

Preetham Grandhi, MD

625 Gramatan Ave
Mount Vernon
NY 10552

Tel# 914-664-9190

Child & Adolescent Evaluation Packet

In order to understand your child it is important to receive accurate information about his or her history. To the best of your ability, please fill in all items as completely as you can. Use extra pages if necessary. If you do not have the information requested, please write “**unknown**” and try to obtain the information. **Write “N/A” if not applicable.** You can attach any previous psychological, psychiatric or school reports.

Thank You for your time.

General Information

Person Completing this form:

Date: _____

Full Name: _____

Relationship to this Child: _____

Phone:

- _____ (Home)
- _____ (Work)
- _____ (Mobile)
- _____ (other/Fax)

Address:

_____ Zip _____

Did someone refer you? Yes/No

If Yes, Who? _____

Child's Name: First _____ Middle _____ Last _____

Sex: ___ M ___ F Age: _____ Date of Birth: ___/___/___ Ethnicity _____

Grade: _____ School: _____

Mother's Name: _____ Occupation: _____

Age: _____ Education: _____

Father's Name: _____ Occupation: _____

Age: _____ Education: _____

Insurance Information

Insurance Co. Name: _____

Plan Name/Contract Type: _____

Ins. Co. Address from Ins. card: _____

Phone No.: _____ Fax No: _____

Contact Person: _____

Policy/Membership/ID No.: _____

Group Number (If any): _____

If Policyholder Other Than Patient

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber's Date of Birth: _____

Subscriber's Relation to Patient: _____

Is this Insurance: Primary: _____ or Secondary _____

Effective Date: ____ / ____ / ____

Authorization Number: _____

Number of Sessions authorized: _____

Pregnancy

Prior to this pregnancy had there been trouble in becoming pregnant? Yes ___ No ___

Prior to or during this pregnancy was there any treatment for infertility? Yes ___ No ___

Previous Pregnancies (if none skip to next section)

How many times had the mother been pregnant before this pregnancy: _____ times

In earlier pregnancies had the mother had a miscarriage or abortion? Yes ___ No ___

During earlier pregnancies were there any problems related to the pregnancy itself? Yes ___ No ___

Pregnancy with this child:

During the pregnancy with this child did the mother suffer from any of the following medical conditions or complications (please check all that apply and explain any medical conditions or complications on the back of this page)

√all that apply

Diabetes , Thyroid disease , Liver Disease , Heart Disease ,

Infections such as syphilis or gonorrhea , Measles , Viral or Flue-like illness ,

Bleeding or threatened miscarriage , High blood pressure ,

Severe nausea , Severe swelling of hands/feet , Other problems

Did the mother have any other serious illness during the pregnancy? Yes ___ No ___

Did the mother have any X-rays (other than dental films) during the pregnancy? Yes ___ No ___

Did the mother receive any medications (other than vitamins) during the pregnancy? Yes ___ No ___

Did the mother consume alcohol during the pregnancy? Yes ___ No ___

Did the mother smoke during the pregnancy? Yes ___ No ___

Did the mother use any non-prescribed or other drugs during the pregnancy? Yes ___ No ___

Was there any concern about the Rh factors of the mother & father? Yes ___ No ___

Notes: *If yes to any question above please describe.*

Labor and Delivery

√all that apply

Was this a single birth (no twins, triplets, etc.) Yes _____ No _____

What was the baby's weight at birth? _____ Pounds _____ Ounces. APGAR SCORES: _____/_____

How long before/after the expected due date was the child born: _____ weeks BEFORE/AFTER (circle)

In what position was the baby born: (√ one) Normal vertex position (head first) , Face , Breech (legs or bottom first) , Caesarean section (why? _____).

How did labor start: Naturally _____ Induced _____ (√ one)

How long was the labor in hours? _____ (hours)

Was there any concern about the baby's condition during labor? Yes _____ No _____

Please check any of the following problems if they occurred during the labor and delivery √ all that apply:

| | Yes | No |
|---|-----|----|
| Excessive bleeding before delivery | | |
| Meconium staining | | |
| Water broke 1 day before delivery | | |
| Fever or infection in mother | | |
| Excessive bleeding during/after delivery | | |
| Forceps used in delivery | | |
| Labor stopped for more than 1 hour | | |
| Umbilical cord around baby's neck | | |
| Placenta previa or abruptio diagnosed | | |
| Difficulties in getting child to breathe on his/her own | | |

Was there any concern about the child's conditions immediately after birth? Yes _____ No _____

Did the child exhibit any congenital abnormality or defect at birth (do not count simple birthmarks)? Yes _____ No _____

Was there any evidence of birth injury? Yes _____ No _____

Did the child require any special care immediately after birth Yes _____ No _____

Please feel free to use the facing page to provide additional information

Condition of the child immediately after Birth

Regarding the child's condition at and shortly after birth please ✓ all that apply following the birth this child:

| | Yes | No |
|---|-----|----|
| Had transient jaundice not treated with lights | | |
| Had jaundice treated with lights | | |
| Was in an incubator | | |
| Had blood transfusions | | |
| Had surgery | | |
| Had poor muscle tone | | |
| Was hard to feed | | |
| Was given oxygen | | |
| Seemed unresponsive | | |
| Had unusual movements poor muscle tone or paralysis | | |
| Was easily upset by noises or stimulation | | |

Feeding

✓all that apply: If there were no concerns circle None and move to next section.

None

How was the baby fed? Breast _____ (until _____ months) Bottle Fed _____ Both _____

Was it hard to feed the child? Yes _____ No _____ if yes, please explain below:

Did the baby gag or choke excessively? Yes _____ No _____

Did the baby spit up or vomit excessively? Yes _____ No _____

When were solid foods introduced: _____ (months)

Were there problems in feeding solid foods? Yes _____ No _____

Did the baby fail to gain weight appropriately? Yes _____ No _____

Was the child very sensitive to foods? Yes _____ No _____

Notes:

Development and Behavior in Infancy and Early Childhood

If there were no concerns circle "none" but fill in pertinent milestones. **None**

When were you first worried about the child's development (months) _____ Why were you worried?

Has the child (now or in the past) had any unusual skills, abilities, or interests (for example, having a very good memory for certain things or having some very special area of interest or ability)? If yes, please describe: _____

Did the child seem to develop normally for a time and then lose skills? If yes, please describe: _____

At what age did the child do the following: (please specify the AGE in months)

| | | | |
|---------------------|-------|----------------------------|-------|
| Smiled | _____ | Sat up without support | _____ |
| Crawl | _____ | Walk alone without support | _____ |
| Say first sentences | _____ | Speak in sentences | _____ |

Please use the facing page to describe the child as an infant - was he/she very easy child to care for? Very undemanding? Very sensitive to the environment? Did he/she seem to notice if parents were not available? Please List any unusual sensitivities the child had to the environment, e.g., unusual responses to smells, sounds, tastes, and so on.

For the following questions check the appropriate box depending on this child's development BEFORE his or her 3rd birthday:

| | Usually | Sometimes | Rarely |
|---|---------|-----------|--------|
| Anticipated being picked up by care giver | | | |
| Could tell the difference between parents and other people | | | |
| Imitated simple adult movements | | | |
| Played simple interaction games (peek-a-boo, pat-a-cake) | | | |
| Showed an interest in children/peers other than siblings | | | |
| Understood at least 10 words | | | |
| Uses gestures appropriately to indicate 'yes', 'no', and 'I want' | | | |
| Used common objects for Imaginative (pretend) play | | | |
| Imitated sounds made by caregiver | | | |
| Said 'dada', 'mama' or other appropriate name for parent(s) | | | |
| Made eye contact with caregiver | | | |
| Pointed at things to draw one's attention to them | | | |
| Responded by turning/coming when their name was called | | | |

Are all immunizations up to date: Yes _____ No _____

Please feel free to use the facing page to provide additional information

Speech, Language & Communication

If your child has no current or past difficulties in any of these areas circle N/A and move to next section:
N/A

How much did your child babble and coo during the first 6 months?

