



Park Nicollet

Alexander Center

NAME:

DOB:

MR#:

HCL# :

LABEL or ADDRESSOGRAPH

INTAKE QUESTIONNAIRE

Child's name	Child's date of birth	Child's age
Form completed by		Date form completed

FAMILY INFORMATION

Parent

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

Parent

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

Family status:

Married Separated (in _____ / _____) Divorced (in _____ / _____) Never married

Does your child have stepparents? No Yes. If yes, please complete below:

Stepparent

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

Stepparent

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

Is your child adopted? No Yes. If yes, how old was child at time of adoption? _____

Is your child aware of the adoption? No Yes

If separated, child's primary residence is with whom? _____

Name of child's legal guardian _____

Name of child's foster parents _____

Foster parent's address _____

SCHOOL INFORMATION

School name	Homeroom teacher	Grade
Address		
Contact person	Phone	Fax

please complete the reverse side

REFERRAL INFORMATION

Primary physician	Primary physician phone	Grade
Primary physician address		
Referred by	Referring physician phone	
Referring physician address		
Insurance company	Will insurance company cover this evaluation? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	

Why are you seeking an evaluation at the Alexander Center? What are your goals? _____

Does your child have a current diagnosis? _____

Do you wish the team to consider any specific diagnosis or questions? _____

Which symptoms or behaviors concern you most at this time? _____

THIS SPACE RESERVED FOR INTAKE INTERVIEWER

HISTORY OF PRESENT ILLNESS / CURRENT BEHAVIOR

1. What is the current health status of child?
 Excellent Good Fair Poor Don't know
2. Yes No Do you have any specific medical concerns about your child?

3. Yes No Does your child take any medications on a daily basis? If yes, please complete table below.
- | Name of medication | Dosage & how often | How long has child taken this |
|--------------------|--------------------|-------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
4. Yes No Is your child allergic to any medications? If yes, please list medications.

5. Yes No Are your child's immunizations up-to-date? Don't know
6. When was your child's last complete physical? _____
7. When was your child's hearing last screened? _____
8. When was your child's vision last screened? _____
9. Yes No Is your child currently seeing any medical specialists or therapists (e.g., neurology, O.T. or P.T.) If yes, please provide name.

10. Yes No Does your child experience any of the following difficulties with sleep?
 Difficulty falling asleep Waking in the night Nightmares Early morning waking
 Night terrors Sleeps too much Snoring Apnea
 Falls asleep during day (other than age appropriate naps)
 Other _____
11. Yes No Does your child have any of the following difficulties with eating?
 Difficulty sitting at the table Over eats Avoids foods due to texture
 Poor food choices Picky eater Odd eating behavior/habits
 Other _____
12. Yes No Does your child have any of the following difficulties with elimination?
 Daytime wetting Toilet refusal Night wetting
 Constipation Soiling Diarrhea
 Other _____
13. Yes No Does your child frequently complain of physical symptoms not related to a medical problem?
 Stomach aches Headaches Joint aches
 Fatigue Dizziness Heart palpitations
 Breathing problems Tremors/shakey
 Other _____

14. Which hand does your child use to complete tasks?
 Right Left Both
15. Yes No Does your child have problems with coordination?
 Large motor coordination
 Small motor coordination (handwriting, cutting, sipping, etc.)
16. Yes No Does your child display any unusual repetitive movements or noises (tics)?
 Head, facial or neck twitches
 Nervous habits, describe: _____
 Repetitive actions when excited, describe: _____
 Problems with balance
 Walks in unusual manner
 Walks on tiptoes
 Is generally clumsy
 Other _____
17. Yes No Does your child act in any of the following ways?
 Frequently seems unaware of others in room/fails to react to noise
 Echoes or repeats words or phrases over and over
 High pain tolerance
 Repeats same behavior over and over
 Becomes agitated if not permitted to perform ritual or routine behavior
 Sensory sensitivities (e.g., textures of food, smells, upset by bright lights, excessive reaction to noise, over reaction to touch)
 Seems unafraid of dangerous activity (e.g., shows no fear when on high playground equipment)
 Speaks using sing-song or high pitched intonation
18. Yes No Does your child have a history of any of the following?
 Depression Chemical abuse Don't know
 Mood swings Alcohol abuse
 Suicidal thought/attempts Unusual thinking
 Physical abuse Anxiety
 Sexual abuse
19. Yes No Does your child have any problems getting along with others?
 Few friends/loner Difficulty making friends Competitive with siblings
 No best friend Difficulty keeping friends Plays mainly with younger children
 Not respectful of authority Plays mainly with older children
20. Please describe your child's personality (e.g., sensitive, happy, compassionate, stubborn, angry, easy going, bubbly)

21. What do you enjoy most about raising your child?

22. What are your child's main strengths?

23. What are your child's main weaknesses?

FAMILY MEDICAL HISTORY

Please indicate all medical conditions that have occurred in the child's biological relatives. Indicate whom in the space provided. Under sibling, please indicate sister (S) or brother (B). For all other relatives, indicate which side of the family, mother (M) or father (F). For example, if the child's mother's sister has a learning disability, you would place an "M" in the box under "Aunt" in the column labeled "learning disability".

	Mother	Father	Sibling	Aunt	Uncle	Cousin	Grandparent	Other
Learning disability								
Attention deficit disorder								
Mental retardation								
Autism								
Pervasive development disorder								
Speech & language disorder								
Hearing loss/deafness								
Tourette's or Tic disorder								
Congenital disorder								
Thyroid disease								
Chronic illness (please list: _____ e.g., Asthma, Arthritis, Diabetes, Lupus)								
Depression								
Manic/depression (Bipolar)								
Suicide attempt								
Anxiety								
Obsessive compulsive disorder								
Schizophrenia								
Psychiatric hospitalization								
Alcohol dependency								
Chemical dependency								
Other								

Yes No Has anyone in the child's family (mother, sibling, father) ever received psychological assessment, treatment or hospitalization including for drug and alcohol abuse? If yes, please explain.

Family member	Age	Clinician or Facility	Reason for treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SPACE BELOW RESERVED FOR INTAKE INTERVIEWER

Number	Mother's family	Number	Father's family
Number	Mother's family	Number	Father's family

CHILD'S MEDICAL HISTORY

PREGNANCY

1. Yes No The pregnancy was mother's _____ of _____ pregnancies with _____ live births.
2. Yes No Did any of the following occur prior to the pregnancy?
 Fertility medications Miscarriages
3. Yes No Did any of the following occur during the pregnancy?
 Maternal injury, describe: _____
 Infections, describe: _____
 Excessive vomiting
 Abnormal weight gain
 Poor weight gain
 Measles
 Toxemia
 Gestational diabetes
 Anemia
 Measles
 Exposure to toxins
 Hypertension
 X-rays, which months: _____
 Bleeding, spotting, which months: _____
 Abnormal emotional stress (e.g., work hours, death of a relative, etc.)
 Prenatal testing (e.g., CMV, HIV, TORCH)
 Don't know
 Alcohol use: amount per day: _____
 Cigarette use: amount per day: _____
 Medication use: describe, which months: _____
 Drugs (e.g., cocaine, marijuana), which months: _____
4. Yes No Did any of the following complications occur during labor or delivery?
 Labor induced Cesarean delivery
 General anesthesia Breech delivery
 Fetal distress Forceps delivery
 Prolonged labor, _____ hrs. Multiple birth
 Other _____

THIS SPACE RESERVED FOR INTAKE INTERVIEWER

BIRTH

1. Mother's age at time of delivery? _____ Father's age? _____
2. Hospital, city and state of birth?

3. Length of pregnancy _____ weeks (If an infant is born on his due date, the pregnancy is 40 weeks long)
4. What was the child's weight at birth? _____ lbs. _____ ozs.
5. Apgar scores _____ 1 minute _____ 5 minutes
6. Child's condition at birth?
 Excellent Good Fair Poor Don't know
7. Length of hospital stay:
 Infant:: _____ Mother: _____

Perinatal Health

8. Yes No Did any of the following complications occur after delivery?

- Infection/fever
- Incubator How long?
- Jaundiced
- