Welcome to the Developmental Medicine Center at Boston Children's Hospital

Thank you for your interest in the Developmental Medicine Center (DMC). We provide:

- High quality diagnostic and follow-up care for children with developmental concerns and their families such as:
  - Autism Spectrum Disorders
  - Attention Disorders (ADD/ADHD)
  - Developmental Delays
- Initial appoints may be with one of the following providers or team of providers:
  - Developmental Pediatrician
  - 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
   Developmental Medicine Center-Fegan 10
   Attn.: Intake Coordinators
   300 Longwood Avenue
   Boston, MA 02115
   Email: DMCIntake@childrens.harvard.edu
   Fax: 617-730-0252

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 Developmental Medicine Center does not prove evaluations for child abuse and neglect, custody determination, immediate sociality, IQ testing for gifted placement, or assessment for acute psychiatric conditions. If you need any of the above series, 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 at 617-355-7025.

Thank you,

Lisa Prock, MD, MPH
Director
Developmental Medicine Center

Elaine LeClair, PhD
Director, Pediatric Psychology
Developmental Medicine Center

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 co0ntacting 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 you 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:** _____

Boston Children's Hospital
Until every child is well™

the Developmental Medicine Center
at Children's Hospital Boston

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 urgent medical 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 Developmental Medicine 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 Developmental Medicine Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (e.g. pediatrician, nurse practitioner):	
Date of last physical exam:	
Has your child been seen in the Developmental Medicine Center before?	☐ Y ☐ N If yes, when?
	Was this for: ☐ a team visit ☐ an appointment with a single provider

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

*__Do any of the following apply to this child?__

DCF (formerly DSS) involvement	☐ Y ☐ N
DDS (formerly DMR) involvement	☐ Y ☐ N
Lives in residential facility	☐ Y ☐ 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	☐ Y, in the past	☐ Y, current	☐ N
Individualized Family Service Plan (IFSP)	☐ Y, in the past	☐ Y, current	☐ N
School (TEAM, CORE) evaluation *If yes, when?*	☐ Y, in the past	☐ Y, current	☐ N
Has/does your child have an Individualized Education Plan (IEP)? If yes, date?	☐ Y, in the past	☐ Y, current	☐ N
504 Plan *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Attends a special needs daycare/preschool	☐ Y, in the past	☐ Y, current	☐ N
Receiving ☐speech ☐occupational ☐physical therapy	☐ Y, in the past	☐ Y, current	☐ N
Participates in Summer School or Extended School Year (ESY) services	☐ Y, in the past	☐ Y, current	☐ N
Psychological testing? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Mental health counseling or behavioral therapy? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
School disciplinary actions, including detention, suspension or expulsion? *If yes, specify & date?*	☐ Y, in the past	☐ Y, current	☐ N
Stay in psychiatric hospital	☐ Y, in the past	☐ Y, current	☐ 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.**

<u>This information may be necessary for the Developmental Medicine Center to get authorization from your insurance company.</u>

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

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

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

Developmental Problems:
- ☐ Speech delay
- ☐ Developmental Delay
- ☐ Behavior problems
- ☐ Autism
- ☐ Attention problems (ADD/ADHD)
- ☐ Learning problems

Mental Health Problems:
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Mood Disorder (Depression, Bipolar, Suicide thoughts or attempts)
- ☐ Psychosis or Schizophrenia
- ☐ Child has had a stay in a psychiatric hospital

*If yes, when/where?

Neurological Problems:
- ☐ Epilepsy/seizures
- ☐ Cerebral Palsy
- ☐ Hearing problems
- ☐ Sleep problems
- ☐ Tics or Tourette
- ☐ Vision problems
- ☐ Head injury
- ☐ Motor delays
- ☐ Headaches

Genetic Disorders:
- ☐ Down Syndrome/trisomy 21
- ☐ Other chromosomal abnormalities
- ☐ Metabolic disorder

General Medical Problems:
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Congenital heart problem
- ☐ Overweight/Obesity
- ☐ Growth problems
- ☐ Underweight/Failure to thrive
- ☐ Allergies
- ☐ Skin problems (rashes, eczema)
- ☐ Respiratory (asthma, pneumonia)
- ☐ Diabetes
- ☐ Thyroid
- ☐ Kidney/urinary problems
- ☐ Cancer
- ☐ Gastrointestinal problems (vomiting, feeding problems, abdominal pain, reflux, constipation, diarrhea)

Surgical History:
Has your child ever had any surgeries? If yes, please list below:

Any other specific medical concerns?

