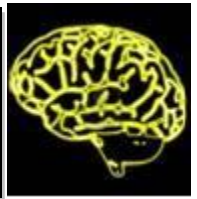




Carmel Neuropsychology Services, P.C.

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DEVELOPMENTAL HISTORY

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to child: _____

Date form completed: _____

General Information

Child's Name: _____ Gender: Male Female

First Middle Last

Date of Birth: _____ Age: _____

Child's Address: _____

Number and Street City State Zip

Home phone: _____ Ethnic/Cultural Background (optional) _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

Referral Information

Who referred you to the clinic/How did you hear about the clinic? _____

If you **DO NOT want us to send a copy of our report to the referral source, please mark here

Current Concerns

What is the main reason for your child's referral today? _____

How long has your child had these problems? _____

What are you hoping to achieve at the completion of this evaluation? _____

Services/Interventions Sought Previously

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Medical Evaluation | <input type="checkbox"/> Neuropsychological Assessment | <input type="checkbox"/> Educational Testing | <input type="checkbox"/> Psychiatric Exam |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Neurological Exam | <input type="checkbox"/> Speech/Language Therapy | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> School Modifications | <input type="checkbox"/> Psychological Counseling or Therapy | <input type="checkbox"/> Occupational/Physical Therapy | <input type="checkbox"/> Tutoring |

Has your child had any of the following forms of psychological treatment? If so, how long did it last?

- | | | |
|--------------------------|--|------------------------------|
| Individual psychotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration of therapy? _____ |
| Group psychotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration of therapy? _____ |
| Parenting classes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration of classes? _____ |
| Residential treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration of placement? _____ |

Is your child currently receiving psychological treatment? If so, with whom and how often? _____

What else have you tried to do to help your child with these problems, and how effective were these interventions?

Family History

(Please circle: Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer _____

Work Phone: _____ Home Phone: _____

Birth / Adoptive / Foster Father's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer _____

Work Phone: _____ Home Phone: _____

Stepmother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer _____

Work Phone: _____ Home Phone: _____

Stepfather's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____

Other Guardian's Name: _____ Age _____ Education (Yrs) _____
Address (if different from child's) _____

Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____
Relationship to child: _____

Foster/Adoptive Information:

(Please complete this information only if the child has ever been adopted or placed in foster care)

What age was the child first placed in foster care? _____

Why was the child placed in foster care? _____

Who has legal custody of the child? _____

Name of child's social worker: _____ Phone number _____

Social worker address: _____

Has the social worker provided consent for this evaluation? Yes No

(If YES, please attach authorization; If NO, please request authorization from county social services)

Is the child adopted? Yes No If yes, specify country of origin if international _____

Age when child was first in home: _____ Date of legal adoption: _____

If the child was adopted, do they know they were adopted? Yes No

How many different foster care / adoptive placements has the child experienced? _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

Does the child have any contact with biological parents? Yes No

If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?

If the child is not yet adopted, is there a plan for this to happen? Yes No

If yes, what is the time frame? _____

How has the child adjusted to foster care / adoption? _____

List all people with whom the child currently resides:

Names of Household Members	Age	Gender M / F	Relationship to Child	Highest Grade Completed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home: _____

Are parents separated or divorced: No Yes (describe below)
 When did you separate/divorce? _____
 Who has physical custody of child? _____
 Who has legal custody of the child? _____
 How often does the other parent see this child? _____

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc)? No Yes (describe below)

<u>Event</u>	<u>Date</u>	<u>Child's Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pre-Natal Period

Did mother receive prenatal care during the pregnancy? Yes No Starting in which month? _____

Number of the following the mother of the child has had (including the child being evaluated):
 Pregnancies _____ Miscarriages _____ Premature births _____

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Emotional stress | <input type="checkbox"/> Infections (cold, flu) | <input type="checkbox"/> Preterm labor/bedrest |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Excessive swelling (edema) | <input type="checkbox"/> Measles/German measles | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Flu | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Vaginal bleeding (when? _____) | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Threatened miscarriage |

- High blood pressure
- Epilepsy/seizure
- Other (Rh incompatibility, etc.)
- Maternal injury. Describe: _____
- Operation/hospitalization during pregnancy. Reason: _____
- X-ray studies
- Diabetes
- Fever
- Other virus

Were any of the following used during pregnancy? (check all that apply)

- Prescribed medications. (Please specify): _____ For: _____
- Tobacco
- Amphetamines
- Cocaine
- Marijuana
- Heroin
- Alcohol
- Methamphetamines
- Methadone
- Other (specify) _____

Birth History

- Age of mother at birth? _____ Age of father at birth? _____
- Was infant born full term? Yes No Number weeks gestation _____
- Birth weight: _____ lbs. _____ oz. Apgar Score (if remembered) _____ at 1 min _____ at 5 min.
- Type of Labor Onset: Induced Spontaneous
- Type of Birth: Vaginal C/Section (Planned? Yes No - Emergency? Yes No)
- Vaginal Birth after C/Section (VBAC) With instruments (forceps)
- Type of Anesthesia: Gas Spinal Local None
- Baby's Presentation: Breech Head Transverse (sideways)

Please check the following problems that may have occurred during labor:

- | | | | | | |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|--|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia/eclampsia | <input type="checkbox"/> | <input type="checkbox"/> | Fetal distress |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal fever | <input type="checkbox"/> | <input type="checkbox"/> | Medications used (please specify): _____ |

Length of active labor: _____ hours. Describe any complications during delivery: _____

Post-Delivery Period

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below:

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble breathing | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Cord around the neck (# of times _____) | <input type="checkbox"/> | <input type="checkbox"/> | Poor feeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Knot in cord | <input type="checkbox"/> | <input type="checkbox"/> | Required a blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting / reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhage (bleeding) in head | <input type="checkbox"/> | <input type="checkbox"/> | Floppy muscle tone |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocephalus (water on the brain) | <input type="checkbox"/> | <input type="checkbox"/> | Incubator care |
| <input type="checkbox"/> | <input type="checkbox"/> | Cyanosis (turned blue) | <input type="checkbox"/> | <input type="checkbox"/> | Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Need for ventilation | <input type="checkbox"/> | <input type="checkbox"/> | Fever |

Please explain all "Yes" answers:

Did infant require X-ray/ CT scan? No Yes
Was infant placed in the NICU? No Yes If yes, how long: _____

Length of stay in hospital: Mother: _____ days. Infant: _____ days.

Developmental History

Was any of the following present in your baby during the first few years of life? If so, please describe:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Did not enjoy cuddling	<input type="checkbox"/>	<input type="checkbox"/>	Was not calmed by being held or stroked
<input type="checkbox"/>	<input type="checkbox"/>	Difficult to comfort	<input type="checkbox"/>	<input type="checkbox"/>	Excessive restlessness
<input type="checkbox"/>	<input type="checkbox"/>	Excessive irritability	<input type="checkbox"/>	<input type="checkbox"/>	Frequent head banging
<input type="checkbox"/>	<input type="checkbox"/>	Difficult feeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Extremely passive	<input type="checkbox"/>	<input type="checkbox"/>	Early learning problems
<input type="checkbox"/>	<input type="checkbox"/>	Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn behavior
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Failure to thrive/poor weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	Poor eye contact
<input type="checkbox"/>	<input type="checkbox"/>	Destructive behavior	<input type="checkbox"/>	<input type="checkbox"/>	Unable to separate from parent
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? Yes No

If no, please describe: _____

As an infant and toddler, was your child interested in social contact (eye contact, social smile, showing things, sharing experiences)? Yes No If no, please describe: _____

As an infant and toddler, describe your child regarding his/her ease of self-regulation (e.g., ability to settle down at night, calm self when upset, etc.)? _____

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A. If unsure, please write DK.

<u>Age:</u> _____ Smile in response (social smile)	<u>Age:</u> _____ Know primary colors
_____ Sit independently	_____ Say the letters of the alphabet
_____ Crawl independently	_____ Print first and last name
_____ Walk independently	_____ Tie shoes
_____ Say "mama" or "dada" specifically	_____ Snap, zip, button clothing
_____ Say 1 st word other than "mama" or "dada"	_____ Began to read

_____ Put two words together _____ Toilet trained (urine)
 _____ Put 4-5 sent. together to relate an experience _____ Toilet trained (bowel)
 _____ You understood 100% of what child said

Has your child ever lost skills that at one time he/she was able to perform? Yes No
 If yes, please explain: _____

Are there any concerns related to toilette training? Yes No
 If yes, please describe: _____

Medical/Health History

What was the date your child's last physical exam? _____

Child's physician _____ Phone number _____

Vision problem? Yes No Date of last vision exam: _____

Hearing problem? Yes No Date of last hearing exam: _____

Appetite concerns? Normal Picky Eats too much Weight loss/ gain

Oral-motor concerns? None Difficulty swallowing Drooling Gagging

Where does your child sleep? Own bedroom Bedroom parent(s) sleep in Shared bedroom with _____

Does your child have problems falling asleep? Yes No
 If a yes, how long does it take for him/her to fall asleep? _____ hours

Does your child wake up in the middle of the night? Yes No
 If Yes, how many times per night typically? _____
 How long does it take for him/her to go back to sleep? _____
 How many hours does your child currently sleep at night? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Has your child been given a specific diagnosis?