Less than expected _____ More than expected _____ Same as siblings _____

When did first words emerge? _____

What were the child's first words? _____

About how many words did the child have at 1&1/2 years? _____

When did he/she begin to use two-word sentences? _____

At present does he/she use speech? Frequently _____ Occasionally _____ Never _____

Does he/she use many gestures (e.g., waving, bye-bye, head shaking or nodding)? (Give examples if possible) _____

Which does the child prefer to use? (✓ one or more)

Complete sentences _____ Phrases _____ One or two words _____ Sounds _____ Gestures _____

How does your child let you know that he/she wants an object that is out of reach?

How does your child let you know that he/she does not want something that you are offering to him/him?

Does he/she make sounds incorrectly? If so, which ones? _____

Does he/she hesitate, "get stuck," repeat, or stutter on sounds or words? If so, describe _____

How does his/her voice sound?

Normal _____ Too High _____ Too Low _____ Hoarse _____ Nasal _____

How well is your child understood? all that apply

| | Well | Fair | Poor |
|--------------------------|------|------|------|
| By Parents | | | |
| By brothers/sisters | | | |
| By relatives & strangers | | | |

Did your child ever acquire speech and then slow down or stop talking? _____

Does he or she imitate speech but not use it spontaneously? _____

How well does your child understand what is said to him/her? _____

Has your child's hearing been tested? Yes/No When? _____ By Whom? _____ What were the results? (Please send a copy of audiological report) _____

√all that apply

| | <u>Yes</u> | <u>No</u> | <u>Comment (Give ages if possible)</u> |
|---|------------|-----------|--|
| Cried less than normal amount | | | |
| Laughed less than normal amount | | | |
| Used screaming or aggression to communicate | | | |
| Very alert to gestures, facial expressions, or movements | | | |
| Generally indifferent to sound | | | |
| Did not respond when spoken to | | | |
| Responded to noises (car horns, telephones) but not to speech | | | |
| Difficulty using tongue | | | |
| Difficulty swallowing | | | |
| Food came out of nose | | | |
| Mouth breather | | | |
| Tongue-tied | | | |
| Difficulty chewing | | | |
| Drooled a lot | | | |
| Made eye contact | | | |
| Participated in social games (e.g., peek-a-boo) | | | |
| Pointed to items he/she wanted | | | |
| Pointed to show off an item or activity | | | |

Does your child currently use any additional/alternative communication systems? √all that apply

Sign language _____ Communication board _____ Picture Exchange (PECS) _____

Computer Assisted _____

Please feel free to use the facing page to provide additional information

Medical Health History

Has the child ever suffered from any significant medical problem? (e.g. seizure disorder or convulsions, severe head Injury with unconsciousness, meningitis or encephalitis, accidents/injuries, failure to grow, obesity, endocrine disease, recurrent ear infections, and so forth) Yes___ No___

Has the child had more than a few of ear infections? Yes___No___

Has the child ever had a hearing test? Yes ___No___

If yes what was the result of the hearing test: _____

Has the child ever had an EEG (brain wave test)? Yes___ No___

If yes what was the result _____

Has the child ever had a CT Scan/MRI Scan (brain imaging study)? Yes___No___

If yes what was the result _____

Has the child ever had a Chromosome Test or been screened for any genetic disorder e.g. Fragile-X? Yes___ No___

If yes what was the result _____

Has the child had asthma, allergies, or unusual responses to immunizations? Yes___ No___

If yes explain: _____

Has the child been seen by any specialists? Yes___ No___

If yes, please identify which, give approximate dates of evaluations, and describe results

| | Date | Results |
|-----------------------------|------|---------|
| Occupational Therapist | | |
| Physical Therapist | | |
| Speech Pathologist | | |
| Psychologist | | |
| Psychiatrist | | |
| Neurologist | | |
| Ophthalmologist/optometrist | | |

Has the child had any Surgery, Physical Trauma or Injury? If Yes, write details: _____

Educational History

Has this child been identified as having any special educational needs? Yes ___ No ___ How old was the child (in years) when he/she was identified as having special needs? ___ years

For each grade in school please ✓ all the following that applied. You need not enter any checks for years that the child was not in school and can go on to the next page if the child has not been in school.

| School Year | Type of School (✓ one) | | Type of Class (✓ one) | | Special Services: List speech language or other services first (note type, if I (individual) or SG (small group), frequency, duration- <i>e.g., speech 20-30 min individual sessions/ week</i>) | | |
|--------------|------------------------|---------|-----------------------|---------|--|------|--------------------|
| | Regular | Special | Regular | Special | Speech/other | Type | Frequency/Duration |
| Pro-K | | | | | | | |
| Kindergarten | | | | | | | |
| 1st | | | | | | | |
| 2nd | | | | | | | |
| 3rd | | | | | | | |
| 4th | | | | | | | |
| 5th | | | | | | | |
| 6th | | | | | | | |
| 7th | | | | | | | |
| 8th | | | | | | | |
| 9th | | | | | | | |
| 10th | | | | | | | |
| 11th | | | | | | | |
| 12th | | | | | | | |

Current Educational Situation:

Name of current school: _____

Main Teacher: _____

You may use the facing page to describe any aspects of the child's educational program. Please note, in particular, any concerns you have about the program - please enclose copies of recent IEP's or other information relevant to the educational program.

Please describe the current classroom setting: # of children _____ # of Teachers _____

of Aides/other adults _____

How much speech-language service is provided? _____ minutes _____ times/week (individual or group?)

How much OT service is provided? _____ minutes _____ times/week (individual or group?)

How much PT service is provided? _____ minutes _____ times/week (individual or group?)

How many days a week does the child attend school _____ how long is the school day _____

How much of the day is the child mainstreamed? _____

Is there a summer program provided by the school? _____

Are any other special services provided? _____

Please feel free to use the facing page to provide additional information

Social Skill/Behavioral History

For each of the following items please mark whether the specific behavior applies in the case of your child. Please mark the appropriate box. If you cannot respond to a question please so indicates. The items are numbered for reference if you want to provide more information about an item on the on the back of the page. ***If your child has no current or past difficulties in any of these areas circle N/A and move to next section:***

N/A

| <u>Behavior</u> | <u>Never</u> | <u>Rarely</u> | <u>Some times</u> | <u>Often</u> | <u>Almost Always</u> | <u>Can't Say</u> |
|--|--------------|---------------|-----------------------|--------------|--------------------------|----------------------|
| 1. Poor speech tone/rhythm | | | | | | |
| 2. Confuses personal pronouns | | | | | | |
| 3. Repeats words/phrases out of current context | | | | | | |
| 4. Repeats questions rather than answering them | | | | | | |
| 5. Asks for things by repeating questions | | | | | | |
| 6. Is constantly restless and "on the go" | | | | | | |
| 7. Could do many things but did not seem to want to | | | | | | |
| 8. Whirls Self or flaps hands or fingers for no reason | | | | | | |
| 9. Runs/walks on toes | | | | | | |
| 10. Engages in body rocking | | | | | | |
| 11. Engages in head banging | | | | | | |
| 12. Assumes fixed body postures for long periods of time | | | | | | |
| 13. Stares into space for long periods | | | | | | |
| 14. Overly preoccupied with noises | | | | | | |
| 15. Overly preoccupied with details | | | | | | |
| | | | | | | |

Please feel free to use the facing page to provide additional information

| <u>Behavior</u> | <u>Never</u> | <u>Rarely</u> | <u>Some times</u> | <u>Often</u> | <u>Almost Always</u> | <u>Can't Say</u> |
|---|--------------|---------------|-----------------------|--------------|--------------------------|----------------------|
| 16. Overly preoccupied with movements of own hands/fingers | | | | | | |
| 17. Overly preoccupied with textures or the "feel" of things | | | | | | |
| 18. Overly preoccupied with twirling or spinning objects | | | | | | |
| 19. Upset by loud noises | | | | | | |
| 20. Upset by bright light | | | | | | |
| 21. Doesn't notice noises which others would | | | | | | |
| 22. Ignores toys | | | | | | |
| 23. Unusual responses to the environment | | | | | | |
| 24. Not aware of painful bumps/falls | | | | | | |
| 25. Lets objects fall as if they didn't exist or flicked them away as if to make them disappear | | | | | | |
| 26. Engages in repetitive activities | | | | | | |
| 27. Is emotionally distant | | | | | | |
| 28. Ignores people | | | | | | |
| 28. Seems to look/walk through people like they weren't there | | | | | | |
| 30. Avoids looking people in the eye | | | | | | |
| 31. Takes a person's hand/arm to get a desired object | | | | | | |
| 32. Would go limp when held or cling without obvious interest | | | | | | |
| 33. Cuddled when held | | | | | | |
| 34. Becomes stiff/rigid when held | | | | | | |
| 35. Ignores affection | | | | | | |
| 36. Actively avoids/withdraws from affection | | | | | | |

Please feel free to use the facing page to provide additional information

| <u>Behavior</u> | <u>Never</u> | <u>Rarely</u> | <u>Some times</u> | <u>Often</u> | <u>Almost Always</u> | <u>Can't Say</u> |
|--|--------------|---------------|-----------------------|--------------|--------------------------|----------------------|
| 37. Accepts affection | | | | | | |
| 38. Not aware of mother's absence | | | | | | |
| 39 Upset by changes in people, places, the environment | | | | | | |
| 40. Seems not to need mother | | | | | | |
| 41. Uses gestures/pointing to communicate | | | | | | |
| 42. Uses words/phrases/sentences to communicate | | | | | | |
| 43. Has normal interest in toys | | | | | | |
| 44. Repeatedly orders/reorders toys | | | | | | |
| 45. Bizarre use of toys | | | | | | |
| 46. Is attached to an unusual object | | | | | | |
| 47. Smiles responsively to mother | | | | | | |
| 48. In development of motor skills was awkward or clumsy | | | | | | |
| 49. Has an Interest in amassing facts/knowledge about one or more topics | | | | | | |

Notes: Please describe any other behavioral problems if not listed here.

Please feel free to use the facing page to provide additional information

Psychiatric Hospitalizations

Has your child been hospitalized on an inpatient unit for psychiatric reasons? If yes, write details below:

| <u>Hospital</u> | <u>From</u> | <u>To</u> | <u>Reason</u> |
|-----------------|-------------|-----------|---------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does your child have a *history of or has been diagnosed* with any of the conditions below.

| <u>Condition</u> | <u>Date First diagnosed</u> | | <u>Is it Resolved?</u> | | <u>Remarks</u> |
|------------------------------|-----------------------------|-----------|------------------------|-----------|----------------|
| | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> | |
| Autism | | | | | |
| Asperger's Syndrome | | | | | |
| Rett's Syndrome | | | | | |
| PDD NOS | | | | | |
| Reactive Attachment Disorder | | | | | |
| Mental Retardation | | | | | |
| Language impairment | | | | | |
| Selective Mutism | | | | | |
| Reading Disorder | | | | | |
| Writing Disorder | | | | | |
| Social Skills Deficits | | | | | |