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	☐ Y ☐ N ☐ Don't know	
EEG	☐ Y ☐ N ☐ Don't know	
CT scan or MRI of the head	☐ Y ☐ N ☐ Don't know	
Sleep study	☐ Y ☐ N ☐ Don't know	
Hearing test	☐ Y ☐ N ☐ Don't know	
Vision test	☐ Y ☐ N ☐ Don't know	

***Review of Systems**

General/constitutional:
- ☐ Significant behavioral changes
- ☐ Significant weight loss or gain
- ☐ Weakness or fatigue
- ☐ Fever or chills

Allergy:
- ☐ Itchy or watery eyes
- ☐ Itchy or runny nose, sneezing
- ☐ Hives
- ☐ Needed to use Epi-Pen

Gastrointestinal:
- ☐ Changes in appetite
- ☐ Abdominal pain or discomfort
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating, indigestion
- ☐ Nausea, vomiting
- ☐ Change in bowel habits (number/consistency)
- ☐ Blood in stool
- ☐ Jaundice (yellow skin or eyes), itching

Neurological:
- ☐ Headaches
- ☐ Dizziness, vertigo
- ☐ Weakness
- ☐ Seizures, convulsions
- ☐ Sleep problems
- ☐ Fainting, blackouts
- ☐ Numbness, tingling
- ☐ Head injuries, concussions
- ☐ Trouble walking
- ☐ Tremor, unusual motor movement (tics)
- ☐ Problems with coordination
- ☐ Problems with concentration, memory

*__Review of Systems (continued)__

Heart: ☐ Chest pain or pressure ☐ Heart racing, skipped beats ☐ Ankle swelling, cold/blue hands, feet ☐ Fainting, fatigue with exercise	**Lungs:** ☐ Cough ☐ Shortness of breath, wheezing ☐ Recent chest X-ray
Eyes, Ears, Nose, Throat: ☐ Sore throats ☐ Ear infections ☐ Sinus infections ☐ Loud snoring, irregular breathing during sleep ☐ Problems with eyes/vision ☐ Problems with ears/hearing	**Bones, joints, and muscles:** ☐ Joint pain, stiffness, swelling ☐ Fingers painful/blue in cold ☐ Dry mouth, red eyes ☐ Back, neck pain ☐ Muscle problems ☐ Fractures, broken bones ☐ Sprains
Endocrine: ☐ Sweating ☐ Fatigue ☐ Hand trembling ☐ Neck swelling ☐ Skin, hair, voice changes ☐ Thirst ☐ Growth difficulties	**Genitourinary:** ☐ Nighttime bedwetting ☐ Daytime urine accidents ☐ Pain with urination ☐ Frequent urination ☐ Blood in urine ☐ Genital rashes or lumps ☐ Heavy or painful menses (periods)
Skin: ☐ Rashes ☐ Changes in mole or spot ☐ Needed stitches	**Hematologic:** ☐ Bruise easily, difficulty stopping bleeding ☐ 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	☐ Y ☐ N	
Use tobacco	☐ Y ☐ N	If yes: how much?
Drink alcohol	☐ Y ☐ N	If yes: how much?
Take drugs or medications	☐ Y ☐ 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?	☐ Y ☐ N or numbers of weeks gestation at birth:
What was the delivery method? *If cesarean, please describe why:*	☐ vaginal ☐ cesarean (C-section)
Were there any prenatal or neonatal complications? *If yes, please describe:*	☐ Y ☐ N
Was a NICU or extended hospital stay required? *If yes, please describe:*	☐ Y ☐ N

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		☐	☐	☐	☐
Crawled		☐	☐	☐	☐
Stood without support		☐	☐	☐	☐
Walked without assistance		☐	☐	☐	☐
Spoke first words		☐	☐	☐	☐
Said phrases		☐	☐	☐	☐
Said sentences		☐	☐	☐	☐
Bowel trained		☐	☐	☐	☐
Bladder trained, day		☐	☐	☐	☐
Bladder trained, night		☐	☐	☐	☐