- Learning disability
- Mental Retardation
- Anxiety Disorder
- Language disorder
- Developmental Delay
- Depression

- Attention Deficit Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Autism/ Asperger's/ PDD
- Other _____
- Epilepsy
- Tourette's Disorder
- Fragile X
- Genetic Disorder _____
- Bipolar Disorder
- Schizophrenia

Surgeries: Age: _____ Reason: _____ Where: _____
 Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
 Other details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____
 Other details _____

Has your child ever been unconscious? Yes No If yes, please explain: _____

Does your child have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) _____				Appetite, digestion, stomach problems			
Poor Hearing				Frequent stomach aches			
Chronic earaches/ infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) _____				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses							
	Yes	No	?		Yes	No	?
Endocrine/ Gland				Blood Disorder			
Thyroid problems				Anemia			
Diabetes				Excessive bleeding or bruising			
Hypo/Hyperpituitarism				Leukemia			
Growth problems				Sickle cell disease			
Other: _____				Other _____			
Nervous system				Urine or bladder problems			
Frequent and/ or severe headaches				Bedwetting			
Seizures or convulsions				Daytime wetting or accidents			
Tremors or twitches				Urine infections			
Paper and pencil coordination problems				Other _____			
Balance or coordination problems							
Other _____				Chest or Breathing			
				Wheezing/ asthma			
				Other: _____			

Has your child had any of the following?

- Ear Tubes Yes No If yes, number of tube placements _____
- Encephalitis Yes No
- Meningitis Yes No
- Poisoning or drug intoxication Yes No
- Coma Yes No
- Staring spells Yes No
- Immune system disorders Yes No

Other significant illness Yes No

If yes to any of the above, please describe: _____

Has your child had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurological Evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
CT scan of head				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
MRI scan of head				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
EEG				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Audiology or hearing evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Vision evaluation				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Genetic Testing				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know
Other laboratory tests				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't Know

Family Medical History

Mother: Health, learning, mental health problems? (please specify) _____

Father: Health, learning, mental health problems? (please specify) _____

Child's siblings: Health, learning, mental health problems? (please specify) _____

Have any of the child's family members had the following problems/disorders? Please specify the family member's relationship to the child and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

<u>Family Member(s) Relation to Child</u>	<u>Family Member(s) Relation to Child</u>
<input type="checkbox"/> Birth defect _____	<input type="checkbox"/> Reading problem _____
<input type="checkbox"/> Genetic disorder _____	<input type="checkbox"/> Other learning disability _____
<input type="checkbox"/> Cerebral palsy _____	<input type="checkbox"/> Speech/ language delay _____
<input type="checkbox"/> Severe head injury _____	<input type="checkbox"/> Did not graduate from high school _____
<input type="checkbox"/> Migraine headaches _____	<input type="checkbox"/> Mental retardation _____

Family Member(s) Relation to Child

Family Member(s) Relation to Child

- Multiple sclerosis _____ Autism/ Aspergers/ PDD _____
- Physical handicap _____ Attention Deficit Disorder _____
- Tuberos sclerosi _____ Oppositional/ defiant behaviors _____
- Huntington’s chorea _____ Antisocial behavior _____
- Muscular dystrophy _____ Aggression _____
- Sickle-cell anemia _____ Tics/ Tourette’s Disorder _____
- Seizures or epilepsy _____ Nervousness/ anxiety _____
- Cancer _____ Obsessive-Compulsive Disorder _____
- Diabetes _____ Depression _____
- Heart Disease _____ Bipolar/ manic depressive disorder _____
- Alcohol/ Drug abuse _____ Schizophrenia _____
- Physical/ sexual abuse _____ Other (specify) _____

Have any maternal family members ever received extra help in school, early intervention, or special education services?
 Yes No

If yes, specify who and the reason _____

Personal/Social Information

What are your child’s main hobbies and interests?

What about your child makes you most proud?

