UNC
SCHOOL OF MEDICINE

Dear Parent(s):

We are looking forward to meeting you and your child. To help us better serve you, we are requesting you return our new patient packet below and bring along documentation related to your child's psychiatric care. If you do not have documentation we will request to obtain these records from your child's past and current providers during your appointment.

Information to bring to your child's appointment includes the following, as applicable:

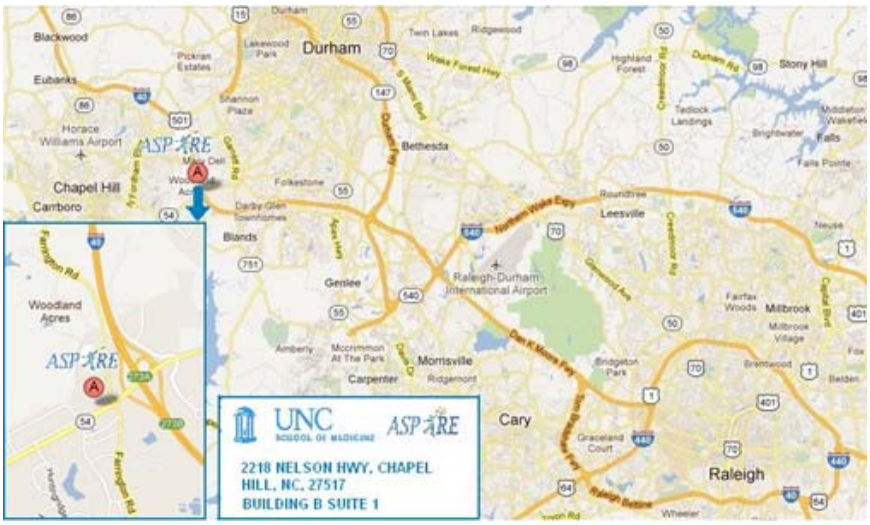
- Documentation regarding your child's mental health diagnosis
- Documentation regarding your child's academic functioning (e.g., IQ testing)
- Individual Educational Plan (IEP)
- Psychiatric inpatient hospitalization discharge paperwork
- Genetic or medical testing

We also recommend you bring along your personal calendar, as we may schedule future appointments.

Lastly, we have attached our site specific directions for your reference. Please contact us if you have any questions.

Sincerely,

The ASPIRE Research Team



If you have a GPS:

- Enter 2218 Nelson Highway (Suite 1) Chapel Hill, NC 27517 as an address

From Highway 54

- Travel **east** on highway 54 towards I-40
- Take a **left** at the stoplight on Huntingridge Road (this is before you reach I-40).
- Take an **immediate** right on Nelson Highway (which runs parallel to highway 54).
- Continue **straight** through the stop sign to the end of Nelson Highway
- Continue **past** Urgent Care and Central Dermatology which will be on the left.
- **Pass** the sign and building for Carolina Crossings, Building A
- Look for the sign for Carolina Crossings, Building B
- Turn **left** into the next parking lot
- Our building is directly to your **left** on the corner in Suite 1.

From I-40 (Raleigh/Cary)