****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 Developmental Medicine 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

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at Children's Hospital Boston

EARLY CHILDHOOD SCREENING ASSESSMENT:

Check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	☐	☐	☐	☐
2. Is difficult to comfort when hurt or distressed	☐	☐	☐	☐
3. Loses temper too much	☐	☐	☐	☐
4. Avoids situations that remind him/her of scary events	☐	☐	☐	☐
5. Is easily distracted	☐	☐	☐	☐
6. Hurts others on purpose (biting, hitting, kicking)	☐	☐	☐	☐
7. Doesn't seem to listen to adults talking to him/her	☐	☐	☐	☐
8. Battles over food and eating	☐	☐	☐	☐
9. Is irritable, easily annoyed	☐	☐	☐	☐
10. Argues with adults	☐	☐	☐	☐
11. Breaks things during tantrums	☐	☐	☐	☐
12. Is easily startled or scared	☐	☐	☐	☐
13. Tries to annoy people	☐	☐	☐	☐
14. Has trouble interacting with other children	☐	☐	☐	☐
15. Fidgets, can't sit quietly	☐	☐	☐	☐
16. Is clingy, doesn't want to separate from parent	☐	☐	☐	☐
17. Is very scared of certain things (needles, insects)	☐	☐	☐	☐
18. Seems nervous or worries a lot	☐	☐	☐	☐
19. Blames other people for mistakes	☐	☐	☐	☐
20. Sometimes freezes or looks very still when scared	☐	☐	☐	☐
21. Avoids foods that specific feelings or tastes	☐	☐	☐	☐
22. Is too interested in sexual play or body parts	☐	☐	☐	☐
23. Runs around in settings when should sit still	☐	☐	☐	☐
24. Has a hard time paying attention to tasks or activities	☐	☐	☐	☐
25. Interrupts frequently	☐	☐	☐	☐
26. Is always "on the go"	☐	☐	☐	☐
27. Reacts too emotionally to small things	☐	☐	☐	☐
28. Is very disobedient	☐	☐	☐	☐
29. Has more picky eating than usual	☐	☐	☐	☐
30. Has unusual repetitive behaviors (rocking, flapping)	☐	☐	☐	☐
31. Might wander off if not supervised	☐	☐	☐	☐
32. Has a hard time falling asleep or staying asleep	☐	☐	☐	☐
33. Doesn't seem to have much fun	☐	☐	☐	☐
34. Is too friendly with strangers	☐	☐	☐	☐
35. Has more trouble talking or learning to talk than others	☐	☐	☐	☐
36. Is learning or developing more slowly than other children	☐	☐	☐	☐
Are you concerned about this child's emotional or behavioral development (please only circle one)?	☐ Yes	☐ Somewhat		☐ No

Please tell us how much of a problem each one has been for you. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
I feel too stressed to enjoy my child	☐	☐	☐	☐
I get more frustrated than I want to with my child's behavior	☐	☐	☐	☐
I feel down, depressed, or hopeless	☐	☐	☐	☐
I feel little interest or pleasure in doing things	☐	☐	☐	☐

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.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time show impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**Needs 24-hour <u>professional</u> care and supervision** due to sever e 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

Early Childhood Educational Questionnaire

Child's Name: *Last _____ *First _____

*Date of Birth: _____ *Gender: ☐**M** ☐**F** ☐**Other**

Child' classroom/age level: _____

Please have early intervention, child care and/or school personnel fill out and return

Child Care/School: _____

Child Care/School 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 improvement?

Please describe the child's strengths.

Please describe any other concerns you have about this child.

