \_\_\_\_\_  
 \*Person completing questionnaire: \_\_\_\_\_

**URGENT CONCERNS**

Please **CHECK** any applicable boxes if you have any of the following urgent concerns.

**MEDICAL:**

- Seizures
- Loss of skills/developmental regression
- Loss of hearing
- Loss of vision
- Difficulty swallowing or choking
- Severe weakness or lack of coordination
- Inability to tolerate exercise
- Severe headache
- Other (please describe): \_\_\_\_\_

**BEHAVIORAL / PSYCHIATRIC**

- Suicidal thinking or attempt of child
  - Safety of any family members (including this child)
- Please explain: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\*\*\* Please understand that the Autism Spectrum Center has a waiting list. Because some problems need more urgent attention, if your child has any of the above problems, please also contact your pediatrician while you are waiting for your appointment.

Please list the question(s) you would like answered by this evaluation (\*at least one **REQUIRED**)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Who referred your child to the Autism Spectrum Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (i.e. pediatrician, nurse practitioner):	
Date of last physical exam:	
Has your child been seen in the Autism Spectrum Center before?	<input type="checkbox"/> Y <input type="checkbox"/> N     If yes, when?
	Was this for: <input type="checkbox"/> a team visit <input type="checkbox"/> an appointment with a single provider

*What languages are spoken in the home?	
*Where does the child live?	<input type="checkbox"/> at home <input type="checkbox"/> away from home at residential facility or school
*Does your child require an interpreter to do the testing?	<input type="checkbox"/> Y <input type="checkbox"/> N
*Does the parent/guardian require an interpreter for the visit?	<input type="checkbox"/> Y <input type="checkbox"/> N

**\*Do any of the following apply to this child?**

DCF (formerly DSS) involvement	<input type="checkbox"/> Y <input type="checkbox"/> N
DDS (formerly DMR) involvement	<input type="checkbox"/> Y <input type="checkbox"/> N
Lives in residential facility	<input type="checkbox"/> Y <input type="checkbox"/> N

**B. CONTACT / DEMOGRAPHIC INFORMATION**

**\*Parent/Caregiver 1 information**

Full Name: Last \_\_\_\_\_ First \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (check preferred number):  home  work  mobile

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you the legal guardian of the child?  Y  N Do you have physical custody of child?  Y  N

**Parent/Caregiver 2 information**

Full Name: Last \_\_\_\_\_ First \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (check preferred number):  home  work  mobile

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you the legal guardian of the child?  Y  N Do you have physical custody of child?  Y  N

**Legal Guardian information (if different from above)**

Full Name: Last \_\_\_\_\_ First \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (check preferred number):  home  work  mobile

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you the legal guardian of the child?  Y  N Do you have physical custody of child?  Y  N

**C. SERVICES**

**CHECK if any of the following have previously or currently applies to your child**

Check here if your child is not yet in child care or school, and skip this table

Early Intervention	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Individualized Family Service Plan (IFSP)	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
School (TEAM, CORE) evaluation <i>If yes, when?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Has/does your child have an Individualized Education Plan (IEP)? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
504 Plan <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Attends a special needs daycare/preschool	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Receiving <input type="checkbox"/> speech <input type="checkbox"/> occupational <input type="checkbox"/> physical therapy	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Participates in Summer School or Extended School Year (ESY) services	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Psychological testing? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Mental health counseling or behavioral therapy? <i>If yes, date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
School disciplinary actions, including detention, suspension or expulsion? <i>If yes, specify &amp; date?</i>	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N
Stay in psychiatric hospital	<input type="checkbox"/> Y, in the past	<input type="checkbox"/> Y, current	<input type="checkbox"/> N

**\*\*Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years.**

**This information may be necessary for the Autism Spectrum Center to get authorization from your insurance company.**

**D. CONCERNS YOU HAVE ABOUT YOUR CHILD'S DEVELOPMENT OR BEHAVIORS**

\*Please check **any concerns you have** about your child:

<input type="checkbox"/> Autism Spectrum Disorder (Asperger's, Autism, PDD)	<input type="checkbox"/> Intellectual disability (formerly mental retardation)	<input type="checkbox"/> Tics/Tourette's
<input type="checkbox"/> Attention problems (ADHD, ADD)	<input type="checkbox"/> Speech/language delay	<input type="checkbox"/> Toileting problem (toilet training, bedwetting, soiling)
<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Communication problems	<input type="checkbox"/> Genetic or chromosomal condition
<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Fine motor problem	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Emotional or psychiatric problems	<input type="checkbox"/> Gross motor problem	<input type="checkbox"/> Obsessive-compulsive disorder (OCD)
<input type="checkbox"/> Learning problem	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Bipolar disorder or mood swings
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Problems with coordination	<input type="checkbox"/> Depression
<input type="checkbox"/> Mood	<input type="checkbox"/> Ataxia	<input type="checkbox"/> PTSD
	<input type="checkbox"/> Severe weakness or inability to tolerate exercise	<input type="checkbox"/> Substance use or abuse

**E. CHILD'S MEDICAL HISTORY**

Check if child's entire medical history is unknown – and answer as you are able.

Please check any conditions your child has been **diagnosed** with:

<p><b>Developmental Problems:</b></p> <input type="checkbox"/> Speech delay <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Behavior problems <input type="checkbox"/> Autism <input type="checkbox"/> Attention problems (ADD/ADHD) <input type="checkbox"/> Learning problems	<p><b>Mental Health Problems:</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Mood Disorder (Depression, Bipolar, Suicide thoughts or attempts) <input type="checkbox"/> Psychosis or Schizophrenia <input type="checkbox"/> Child has had a stay in a psychiatric hospital *If yes, when/where?
<p><b>Neurological Problems:</b></p> <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> Sleep problems <input type="checkbox"/> Head injury <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tics or Tourette <input type="checkbox"/> Motor delays <input type="checkbox"/> Hearing problems <input type="checkbox"/> Vision problems <input type="checkbox"/> Headaches	<p><b>Genetic Disorders:</b></p> <input type="checkbox"/> Down Syndrome/trisomy 21 <input type="checkbox"/> Other chromosomal abnormalities <input type="checkbox"/> Metabolic disorder
<p><b>General Medical Problems:</b></p> <input type="checkbox"/> Heart disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart murmur <input type="checkbox"/> Thyroid <input type="checkbox"/> Congenital heart problem <input type="checkbox"/> Kidney/urinary problems <input type="checkbox"/> Overweight/Obesity <input type="checkbox"/> Cancer <input type="checkbox"/> Growth problems <input type="checkbox"/> Gastrointestinal problems <input type="checkbox"/> Underweight/Failure to thrive      (vomiting, feeding <input type="checkbox"/> Allergies      problems, abdominal <input type="checkbox"/> Skin problems (rashes, eczema)      pain, reflux, constipation, <input type="checkbox"/> Respiratory (asthma, pneumonia)      diarrhea)	<p><b>Surgical History:</b>                  Has your child ever had any surgeries? If yes, please list below:</p> <hr/> <p><b>Any other specific medical concerns?</b></p>

Has the child ever had any of the following screening/ diagnostic tests or procedures?	If yes, when, where, and results? (Please send in copies of results if available)
Genetic and/or metabolic testing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
EEG	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
CT scan or MRI of the head	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Sleep study	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Hearing test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know
Vision test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know

**\*Review of Systems**

<p><b>General/constitutional:</b></p> <input type="checkbox"/> Significant behavioral changes <input type="checkbox"/> Significant weight loss or gain <input type="checkbox"/> Weakness or fatigue <input type="checkbox"/> Fever or chills	<p><b>Allergy:</b></p> <input type="checkbox"/> Itchy or watery eyes <input type="checkbox"/> Itchy or runny nose, sneezing <input type="checkbox"/> Hives <input type="checkbox"/> Needed to use Epi-Pen
<p><b>Gastrointestinal:</b></p> <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Abdominal pain or discomfort <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloating, indigestion <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Change in bowel habits (number/consistency) <input type="checkbox"/> Blood in stool <input type="checkbox"/> Jaundice (yellow skin or eyes), itching	<p><b>Neurological:</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> Sleep problems <input type="checkbox"/> Dizziness, vertigo <input type="checkbox"/> Fainting, blackouts <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Seizures, convulsions <input type="checkbox"/> Head injuries, concussions <input type="checkbox"/> Trouble walking <input type="checkbox"/> Tremor, unusual motor movement (tics) <input type="checkbox"/> Problems with coordination <input type="checkbox"/> Problems with concentration, memory

**\*Review of Systems (continued)**

<p><b>Heart:</b></p> <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Heart racing, skipped beats <input type="checkbox"/> Ankle swelling, cold/blue hands, feet <input type="checkbox"/> Fainting, fatigue with exercise	<p><b>Lungs:</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath, wheezing <input type="checkbox"/> Recent chest X-ray
<p><b>Eyes, Ears, Nose, Throat:</b></p> <input type="checkbox"/> Sore throats <input type="checkbox"/> Ear infections <input type="checkbox"/> Sinus infections <input type="checkbox"/> Loud snoring, irregular breathing during sleep <input type="checkbox"/> Problems with eyes/vision <input type="checkbox"/> Problems with ears/hearing	<p><b>Bones, joints, and muscles:</b></p> <input type="checkbox"/> Joint pain, stiffness, swelling <input type="checkbox"/> Fingers painful/blue in cold <input type="checkbox"/> Dry mouth, red eyes <input type="checkbox"/> Back, neck pain <input type="checkbox"/> Muscle problems <input type="checkbox"/> Fractures, broken bones <input type="checkbox"/> Sprains
<p><b>Endocrine:</b></p> <input type="checkbox"/> Sweating <input type="checkbox"/> Fatigue <input type="checkbox"/> Hand trembling <input type="checkbox"/> Neck swelling <input type="checkbox"/> Skin, hair, voice changes <input type="checkbox"/> Thirst <input type="checkbox"/> Growth difficulties	<p><b>Genitourinary:</b></p> <input type="checkbox"/> Nighttime bedwetting <input type="checkbox"/> Daytime urine accidents <input type="checkbox"/> Pain with urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Genital rashes or lumps <input type="checkbox"/> Heavy or painful menses (periods)
<p><b>Skin:</b></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Changes in mole or spot <input type="checkbox"/> Needed stitches	<p><b>Hematologic:</b></p> <input type="checkbox"/> Bruise easily, difficulty stopping bleeding <input type="checkbox"/> Lumps under arms or on neck

**F. CHILD'S BIRTH HISTORY**

Check if birth history is unknown

Age of mother at delivery: \_\_\_\_\_

Age of father at delivery: \_\_\_\_\_

Number of previous pregnancies (including miscarriages or terminations): \_\_\_\_\_

During pregnancy, did the mother:

Take prenatal vitamins	<input type="checkbox"/> Y <input type="checkbox"/> N
Use tobacco	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: how much?
Drink alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: how much?
Take drugs or medications	<input type="checkbox"/> Y <input type="checkbox"/> N If yes: what drug(s) or medication(s), and during which trimester(s):

Birth Measurements:	Weight:	Height:	Head Circumference:
APGAR score (if known):	1 minute:	5 minute:	
Was the baby born at term?	<input type="checkbox"/> Y <input type="checkbox"/> N or numbers of weeks gestation at birth:		
What was the delivery method?	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean (C-section) <i>If cesarean, please describe why:</i>		
Were there any prenatal or neonatal complications?	<input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, please describe:</i>		
Was a NICU or extended hospital stay required?	<input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, please describe:</i>		



**G. CHILD'S DEVELOPMENTAL HISTORY**

As best as you can remember, list the age or check off the approximate time at which your child reached the following developmental milestones.

Developmental Skill	Age (if known)	Not yet	Only if exact age cannot be recalled		
			Early	At Normal Time	Late
Sat without support		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stood without support		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked without assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoke first words		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said phrases		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said sentences		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel trained		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, day		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, night		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years. This information may be necessary for the Autism Spectrum Center to get authorization from your insurance company.**