Please feel free to use the facing page to provide additional information

| | | | <u>Date First diagnosed</u> | <u>Is it Resolved?</u> | | <u>Remarks</u> |
|-------------------------------|-----|----|-----------------------------|------------------------|----|----------------|
| | Yes | No | | Yes | No | |
| ADHD | | | | | | |
| Oppositional Defiant Disorder | | | | | | |
| Conduct Disorder | | | | | | |
| Anorexia | | | | | | |
| Bulimia | | | | | | |
| Enuresis | | | | | | |
| Encopresis | | | | | | |
| Firesetting | | | | | | |
| Gender Identity Disorder | | | | | | |
| Tourette's Disorder | | | | | | |
| Motor Tic Disorder | | | | | | |
| Vocal Tic Disorder | | | | | | |
| Schizophrenia | | | | | | |
| Psychotic Disorder | | | | | | |
| Depressive Disorder | | | | | | |
| Bipolar Disorder | | | | | | |
| Suicidal Ideation | | | | | | |
| Suicide attempt | | | | | | |
| Uncontrollable Aggression | | | | | | |
| Homicidal Ideation | | | | | | |
| | | | | | | |

Please feel free to use the facing page to provide additional information

| | | | <u>Date First diagnosed</u> | <u>Is it Resolved?</u> | | <u>Remarks</u> |
|--------------------------------|-----|----|-----------------------------|------------------------|----|----------------|
| | Yes | No | | Yes | No | |
| Panic Disorder | | | | | | |
| Separation Anxiety Disorder | | | | | | |
| School Phobia | | | | | | |
| Generalized Anxiety Disorder | | | | | | |
| Social Phobia | | | | | | |
| Specific Phobia | | | | | | |
| OCD | | | | | | |
| Post Traumatic Stress Disorder | | | | | | |
| School Refusal | | | | | | |
| Sleep Disturbance | | | | | | |
| Alcohol Use | | | | | | |
| Drug Use | | | | | | |
| Sexual Abuse | | | | | | |
| Physical Abuse | | | | | | |
| Neglect | | | | | | |
| Failure to Thrive | | | | | | |
| Natural Disaster | | | | | | |
| Motor Vehicle Accident | | | | | | |
| Chronic Medical Condition | | | | | | |
| Psychosomatic Disorder | | | | | | |

Please feel free to use the facing page to provide additional information

Please rate the below items about your child's behavior in the *past one month*. only **one** that applies

| | Not true at all (Never, Seldom) | Just a little true (Occasion- nally) | Pretty much true (Often, Quite a bit) | Very Much True (Very Often, Very Frequent) |
|--|--|---|--|---|
| 1. Angry and resentful | | | | |
| 2. Difficulty doing or completing homework | | | | |
| 3. Is always "on the go" or acts as if driven by a motor | | | | |
| 4. Timid, easily frightened | | | | |
| 5. Everything must be just so | | | | |
| 6. Has no friends | | | | |
| 7. Stomach aches | | | | |
| 8. Fights | | | | |
| 9. Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework) | | | | |
| 10. Has difficulty sustaining attention in tasks or play activities | | | | |
| 11. Argues with adults | | | | |
| 12. Fails to complete assignments | | | | |
| 13. Hard to control in malls or while grocery shopping | | | | |
| 14. Afraid of people | | | | |
| 15. Keeps checking things over again and again | | | | |
| 16. Loses friends quickly | | | | |
| 17. Aches and pains | | | | |
| 18. Restless or overactive | | | | |
| 19. Has trouble concentrating in class | | | | |
| 20. Does not seem to listen to what is being said to him/her | | | | |
| 21. Loses temper | | | | |
| 22. Needs close supervision to get through assignments | | | | |
| 23. Runs about or climbs excessively in situations where it is inappropriate | | | | |
| 24. Afraid of new situations | | | | |
| 25. Fussy about cleanliness | | | | |
| 26. Does not know how to make friends | | | | |
| 27. Gets aches and pains or stomachaches before school | | | | |
| 28. Excitable, impulsive | | | | |
| | Not true | Just a little | Pretty | Very |

Please feel free to use the facing page to provide additional information

| | at all <i>(Never, Seldom)</i> | true <i>(Occasion- nally)</i> | much true <i>(Often, Quite a bit)</i> | Much True <i>(Very Often, Very Frequent)</i> |
|--|---|---|---|--|
| 29. 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) | | | | |
| 30. Has difficulty organizing tasks and activities | | | | |
| 31. Irritable | | | | |
| 32. Restless in the “squirmy sense” | | | | |
| 33. Afraid of being alone | | | | |
| 34. Things must be done the same way every time | | | | |
| 35. Does not get invited over to friends’ houses | | | | |
| 36. Headaches | | | | |
| 37. Fails to finish things he/she starts | | | | |
| 38. Inattentive, easily distracted | | | | |
| 39. Talks excessively | | | | |
| 40. Actively defies or refuses to comply with adults’ requests | | | | |
| 41. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities | | | | |
| 42. Has difficulty awaiting in lines or awaiting turn in games or group situations | | | | |
| 43. Has a lot of fears | | | | |
| 44. Has rituals that he/she must go through | | | | |
| 45. Distractibility or attention span a problem | | | | |
| 46. Complains about being sick even when nothing is wrong | | | | |
| 47. Temper outbursts | | | | |
| 48. Gets distracted when given instructions to do something | | | | |
| 49. Interrupts or intrudes on others (e.g., butts into others’ conversations or games) | | | | |
| 50. Forgetful in daily activities | | | | |
| 51. Cannot grasp arithmetic | | | | |
| 52. Will run around between mouthfuls at meals | | | | |
| 53. Afraid of the dark, animals, or bugs | | | | |
| 54. Sets very high goals for self | | | | |
| 55. Fidgets with hands or feet or squirms in seat | | | | |
| 56. Short attention span | | | | |
| 57. Touchy or easily annoyed by others | | | | |
| | Not true | Just a little | Pretty | Very |

Please feel free to use the facing page to provide additional information

| | at all <i>(Never, Seldom)</i> | true <i>(Occasion- nally)</i> | much true <i>(Often, Quite a bit)</i> | Much True <i>(Very Often, Very Frequent)</i> |
|--|---|---|---|--|
| 58. Has sloppy handwriting | | | | |
| 59. Has difficulty playing or engaging in leisure activities quietly | | | | |
| 60. Shy, withdrawn | | | | |
| 61. Blames others for his/her mistakes or misbehavior | | | | |
| 62. Fidgeting | | | | |
| 63. Messy or disorganized at home or school | | | | |
| 64. Gets upset if someone rearranges his/her things | | | | |
| 65. Clings to parents or other adults | | | | |
| 66. Disturbs other children | | | | |
| 67. Deliberately does things that annoy other people | | | | |
| 68. Demands must be met immediately — easily frustrated | | | | |
| 69. Only attends if it is something he/she is very interested in | | | | |
| 70. Spiteful or vindictive | | | | |
| 71. Loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools or toys) | | | | |
| 72. Feels inferior to others | | | | |
| 73. Seems tired or slowed down all the time | | | | |
| 74. Spelling is poor | | | | |
| 75. Cries often and easily | | | | |
| 76. Leaves seat in classroom or in other situations in which remaining seated is expected | | | | |
| 77. Mood changes quickly and drastically | | | | |
| 78. Easily frustrated in efforts | | | | |
| 79. Easily distracted by extraneous stimuli | | | | |
| 80. Blurts out answers to questions before the questions have been completed | | | | |

Thank you for your time and patience in filling out this information. Please mail before your scheduled appointment. If unable to mail before please bring this along with you for your first appointment.

Please feel free to use the facing page to provide additional information