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

If yes, what language? _____

ACADEMIC READINESS: Please check the appropriate column

	Not Yet	Progressing	Proficient
A. Basic Concepts			
1. Knows colors	☐	☐	☐
2. Knows letters of alphabet	☐	☐	☐
3. Knows numbers and counts past 10	☐	☐	☐
4. Adds and subtracts things	☐	☐	☐
5. Size concepts	☐	☐	☐
6. Location concepts	☐	☐	☐
B. Language and Communication			
1. Uses speech to communicate	☐	☐	☐
2. Explains and describes things	☐	☐	☐
3. Rhymes words and remembers poems/songs	☐	☐	☐
4. Uses uncommon words	☐	☐	☐
5. Uses long sentences	☐	☐	☐
6. Tells or retells stories or events	☐	☐	☐
7. Speaks understandably	☐	☐	☐
8. Follows oral instructions on level with peers	☐	☐	☐
9. Uses correct grammar (e.g. verb tense)	☐	☐	☐
10. Uses sign language or other communication system	☐	☐	☐
11. Follows classroom routine	☐	☐	☐
C. Emergent Literacy			
1. Listens to stories in books	☐	☐	☐
2. Asks questions about words	☐	☐	☐
3. Reads words on signs and labels	☐	☐	☐
4. Reads words in books	☐	☐	☐
5. Recites books from memory	☐	☐	☐
6. Reads "easy" books	☐	☐	☐
7. Writes or copies words	☐	☐	☐
8. Dictates stories	☐	☐	☐
9. Writes "little" stories	☐	☐	☐
10. Answers questions about orally read story	☐	☐	☐
D. Motor Skills			
1. Constructs puzzles or builds things	☐	☐	☐
2. Uses pencils and pens correctly	☐	☐	☐
3. Uses scissors well	☐	☐	☐
4. Copies and traces shapes	☐	☐	☐
5. Draws recognizable objects	☐	☐	☐
6. Is coordinated in outdoor recess activities	☐	☐	☐
7. Ties shoe laces	☐	☐	☐

EARLY CHILDHOOD SCREENING ASSESSMENT:

Please check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	☐	☐	☐	☐
2. Is difficult to comfort when hurt or distressed	☐	☐	☐	☐
3. Loses temper too much	☐	☐	☐	☐
4. Avoids situations that remind him/her of scary events	☐	☐	☐	☐
5. Is easily distracted	☐	☐	☐	☐
6. Hurts others on purpose (biting, hitting, kicking)	☐	☐	☐	☐
7. Doesn't seem to listen to adults talking to him/her	☐	☐	☐	☐
8. Battles over food and eating	☐	☐	☐	☐
9. Is irritable, easily annoyed	☐	☐	☐	☐
10. Argues with adults	☐	☐	☐	☐
11. Breaks things during tantrums	☐	☐	☐	☐
12. Is easily startled or scared	☐	☐	☐	☐
13. Tries to annoy people	☐	☐	☐	☐
14. Has trouble interacting with other children	☐	☐	☐	☐
15. Fidgets, can't sit quietly	☐	☐	☐	☐
16. Is clingy, doesn't want to separate from parent	☐	☐	☐	☐
17. Is very scared of certain things (needles, insects)	☐	☐	☐	☐
18. Seems nervous or worries a lot	☐	☐	☐	☐
19. Blames other people for mistakes	☐	☐	☐	☐
20. Sometimes freezes or looks very still when scared	☐	☐	☐	☐
21. Avoids foods with specific textures or tastes	☐	☐	☐	☐
22. Is too interested in sexual play or body parts	☐	☐	☐	☐
23. Runs around in settings when should sit still	☐	☐	☐	☐
24. Has a hard time paying attention to tasks or activities	☐	☐	☐	☐
25. Interrupts frequently	☐	☐	☐	☐
26. Is always "on the go"	☐	☐	☐	☐
27. Reacts too emotionally to small things	☐	☐	☐	☐
28. Is very disobedient	☐	☐	☐	☐
29. Has more picky eating than usual	☐	☐	☐	☐
30. Has unusual repetitive behaviors (rocking, flapping)	☐	☐	☐	☐
31. Might wander off if not supervised	☐	☐	☐	☐
32. Has a hard time falling asleep or staying asleep	☐	☐	☐	☐
33. Doesn't seem to have much fun	☐	☐	☐	☐
34. Is too friendly with strangers	☐	☐	☐	☐
35. Has more trouble talking or learning to talk than others	☐	☐	☐	☐
36. Is learning or developing more slowly than other children	☐	☐	☐	☐
Are you concerned about this child's emotional or behavioral development (please only circle one)?	☐ Yes	☐ Somewhat	☐ No	

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.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time show impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**Needs 24-hour <u>professional</u> care and supervision** due to sever e behavior or gross impairment(s)

Please describe this child's social-emotional functioning, including moods and relationship with peers.

Please describe this child's behavior.

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

*Teacher Signature *Print Name *Date