**PLEASE FEEL FREE TO ATTACH ANY ADDITIONAL INFORMATION THAT YOU THINK MIGHT HELP US BETTER UNDERSTAND YOUR CHILD.**

\_\_\_\_\_  
\*Parent/Guardian Signature

\_\_\_\_\_  
\*Print Name

\_\_\_\_\_  
\*Date

\_\_\_\_\_  
\*Relationship to patient

## A. Child's Behavioral and Emotional Functioning

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
1. Fails to give close attention to detail or makes careless mistakes in schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has difficulty sustaining attention in tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does not listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does not follow through when given directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has difficulties organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Avoids, dislikes, or does not want to start tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Loses things necessary for tasks or activities (school assignments, books, pencils, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is easily distracted by noises or other things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (I)	(1-9)___/9	<input type="checkbox"/> ≥6/9	SUBTOTAL: _____	
10. Fidgets with hands or feet or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Leaves seat when he/she is supposed to stay in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Runs about or climbs too much when he/she is supposed to stay seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has difficulty playing or starting quiet games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is "on the go" or acts as if "driven by a motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has difficulty waiting his/her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Interrupts or bothers others when they are talking or playing games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (HI)	(1-9)___/9	<input type="checkbox"/> ≥6/9	SUBTOTAL: _____	
19. Argues with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Actively disobeys or refuses to follow adult's requests or rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Bothers people on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Blames others for his or her mistakes or misbehaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Is touchy or easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Is angry or bitter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Is hateful and wants to get even	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (ODD):	(19-26)___/8	<input type="checkbox"/> ≥4/8		

**Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS**

	Never or rarely	Occasionally	Often	Very Often
27. Bullies, threatens, or scares others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Starts physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Skips school without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Is physically unkind to people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Has stolen things that have value	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Destroys others' property on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Is physically mean to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Has set fires on purpose to cause damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Has broken into someone else's home, business, or car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Has stayed out all night without permission or run away from home overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Has used a weapon that can cause serious physical harm (e.g., bat, broken bottle, brick)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (CD):	(27-38)___/12		<input type="checkbox"/> ≥3/12	
39. Is fearful, anxious, or worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Is afraid to try new things for fear of making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Feels useless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Blames self for problems, feels at fault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Feels lonely, unwanted, or unloved; complains that "no one loves me"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Is sad or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Feels different and easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Is overly concerned about health/body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (Anx/Dep):	(39-46)___/8		<input type="checkbox"/> ≥3/8	
47. Has problems getting along with parent(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Has problems getting along with others his/her own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Has problems getting along with his/her own siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Has problems in group activities such as games or team play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (Anx/Dep):	(39-46)___/8		<input type="checkbox"/> ≥3/8	
51. Decreased interest or pleasure in all, or almost all, activities of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Has said things like "I wish I were dead" or has tried to hurt self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Recurrent excessive distress when separated from home or caretakers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Has distinct periods where mood is unusually irritable or unusually good, cheerful mood (different from normal mood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Has prolonged temper tantrums (greater than 20-30 minutes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS</b>				
	<b>Never or rarely</b>	<b>Occasionally</b>	<b>Often</b>	<b>Very Often</b>
56. Has compulsions (e.g., child seems driven to wash hands, count, erase until holes appear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Has obsessions (e.g., persistent or repetitive distressing thoughts, germs, doors left unlocked)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Has recurrent recollections or dreams of a traumatic event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Seems to avoid or have phobias of specific people, animals, things or situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Seem unaware of others' existence, is uninterested in interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Has odd, eccentric, or unusual preoccupations (e.g., clothing items, toys, neatness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Appears uninterested in activities children his/her own age usually like or participate in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Has experimented with or abused drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (MH):	(51-64)___/14		<input type="checkbox"/> ≥0/14	

## B. Child's Current School Performance

Please check the column that best describes your child's current performance at school, or check "not applicable"

	<b>Not applicable</b>	<b>Excellent</b>	<b>Above average</b>	<b>Average</b>	<b>Somewhat of a problem</b>	<b>Problematic</b>
1. Overall school performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Completing classroom assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Completing homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Getting homework to and from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Written expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### C. Child's Overall Functioning

Please summarize this child's **OVERALL FUNCTIONING** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from your experience.

**Please circle only one number.**

<input type="checkbox"/>	<b>Excellent</b> functioning/No impairment in settings
<input type="checkbox"/>	<b>Good</b> functioning /Rarely shows impairment in settings
<input type="checkbox"/>	<b>Mild</b> difficulty in functioning/Sometimes shows impairment in settings
<input type="checkbox"/>	<b>Moderate</b> difficulty in functioning/Usually shows impairment in settings
<input type="checkbox"/>	<b>Severe</b> difficulties in functioning/Most of the time shows impairment in settings
<input type="checkbox"/>	<b>Needs considerable supervision</b> in all settings to prevent from hurting self or others
<input type="checkbox"/>	<b>Needs 24-hour professional care and supervision</b> due to severe behavior or gross impairment(s)

Have there been any other recent changes in your child's physical, emotional, psychological, or behavioral health that you are concerned about? Please describe:

\_\_\_\_\_  
\*Parent/Guardian Signature

\_\_\_\_\_  
\*Print Name

\_\_\_\_\_  
\*Date

\_\_\_\_\_  
\*Relationship to patient



## K-12 School Questionnaire

Child's Name: \*Last \_\_\_\_\_ \*First \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ \*Gender:  M  F  Other

Child's classroom/age level: \_\_\_\_\_

**Please have school or daycare personnel fill out and return.**

*Mail: Boston Children's Hospital, Autism Spectrum Center BCH3433, 300 Longwood Ave., Boston, MA 02115*

*Email: AutismCenter@childrens.harvard.edu Fax: 617-730-4823*

School/daycare: \_\_\_\_\_

School/daycare address: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Position: \_\_\_\_\_

With help from: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone number and best time to call: \_\_\_\_\_

Email address \_\_\_\_\_

List up to 3 specific questions you would like answered as a result of this evaluation that would help you better meet this child's developmental and educational needs

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**In your opinion, what areas of this child's functioning need the most improvement?**

**Please describe this child's strengths.**

**Please describe any other concerns you have about this child.**

Has this child ever been evaluated for learning or academic problems? If yes, when? \_\_\_\_\_

**Please send copies of previous testing results and copy of the current Individual Educational Plan (IEP).**

Besides English, are there any additional languages used for the child's instruction?  Y  N

If yes, what language? \_\_\_\_\_

**A. ACADEMIC PERFORMANCE:**

**Current school performance: Please check the appropriate column below**

	Excellent	Above average	Average	Somewhat of a problem	Problematic
1. Reading decoding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reading rate and fluency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Spelling accuracy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mathematics concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Mathematics computation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Writing rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Punctuation/grammar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to express thoughts through writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Gross motor skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Fine motor skills (using pencil & scissors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Overall school performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Current classroom behavior: Please check the appropriate column below**

	Excellent	Above average	Average	Somewhat of a problem	Problematic
1. Understanding verbal instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Completing classroom assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Getting homework to and from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Completing homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Relationship with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Following directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Disrupting class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Verbally participating in class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**LEARNING PROBLEMS. Check the column that best describes the child's learning problems (i.e., above and beyond what would be expected for his or her developmental age) over the past 6 months.**

	Never or rarely	Occasionally	Often	Very Often
1. Has trouble learning new material in an appropriate time from for age and skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has little desire to master new skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Unable to tell time, days of the week, months of the year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can't repeat information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Knows material one day; doesn't know it the next	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has trouble holding several different things in mind while working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has trouble following multi-step directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has difficulty copying written material from blackboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (Gen):	(1-8)___/8		<input type="checkbox"/> ≥4/8	
9. Difficulty orienting self (e.g., gets lost, can't find way, or gets turned around easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has poor spatial judgment and often bumps into things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Confuses directionality (up/down, left/right, over/under)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has poor spatial organization on paper (difficult staying in lines, maintaining space between words, staying within page margins)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Mixes up capital and lower case letters when writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Reverses letters and numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (VSP):	(9-14)___/9		<input type="checkbox"/> ≥3/6	
15. Has trouble expressing words or events in correct order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Often mispronounces known or familiar words or uses wrong word	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has trouble verbally expressing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Says things that have little or no connection to what others are discussing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has difficulty distinguishing long vowel sounds and short vowel sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Depends on teacher or others for repetition of task instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (Lang):	(15-20)___/6		<input type="checkbox"/> ≥3/6	
21. Displays poor word attack skills (can't sound out words)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Puts wrong number of letters in words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Confuses consonant sounds, e.g.: b-d, d-t, m-n, p-b, f-v, s-z	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Unable to keep place on page when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (R/W):	(21-24)___/4		<input type="checkbox"/> ≥2/4	



**CLASSROOM SETTING:** Please check all that apply, and provide details

Type of Setting	Number of Students	Number of Instructors	Aide Present for Child?		
<input type="checkbox"/> Mainstream			<input type="checkbox"/> 1:1	<input type="checkbox"/> Shared	<input type="checkbox"/> None
<input type="checkbox"/> Integrated			<input type="checkbox"/> 1:1	<input type="checkbox"/> Shared	<input type="checkbox"/> None
<input type="checkbox"/> Substantially separate			<input type="checkbox"/> 1:1	<input type="checkbox"/> Shared	<input type="checkbox"/> None

**GENERAL EDUCATION SETTING:** Please list any specific curricula or instructional methodologies used in the child's general education setting, if applicable

Academic Area	Methodology or curriculum
Reading/reading-related materials	
Mathematics	
Writing/written expression	

**SPECIAL EDUCATION AND RELATED SERVICES FOR CHILD:** Please check all that apply and describe specific curriculum or instructional methodology, if applicable

Check here if you are not familiar with the child's IEP services

Type of service	Consultation	Direct service within general education classroom	Direct service in other settings	Specific curriculum or instructional methodology, if applicable (e.g., reading –Wilson)
<input type="checkbox"/> Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Speech/language therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Written language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Social skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Individual counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Home-based services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### B. CHILD'S ATTENTION, ACTIVITY, AND BEHAVIOR

Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS

	Never or rarely	Occasionally	Often	Very Often
1. Fails to give close attention to detail or makes careless mistakes in schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has difficulty sustaining attention in tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does not listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has difficulties organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Loses things necessary for tasks or activities (e.g., school assignments, books, pencils, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is easily distracted by extraneous stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (I)	(1-9)___/9	<input type="checkbox"/> ≥6/9	SUBTOTAL:___	
10. Fidgets with hands or feet or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Leaves seat when he/she is supposed to stay in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Runs about or climbs too much when he/she is supposed to stay seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has difficulty playing or engaging in leisure activities quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is "on the go" or acts as if "driven by a motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Talks excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has difficulty waiting his/her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Interrupts or intrudes on others (e.g. when they are talking or playing games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (HI)	(1-9)___/9	<input type="checkbox"/> ≥6/9	SUBTOTAL:___	

**Check the column that best describes this child's behavior OVER THE PAST 6 MONTHS**

	Never or rarely	Occasionally	Often	Very Often
19. Loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Actively defies or refuses to comply with adult's requests or rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Is angry or resentful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is spiteful and vindictive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Bullies, threatens, or scares others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Initiates physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Is physically cruel to people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Has stolen items of nontrivial value	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Deliberately destroys others' property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (ODD/CD):	(19-28)___/10		<input type="checkbox"/> ≥3/10	
29. Appears fearful, anxious, or worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Appears self-conscious or easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Appears afraid to try new things for fear of making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Feels worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blames self for problems, feels guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Feels lonely, unwanted, or unloved; complains that "no one loves me"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Appears sad, unhappy, or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (Anx/Dep):	(29-35)___/7		<input type="checkbox"/> ≥3/7	
36. Skips school without permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Has set fires on purpose to cause damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Destroys others' property on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Has broken into someone else's home, business, or car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Has said things like "I wish I were dead" or has tried to hurt self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Has distinct periods where mood is unusually irritable or unusually good, cheerful, or high which is clearly excessive or different from normal mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Seems to have compulsions (repetitive behaviors that this child seems driven to carry out, such as repeated hand washing, counting, or erasing until holes appear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Has prolonged temper tantrums (greater than 20-30 minutes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Seems unaware of others' existence, is uninterested in interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Has odd, eccentric, or unusual preoccupations (e.g., clothing items, toys, neatness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Appears uninterested in activities children his/her own age usually like or participate in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OFFICE USE ONLY (MH):	(36-46)___/11		<input type="checkbox"/> ≥1/11	

Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from you experience.

Please circle only one number.

<input type="checkbox"/>	<b>Excellent</b> functioning/No impairment in settings
<input type="checkbox"/>	<b>Good</b> functioning /Rarely shows impairment in settings
<input type="checkbox"/>	<b>Mild</b> difficulty in functioning/Sometimes shows impairment in settings
<input type="checkbox"/>	<b>Moderate</b> difficulty in functioning/Usually shows impairment in settings
<input type="checkbox"/>	<b>Severe</b> difficulties in functioning/Most of the time shows impairment in settings
<input type="checkbox"/>	<b>Needs considerable supervision</b> in all settings to prevent from hurting self or others
<input type="checkbox"/>	<b>Needs 24-hour professional care and supervision</b> due to severe behavior or gross impairment(s)

Please describe this child's personality – moods, behavior, emotional functioning, etc.

Please describe this child's relationship with peers.

Is there any other information you think would be helpful for evaluating this child?

\_\_\_\_\_  
\*Teacher Signature

\_\_\_\_\_  
\*Print Name

\_\_\_\_\_  
\*Date