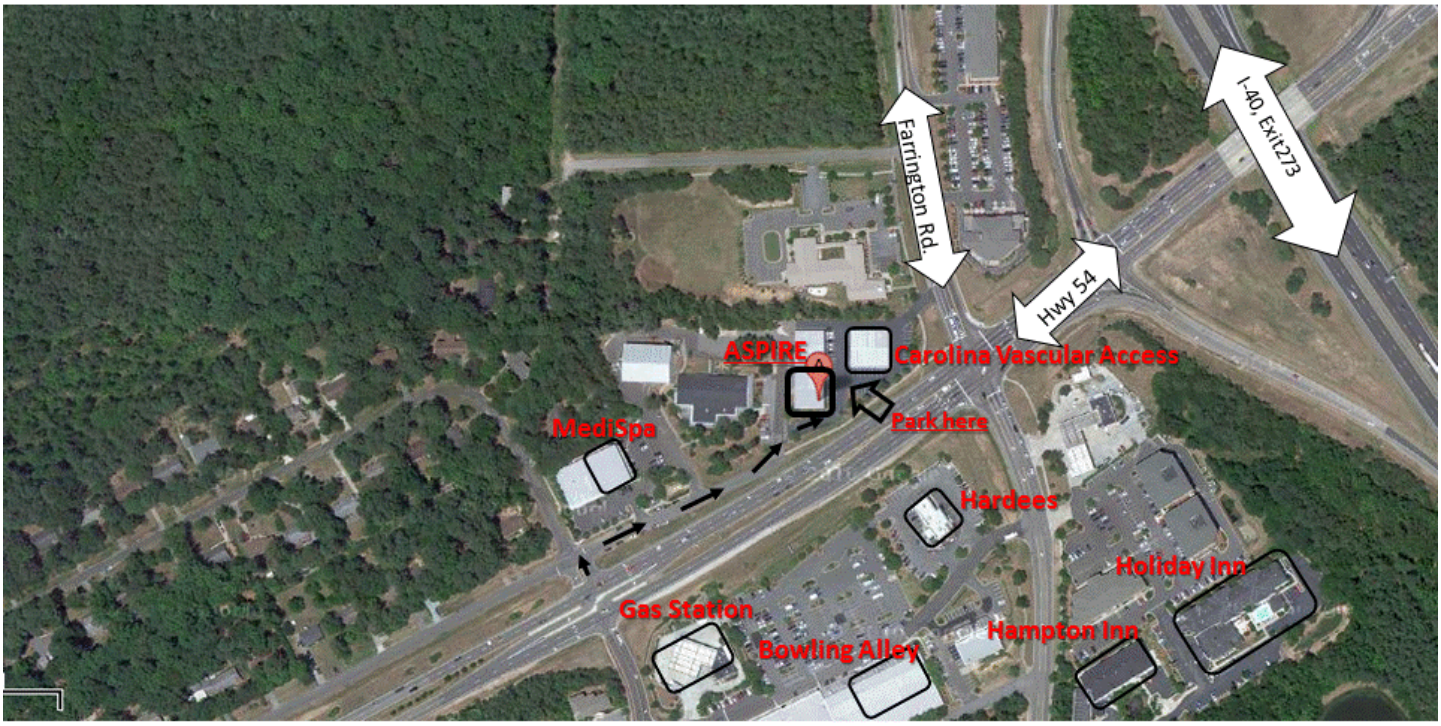
- Travel **West** on I-40
- Take exit **273A** for 54 **West** and merge on to 54 **West** (stay in the right lane)
- Take a **right** at the second stoplight on Farrington Road
- Make an immediate **left** into the parking lot before the church (look for the ASPIRE Research sign shown below)
- Take a **left** after you pass behind the first building (Carolina Vascular Access)
- Our building is on the **right**
- Our office (Suite 1) on the far **left** side of the building

From I-40 (Greensboro/Burlington)

- Travel **East** on I-40
- Take exit **273** for 54 **West**
- Take a **right** on to 54 **West** at the stoplight at the top of the exit ramp (stay in the right lane)
- Immediately take a **right** at the first stoplight on Farrington Road
- Make an immediate **left** into the parking lot before the church (look for the ASPIRE Research sign shown below)
- Take a **left** after you pass behind the first building (Carolina Vascular Access)
- Our building is on the **right**
- Our office (Suite 1) on the far **left** side of the building

Look for the ASPIRE direction signs for help with making turns!

Please feel free to park wherever you can find a space. Check in at the front desk and have a seat in the waiting room. If you are running late or get lost along the way, please call the front desk at 919-972-7500. **We are the building <u>BEHIND</u> Carolina Vascular Access. Look for the building with the American Flag.**


Farrington Rd.
I-40, Exit 273
Hwy 54
ASPIRE
Carolina Vascular Access
Park here
MediSpa
Hardees
Holiday Inn
Gas Station
Hampton Inn
Bowling Alley

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Today's Date: _____

Patient Demographic Information

_____	_____	_____
Patient's Full Name	Nickname	Date of Birth

_____	_____	_____	_____
Address	City	State	Zip Code

(_____)_____	(_____)_____
Telephone Number: Home	Telephone Number: Cell

Current Medical Care

_____	(_____)_____	
Pediatrician/Primary Care Doctor	Telephone	
_____	_____	_____
Previous Treatment at UNC, Medical Center (Yes or No)	If Yes, When	MRN, If Known

Current Mental Health Care

_____	(_____)_____	_____
Psychiatrist	Telephone	Location
_____	(_____)_____	_____
Therapist	Telephone	Location

Home Information

Please list everyone who **lives in the home** with your child. If he or she splits time between 2 homes, please list each home separately.

Name	**Age**	**Relationship to Patient**	**Highest Grade of School Completed (or current grade)**

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Family Information--If mother, father, brothers or sisters live **outside the home**, please list them here.

Name	Age	Relationship to Patient	Highest Grade of School Completed (or current grade)	Where do they live?

Adoption Status, if applicable:

Is your child adopted? ☐Yes ☐No

If yes, please provide details of the adoption including **age** of child when adopted _____, anything that is known about mental and physical health of biological parents and **circumstances** of the adoption:

Parent Marital Status

Parents' Marital Status (check): ☐Married ☐Divorced ☐Separated ☐Never Married	If parents are separated or divorced, who has physical custody? _____
How often does non-custodial parent see your child? _____	If divorced or separated, has either parent remarried? ☐Yes ☐No If yes, who? _____

Parents' or Caretakers Employment and Education

_____ Mother's Job/Profession	_____ Highest Level of Education	_____ Hours Worked Weekly
_____ Father's Job/Profession	_____ Highest Level of Education	_____ Hours Worked Weekly
_____ Caretaker's Job/Profession	_____ Highest Level of Education	_____ Hours Worked Weekly
Approximate Gross Family Yearly Income From All Sources(**optional**): $_____,000		

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Community Alternatives Program (CAP) for Children

Does your child have a CAP worker? □Yes □No

If yes, how many days per week does the CAP worker work with your child? _____

What are you hoping to obtain from your visit? (Please check all that apply)

☐Clear diagnosis	☐Potential participation in research
☐Medication Evaluation	☐Education on medication or diagnosis
☐New provider	☐Other, please explain:

Questions about your child

What is a typical weekday like for your child? Include times waking up, napping, lying down, falling asleep, school, activities, chores etc:
What is a typical weekend or holiday day like for your child?
What do you feel are your child's strengths?
What do you feel are your child's biggest challenges?
What do you like best about your child?

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What are the **MAJOR** problems for which the child is coming see us? (You may continue on the back.)
If multiple different problems try to answer the following questions for the biggest problem on this page and the others on the back.

How long have these problems been going on?

How long have these problems been going on?

How often do they occur?

Where do they occur?

What are the consequences of the problems on child's mood, school work, independence, relationships?

Are there things that you think make the problems worse or better?

Have the problems gotten better or worse since the time you first noticed them?

Please indicate any stressful events that you believe may be related to the problems noted above:

Current Medications for Problems Listed above or for other Medical Conditions

Name of Medication	Daily Dose, if known	What is it for?	How long has he/she been taking it?	Good Effects	Bad Effects

Current Therapy for Problems Listed above or for other Medical Conditions

Therapist Name	Phone/Fax	Primary Problem(s) addressed by therapist

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Medication Allergies

Is your child allergic to any medications? □Yes □No If yes, please list medication and allergic response:
Medication: _____ Allergic Response: _____
Medication: _____ Allergic Response: _____
Medication: _____ Allergic Response: _____

Past Psychiatric History of Child

Has your child had previous outpatient treatment for the problem(s) mentioned above or any other psychological or developmental problems? □Yes □No

If yes, please provide the following information:

Clinician Name	Type of Treatment	Diagnoses	Date Treatment Began	Date Treatment Ended

Previous Medications for these problems or other Psychological or Developmental issues

Name of Medication	Daily Dose, if known	What is it for?	How long has he/she been taking it?	Good Effects	Bad Effects

Self-Harm, Hospitalization, Legal, Trauma, and Drinking/Drug Use

Has your child ever tried to kill himself or herself ?	□Yes □No □Unknown	If yes, How many times? _____ When? _____ What happened?
Has your child ever hurt him or herself without intending to die, for example cutting or burning self?	□Yes □No □Unknown	If yes, How? _____ How often? _____ When did this start? _____ _____ Is it still going on □Yes □No □Unknown
Has your child ever seriously hurt someone else?	□Yes □No □Unknown	If yes, How many times? _____ When? _____ What happened?

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Self-Harm, Hospitalization, Legal, Trauma, and Drinking/Drug Use…Continued

Has your child ever been hospitalized for psychiatric, drug or neurological problems?	□Yes □No □Unknown	If yes, how many times? _____ When?_____ Where?_____ Reason:_____ _____
Has your child ever been involved with police, juvenile court/probation officer?	□Yes □No □Unknown	If so, what happened?
Has your child ever been involved with Child Protective Services?	□Yes □No □Unknown	If so, what happened?
Do you have any concerns that your child may have been abused in any way?	□Yes □No □Unknown	If so, please tell us what your concerns are?
Do you have any concerns that your child may have been or may be being bullied?	□Yes □No □Unknown	If so, please tell us what your concerns are?
Do you have any concerns that your child has ever had issues with drinking or using drugs	□Yes □No □Unknown	If so, please tell us what your concerns are?
Has your child ever been exposed to anything that was really traumatic to him or her (like sever e accident or injury, disaster, someone close dying)?	□Yes □No □Unknown	If so, please tell us about the event.

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Development and Pregnancy

Did mom have any medical problems during her pregnancy?	□Yes □No □Unknown	If so, what?
Did mom take any medicines during her pregnancy?	□Yes □No □Unknown	If so, what?
Did mom smoke, drink alcohol, use nonprescribed drugs or have any other problems while pregnant?	□Yes □No □Unknown	If so, please explain?

Labor

Was this child born late or early?	□Yes □No □Unknown	If so, when:
Normal delivery	□Yes □No □Unknown	
C-section: emergency? planned or repeat?	□C-section □Emergency □Planned □Repeat	Please describe:
Fetal bradycardia (slow heart rate)?	□Yes □No □Unknown	If yes, please describe:
Other Problems	□Yes □No □Unknown	If yes, please describe:

Condition at Birth

Birthweight of child: _____ Pounds _____Ounces Apgar scores ? _____

Jaundice?	□Yes	□No	□Unknown
Transfusions required?	□Yes	□No	□Unknown
Was the infant kept in the hospital (NICU: Neonatal Intensive Care) longer than the mother?	□Yes If yes, why?	□No	□Unknown
Did the mother experience postpartum depression?	□Yes	□No	□Unknown

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Infancy and Early Childhood

Who were the primary caretakers during your child's infancy and childhood? Did the child attend preschool? At what age? Were there any problems with preschool?

Infancy and Early Childhood

Feeding problems?	□Yes □No □Unknown
Sleeping problems?	□Yes □No □Unknown
Bonding problems	□Yes □No □Unknown
How would you describe your baby's temperament?	□Happy □Always Crying □Tense □Easy-Going □Soothable □Other
Was your child unusually sensitive to clothing, movement, touch, light, etc.?	□Yes □No □Unknown
Did your young child become overstimulated in a noisy environment?	□Yes □No □Unknown
How did your child interact with other kids?	Please Comment:

Milestones

In general, did your child meet development milestones	□Earlier than normal □Within normal limits □Somewhat later than normal
Age baby walked unassisted	
Age baby spoke first words	
Age baby put 2-3 words together in a sentence	
Age at toilet training	
Any other information you would like to tell us about your child's early development?	

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Loss of Skills

Did your child have a period of time in which he/she seemed to lose a great number of skills?	□Yes □No □Unknown If yes, how old was your child_____ How long did this period last?_____months

Friends

Does your child have friends?	□Yes □No □Unknown
Has there have been a period of time when your child had a hard time making or keeping friends?	□Yes □No □Unknown

School Information, if applicable

_____ Patient's School	_____ Public or Private	_____ School #	_____ Name of School
_____ Patient's Teacher	_____ Grade		_____ Classroom Size
If not attending school, what is the school situation?			

Academic History

Has your child ever repeated a grade?	□Yes □No □Unknown	If so, which one(s)
Has your child ever skipped a grade?	□Yes □No □Unknown	If so, which one(s):

How many schools has your child attended?

What were the reasons for any moves?

Has your child received educational or language testing? □Yes □No

If so, by whom? What were the results?

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Has your child received speech therapy? □Yes □No

If so, by whom? _____ When was the most recent speech therapy session? _____

If current receiving speech therapy, how frequently? _____

Has your child received occupational therapy? □Yes □No

If so, by whom? _____ When was the most recent occupational therapy session? _____

If current receiving occupational therapy, how frequently? _____

Has your child ever had an IEP or 504 Plan? □Yes □No

If yes: What was the date of the most recent IEP or 504 Plan Meeting?

If yes: What are the special services or accommodations he/she received?

Classroom Environment

Does your child attend EC courses? □Yes □No How many?_____

Does your child attend mainstream courses? □Yes □No How many?_____

Has your child had any previous hospitalizations, surgery, or major illnesses? □Yes □No □Unknown

If yes, please list below:

Nature of medical problem	Dates of treatment/illness	Outcome of condition/treatment

Has your child had any of the following?

Traumatic head injuries	□Yes □No □Unknown	If yes, please explain
Heart problems	□Yes □No □Unknown	If yes, please explain
Seizures	□Yes □No □Unknown	If yes, please explain
Genetic testing	□Yes □No □Unknown	If yes, please explain

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Allergies to medications	□Yes □No □Unknown	If yes, please specify
Other allergies (e.g., specific food allergies, ragweed, cats, etc.):	□Yes □No □Unknown	If yes, please specify
Chronic earaches	□Yes □No □Unknown	If yes, how many? Age 0-2_____ Tubes? _____ Age 2-4_____ Tubes? _____ Age 4-6_____ Tubes? _____
Frequent headaches	□Yes □No □Unknown	How often?
Frequent stomachaches	□Yes □No □Unknown	How often?
Last hearing test (month/year)		
Last vision test (month/year)		

Family Stressors (check any that apply):

☐Marital Conflicts	☐Parent Child Conflicts	☐Medical problems
☐Financial Problems	☐Physical Illness	☐Sexual/physical
☐Domestic Violence	☐Drug alcohol/abuse by parent	☐Frequent Moves
☐Multiple Caretakers	☐Recent Significant Deaths	☐Other

Has any family member committed suicide?	□Yes □No □Unknown	If yes, please explain
Are there any guns in the house or in the house of close friends or relatives?	□Yes □No □Unknown	If yes, please explain

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Family History – Please check all that apply.

	Psychiatric															Medical				Etc.	
	Depression	Anxiety	Panic Attacks	Post Traumatic Stress Disorder	Suicide	Drug Abuse	Alcoholism	Bipolar (manic/depressive)	Schizophrenia	Autism	ADHD	Learning Disability	Hyperactivity	Childhood Behavioral Problems	Personality Disorders	High Blood Pressure	Heart Problems	Diabetes	Overweight	School/Academic Problems	Legal Issues
Biological Father's Side																					
Father																					
Grandfather																					
Grandmother																					
Aunts																					
Uncles																					
Biological Mother's Side																					
Mother																					
Grandfather																					
Grandmother																					
Aunts																					
Uncles																					
Siblings																					
Other Individuals Significant to Patient (List Below)																					

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Current Functioning

Please place an "x" on the following scale to indicate how well you think your child is functioning compared to other children. 100% means the your child is functioning as well as most children.

At home: 0%--------10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%-------90%-------100%

At school: 0%--------10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%-------90%-------100%
If there is **anything else** you would like to tell us about **your child's situation**, please use the space here:

Problem Checklist

Circle the choice that best describes *YOUR* child.

- **I *don't know*=unknown**
- **This does *not* apply to my child=0**
- **This does apply to my child, at least *some* of the time=1**
- **This applies to my child *often*=2**

Depressed mood	□Unknown □0 □1 □2
Lack of interest or motivation, boredom	□Unknown □0 □1 □2
Withdrawal from friends**?**	□Unknown □0 □1 □2
Changes in: □ sleep □ appetite, or □ weight	□Unknown □0 □1 □2
Multiple unfounded medical complaints	□Unknown □0 □1 □2
Decreased self-esteem	□Unknown □0 □1 □2
Excessive self-blame and guilt	□Unknown □0 □1 □2
Suicidal behavior or thoughts	□Unknown □0 □1 □2
Increased tearfulness or rapid changes of mood	□Unknown □0 □1 □2
Has a hard time making, keeping friends	□Unknown □0 □1 □2
Increased irritability, hard to please, overly sensitive to others	□Unknown □0 □1 □2
Rages that last an hour or more	□Unknown □0 □1 □2
Sudden drop into depression	□Unknown □0 □1 □2
Speech that is rapid and continuous	□Unknown □0 □1 □2
Inflated beliefs about self and abilities	□Unknown □0 □1 □2
Decrease in need for sleep	□Unknown □0 □1 □2
Wakes up very early on his/her own?	□Unknown □0 □1 □2
Has periods when is very active or productive and others when doesn't do much?	□Unknown □0 □1 □2
Is overly interested in sexual things	□Unknown □0 □1 □2

Overreacts to small negative events	□Unknown □0 □1 □2
Overactive or fidgets constantly	□Unknown □0 □1 □2
Easily distracted or inattentive	□Unknown □0 □1 □2
Impulsive	□Unknown □0 □1 □2
Difficulty following through on instructions	□Unknown □0 □1 □2
Loses things easily	□Unknown □0 □1 □2
Shifts from one incomplete activity to another	□Unknown □0 □1 □2
Often blames others for his/her mistakes or misbehaviors	□Unknown □0 □1 □2
Consistently refuses to comply with reasonable rules	□Unknown □0 □1 □2
Defiant towards authority	□Unknown □0 □1 □2
Loses his/her temper often	□Unknown □0 □1 □2
Steals, forgery, breaking and entering	□Unknown □0 □1 □2
Running away from home, school truancy	□Unknown □0 □1 □2
Fire-setting	□Unknown □0 □1 □2
Physical fights	□Unknown □0 □1 □2
Homicidal behaviors or plans	□Unknown □0 □1 □2
Dangerous behavior or plans	□Unknown □0 □1 □2
Lying	□Unknown □0 □1 □2
Using obscene language	□Unknown □0 □1 □2
Deliberate cruelty to animals or people	□Unknown □0 □1 □2
Sexual abuse of others	□Unknown □0 □1 □2
Binge eating	□Unknown □0 □1 □2
Overuse of laxatives, diuretics, or diet pills	□Unknown □0 □1 □2
Fasting or strict dieting not prescribed by a doctor	□Unknown □0 □1 □2
Persistent concern with body shape/weight	□Unknown □0 □1 □2
Excessive exercise or preoccupation with exercise	□Unknown □0 □1 □2
Fearful about being separated from caregiver (at school, at night, being left with a sitter)	□Unknown □0 □1 □2
Fears that harm will come to caregiver or to the child during absences (killed, kidnapped, accident)	□Unknown □0 □1 □2
Painfully or excessively shy when with unfamiliar people	□Unknown □0 □1 □2
Startles easily, seems on edge	□Unknown □0 □1 □2
Stuck on traumatic event	□Unknown □0 □1 □2
Nightmares about past event (If so, how frequent_____?	□Unknown □0 □1 □2
Preoccupation with cleanliness, excessive hand-washing or peculiar orderliness	□Unknown □0 □1 □2
"Habits" or rituals that child just cannot seem to help	□Unknown □0 □1 □2
Has unpleasant, persistent thoughts, or unnecessary worries	□Unknown □0 □1 □2

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Never talks outside the home, limits who he/she will talk to	□Unknown □0 □1 □2
Abnormal movements, jerks or tics of the head, shoulders, mouth, upper or lower body	□Unknown □0 □1 □2
History of frequent coughing, throat clearing, stuttering, or unusual noises	□Unknown □0 □1 □2
Difficulty understanding spoken directions with many steps or long sentences	□Unknown □0 □1 □2
Needs someone to "interpret" what someone else has said	□Unknown □0 □1 □2
Difficulty expressing ideas or feelings, fully answering questions	□Unknown □0 □1 □2
Difficulty following television programs	□Unknown □0 □1 □2
Doesn't understand gestures or facial expressions of others	□Unknown □0 □1 □2
Doesn't make good eye contact	□Unknown □0 □1 □2
Restricted or repetitive patterns of behavior, interests, activities or routines	□Unknown □0 □1 □2
Difficulty following social rules (when/how to interrupt, taking turns, personal space)	□Unknown □0 □1 □2
Does not play well or interact with other children; prefers to play alone	□Unknown □0 □1 □2
Unusual fascination with objects (not toys)	□Unknown □0 □1 □2
Has strange ideas, bizarre behavior, unusual worries or thoughts	□Unknown □0 □1 □2
Asks if you've called when you haven't	□Unknown □0 □1 □2
Lies about obvious or unimportant things	□Unknown □0 □1 □2
Sees or hears things that others do not	□Unknown □0 □1 □2
Speech does not make sense to others (loosely connected ideas, rambling, etc.)	□Unknown □0 □1 □2
Loner, avoids social contact	□Unknown □0 □1 □2
Fights for control over everything, bossy with other children	□Unknown □0 □1 □2
Engages in hoarding or gorging on food	□Unknown □0 □1 □2
Stealing	□Unknown □0 □1 □2
Destruction of own or others' things	□Unknown □0 □1 □2
Clingy	□Unknown □0 □1 □2
Avoids physical contact	□Unknown □0 □1 □2
Indiscriminately affectionate with strangers	□Unknown □0 □1 □2
Stool accidents	□Day □Night
Wetting accidents	□Day □Night
Substance use, abuse, or suspected abuse	□Alcohol □Marijuana □Hallucinogens □Heroin □Prescription Drugs □Cocaine □Ectasy
Others?	Please describe:

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Please check off any of the following behaviors which describe your child, both as he/she is now and was in the past. You may check more than one:

Speech	Current	Past
Speech developing too slowly		
Repeats questions instead of answering them		
Hard to understand what he/she is saying		
Unusual tone or pitch		
Seldom speaks unless prodded		
Says some words or phrases over and over		
Has language of his/her own (maybe sounds like foreign language), jargon babbles		
Doesn't seem to understand what is said to him/her without gestures		
No speech currently		

Relating to Other People	Current	Past
Not cuddly		
Prefers to be by self		
"In world of his/her own"		
Ignores people generally		
Aloof, distant		
"Clings" to people		
Doesn't recognize parents		
Very fearful of strangers		
Likes to be held		
Doesn't play with other children		
Prefers to play with younger children		
Other	Please describe:	

Imitation	Current	Past
Doesn't imitate waving "bye bye" patty cake", etc. (physical imitation)		
Doesn't repeat words said to him/her (verbal imitation)		
Doesn't repeat words generally, but usually will do what he/she is asked to do		

Visual Response	Current	Past
Often avoids looking at people when they are talking to him/her		
Fascinated by lights - stares at certain ones		
Stares vacantly around room		
Often doesn't look at anything		
Very interested in small parts of an object		
Likes to look at self in mirror		
Likes to look at shiny objects		
Stares at parts of body (hands)		
Seems to look at things out of the corner of his/her eye and not by looking directly at them		
Plays with turning lights on and off		

Response to Sounds, Speech	Current	Past
Often ignores what is said to him/her (speech)		
Often ignores sounds		
Afraid of certain sounds		
Seems to hear distant or soft sounds which most other people notice		
Really likes certain sounds (for example, music or motors)		
Unpredictable response to sounds (sometimes reacts, sometimes doesn't)		
Responds to speech and sounds like other children his age		
Other	Please Describe:	

Other Senses	Current	Past
Puts many objects in mouth		
Licks objects		
Tries to chew or eat objects that are not supposed to be eaten (for example, clay)		
Doesn't seem to notice if something tastes bad		
	Current	Past

Other senses, cont.		
Smells objects not usually smelled or smells unfamiliar objects		
Doesn't notice pain as much as most people		
Overreacts to pain		
Likes vibrations		

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Coordination	Current	Past
Clumsy, awkward when running, jumping, etc		
Has trouble using hands for fine work		

Non-Verbal Communication	Current	Past
Does not let you know what he/she wants with gestures (without speech)		
Takes your hand for help, or lead you to what he/she wants		

Emotional Responses	Current	Past
temper tantrums		
mood change very quickly, sometimes for no apparent reason		
often has blank expression on face – little response to what is happening around him/her		
over-responds to situations		
laughs or smiles for no apparent reason		
cries or seems sad for no apparent reason		

Use of Body	Current	Past
rocks from foot to foot		
rocks in bed or chair		
holds hands in strange positions		
wiggles hands or fingers in strange ways		
has unusual posture		
bites himself/herself		
masturbates		
bangs head		
Spins or twirls himself/herself		
walks on tiptoes		
nothing unusual about his body		
Other	Please Describe:	

Use of Materials and Objects	Current	Past
Has strong attachment to a particular object		
Spins wheels or small parts of toys		
Dangles strings, straws, etc		
Doesn't play with toys as they are supposed to be used		
Gets involved in a simple activity for long periods of time		
Plays with toys appropriately		
Other	Please Describe:	

Activity Level	Current	Past
Often overactive		
Often underactive		
Both overactive and underactive		
Activity level appropriate to age		
Other	Please Describe:	