What does your child dislike doing most?

How many close friends does your child have? _____

Does your child have a best friend? Yes No If yes, how old is he or she? _____

How long have they been friends? _____ years _____ months

How easily does your child make friends? Worse than average Average Better than average

Does your child have problems keeping friends? Yes No

How well does your child get along with friends? Worse than average Average Better than average

If Below Average, please explain: _____

Does your child get along best with: Older children Children of the same age Younger children

Educational History

Has your child received Early Childhood Intervention services? Yes (Dates: _____) No

Did your child attend preschool? Yes No If yes, at what age? _____

Name of preschool: _____

Were there any adjustment problems in preschool? Yes No

Were you concerned about your child's ability to succeed in preschool? Yes No

Name of child's current school: _____

School district: _____

Address of school: _____

Telephone: _____ Grade: _____ Teacher: _____

Has your child ever been retained? Yes No What grade? _____ Why? _____

Is your child absent from school: Often Seldom Never

Usual reason for absence _____

If your child is in school please, comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities (e.g., teams)					

Has testing been completed by school? Yes No Date: _____

(Please attach a copy of the school evaluation)

Present class placement: Regular class Special class (if so, specify) _____
 Bilingual/ESL Gifted & Talented

Does your child have an IEP (Individualized Education Plan)? Yes No
Does your child have a 504 Plan? Yes No

If yes, for what reason? _____
(Please attach a copy of the IEP/504 Plan)

Special Education Categories: Please check all that apply (specify since what grade child has been in this placement):

- | | |
|---|--------------|
| <input type="checkbox"/> Autism Spectrum Disorder (ASD) | Grade: _____ |
| <input type="checkbox"/> Communication Disorder | Grade: _____ |
| <input type="checkbox"/> Deaf-blind | Grade: _____ |
| <input type="checkbox"/> Developmental Delay | Grade: _____ |
| <input type="checkbox"/> Emotional Disability (ED) | Grade: _____ |
| <input type="checkbox"/> Hearing Impairment | Grade: _____ |
| <input type="checkbox"/> Learning Disability (LD) | Grade: _____ |
| <input type="checkbox"/> Mental Disability | Grade: _____ |
| <input type="checkbox"/> Multiple Disabilities | Grade: _____ |
| <input type="checkbox"/> Orthopedic Impairment | Grade: _____ |
| <input type="checkbox"/> Other Health Impairment (OHI) | Grade: _____ |
| <input type="checkbox"/> Traumatic Brain Injury | Grade: _____ |
| <input type="checkbox"/> Visual Impairment | Grade: _____ |

Have any of the following instructional modifications been attempted?

- | | |
|---|---|
| <input type="checkbox"/> Oral tests | <input type="checkbox"/> Peer teaching |
| <input type="checkbox"/> Additional instructions | <input type="checkbox"/> Reduced paper and pencil work |
| <input type="checkbox"/> Manipulatives in math | <input type="checkbox"/> Repeated review |
| <input type="checkbox"/> Preferential seating | <input type="checkbox"/> Study carrel |
| <input type="checkbox"/> Extended time to complete assignments | <input type="checkbox"/> Outlines |
| <input type="checkbox"/> Shortened or modified assignments | <input type="checkbox"/> Positive reinforcers |
| <input type="checkbox"/> Study Sheets | <input type="checkbox"/> Behavior check cards / charts |
| <input type="checkbox"/> Control of distractions | <input type="checkbox"/> Predictable routines and classroom rules |
| <input type="checkbox"/> Behavior modification program | <input type="checkbox"/> Increased positive feedback |
| <input type="checkbox"/> Technologic assistance (word processor, calculator, augmentative communication device, etc.) | |
| <input type="checkbox"/> Other _____ | |

How successful have the above interventions been? _____

Behavior and Discipline

Please describe briefly any behavioral problems at school: _____

Has your child ever been assigned: Out of School Suspension Number of suspensions _____
 In School Suspension Number of suspensions _____
 Expulsion Number of expulsions _____

Please describe briefly any behavioral problems at home: _____

Types of discipline you use with your child:

- | | |
|---|---|
| <input type="checkbox"/> Rewards | <input type="checkbox"/> Verbal reprimands / verbal demands |
| <input type="checkbox"/> Time out (isolation) | <input type="checkbox"/> Removal of privileges |
| <input type="checkbox"/> Ignoring behavior | <input type="checkbox"/> Physical punishment |
| <input type="checkbox"/> Giving in to child | <input type="checkbox"/> Other (please specify) _____ |

Which form(s) of discipline has proven most effective? _____

Which form(s) of discipline has proven least effective? _____

Does your child currently (within the past 6 months) display any of the following behaviors frequently?

<input type="checkbox"/> Fainting, falling	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Physical aggression
<input type="checkbox"/> Clumsiness	<input type="checkbox"/> Unusual fears	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Stealing
<input type="checkbox"/> Shy, timid	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Use of profanity
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Laziness	<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Skipping school
<input type="checkbox"/> Lack of confidence	<input type="checkbox"/> Obsessive-compulsive behaviors	<input type="checkbox"/> Irritability	<input type="checkbox"/> Fire setting
<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Stereotyped/repetitive behaviors	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Destructiveness
<input type="checkbox"/> Crying episodes	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Oppositional behavior	<input type="checkbox"/> Cruelty to animals
<input type="checkbox"/> Unhappiness	<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Noncompliance	<input type="checkbox"/> Gang Involvement
<input type="checkbox"/> Concern with weight	<input type="checkbox"/> Short attention span	<input type="checkbox"/> Defiance	<input type="checkbox"/> Cigarette use
<input type="checkbox"/> Sleep problem	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Lying	<input type="checkbox"/> Alcohol / Substance use
<input type="checkbox"/> Other:			

My child:	Not at all	Just a little	Pretty much	Very much	Not applicable
Does not pay attention to detail or makes careless mistakes with, for example, homework					
Has difficulty keeping attention to what needs to be done					
Does not seem to listen when spoken to directly					
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)					
Has difficulty organizing tasks and activities					

My child:	Not at all	Just a little	Pretty much	Very much	Not applicable
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort					
Loses things necessary for tasks or activities (toys, assignments, pencils, or books)					
Is easily distracted by noises or other stimuli					
Is forgetful in daily activities					
Fidgets with hands or feet or squirms in seat					
Leaves seat when remaining in seat is expected.					
Runs about or climbs too much when remaining seated is expected.					
Has difficulty playing or beginning quiet play activities.					
Is "on the go" or acts as if "driven by a motor"					
Talks too much					
Blurts out answers before questions have been completed					
Has difficulty waiting his or her turn					
Interrupts or intrudes in on others' conversations and/or activities					
Loses temper					
Argues with adults					
Actively defies or refuses to go along with adults' requests or rules					
Deliberately annoys people					
Blames others for his or her mistakes or misbehaviors					
Is touchy or easily annoyed by others					
Is angry and resentful					
Is spiteful and wants to get even					
Bullies, threatens or intimidates others					
Starts physical fights					
Lies to get out of trouble or to avoid obligations (i.e., "cons" others)					
Is truant from school (skips school) without permission.					
Is physically cruel to people					
Has stolen things that have value					
Deliberately destroys others' property					

My child:	Not at all	Just a little	Pretty much	Very much	Not applicable
Has used a weapon that can cause physical harm (bat, knife, brick, gun)					
Is physically cruel to animals					
Has deliberately set fires to cause damage					
Has broken into someone else's home, business, or car					
Has stayed out all night without permission					
Has run away from home overnight					
Has forced someone into sexual activity					
Has a depressed mood					
Has decreased interest or pleasure in daily activities					
Has significant weight loss or gain, poor appetite or over-eating without deciding to diet or trying to gain.					
Has difficulty sleeping or is sleeping too much					
Has low energy or fatigue					
Seems excessively agitated___or slowed down___ (check if positive)					
Feels lonely, unwanted, or unloved; complains that "no one loves him or her"					
Has or difficulty making decisions					
Has feelings of hopelessness					
Has recurrent thoughts of death					
Has talked about or attempted suicide					
Has a persistent refusal to go to school in order to stay home with a parent					
Has excessive anxiety or worry					
Feels that worry is difficult to control					
Is restless or feels keyed up or "on edge"					
Is easily fatigued					
Has irritability					
Has muscle tension					
Has difficulty falling or staying asleep, or restless unsatisfying sleep					
Has repetitive behaviors, such as hand-washing, lining things up, checking on things before leaving a room or leaving the house, or mental acts such as a need to keep counting things or repeating words over and over.					

My child:	Not at all	Just a little	Pretty much	Very much	Not applicable
Has daytime wetting					
Has soiling					

Will any procedures that will be conducted at our offices be part of an ongoing or expected legal case, and if so, please describe: _____