Eating	Current	Past
Likes only a few foods		
Has trouble chewing		
Poor appetite		

Reaction to Change	Current	Past
Gets upset when routine changes		
Will wear only certain clothes		
Gets upset if objects in house are moved (furniture, his place at the table, etc)		
Age appropriate adaptability to change		
Other	Please Describe:	

Please rate your child's behavior for the last four weeks. For each item, decide whether the behavior is a problem and circle the appropriate number.	***Not at all a problem***	***Behavior is a problem, but slight in degree***	***Problem is moderately serious***	***Problem is severe in degree***
1. Excessively active at home, school, work or elsewhere ...	0	1	2	3
2. Injures self on purpose	0	1	2	3
3. Listless, sluggish, inactive	0	1	2	3
4. Aggressive to other children or adults (verbally or physically)	0	1	2	3
5. Seeks isolation from others	0	1	2	3
6. Meaningless, recurring body movements	0	1	2	3
7. Boisterous (inappropriately noisy and rough)	0	1	2	3

	Not at all a problem	*Behavior is a problem, but slight in degree*	*Problem is moderately serious*	*Problem is severe in degree*
8. Screams inappropriately	0	1	2	3
9. Talks excessively	0	1	2	3
10. Temper tantrums/outbursts	0	1	2	3
11. Stereotyped behavior; abnormal, repetitive movements	0	1	2	3
12. Preoccupied; stares into space	0	1	2	3
13. Impulsive (acts without thinking)	0	1	2	3
14. Irritable and whiny	0	1	2	3
15. Restless, unable to sit still	0	1	2	3
16. Withdrawn; prefers solitary activities	0	1	2	3
17. Odd, bizarre in behavior	0	1	2	3
18. Disobedient; difficult to control	0	1	2	3
19. Yells at inappropriate times	0	1	2	3
20. Fixed facial expression; lacks emotional responsiveness	0	1	2	3
21. Disturbs others	0	1	2	3
22. Repetitive speech	0	1	2	3
23. Does nothing but sit and watch others	0	1	2	3
24. Uncooperative	0	1	2	3
25. Depressed mood	0	1	2	3
26. Resists any form of physical contact	0	1	2	3
27. Moves or rolls head back and forth repetitively	0	1	2	3
28. Does not pay attention to instructions	0	1	2	3
29. Demands must be met immediately	0	1	2	3
30. Isolates himself/herself from other children or adults	0	1	2	3

	Not at all a problem	Behavior is a problem, but slight in degree	Problem is moderately serious	Problem is severe in degree
31. Disrupts group activities	0	1	2	3
32. Sits or stands in one position for a long time	0	1	2	3
33. Talks to self loudly	0	1	2	3
34. Cries over minor annoyances and hurts	0	1	2	3
35. Repetitive hand, body, or head movements	0	1	2	3
36. Mood changes quickly	0	1	2	3
37. Unresponsive to structured activities (does not react)	0	1	2	3
38. Does not stay in seat (e.g., during lesson or training periods, meals, etc.)	0	1	2	3
39. Will not sit still for any length of time	0	1	2	3
40. Is difficult to reach, contact, or get through to	0	1	2	3
41. Cries and screams inappropriately	0	1	2	3
42. Prefers to be alone	0	1	2	3
43. Does not try to communicate by words to gestures	0	1	2	3
44. Easily distractible	0	1	2	3
45. Waves or shakes the extremities repeatedly	0	1	2	3
46. Repeats a word or phrase over and over	0	1	2	3
47. Stamps feet or bangs objects or slams doors	0	1	2	3
48. Constantly runs or jumps around the room	0	1	2	3
49. Rocks body back and forth repeatedly	0	1	2	3
50. Deliberately hurts himself/herself	0	1	2	3
51. Pays no attention when spoken to	0	1	2	3
52. Does physical violence to self	0	1	2	3
53. Inactive, never moves spontaneously	0	1	2	3

	Not at all a problem	*Behavior is a problem, but slight in degree*	*Problem is moderately serious*	*Problem is severe in degree*
54. Tends to be excessively active.....	0	1	2	3
55. Responds negatively to affection.....	0	1	2	3
56. Deliberately ignores directions.....	0	1	2	3
57. Has temper outbursts or tantrums when he/she does not get own way.....	0	1	2	3
58. Shows few social reactions to others.....	0	1	2	3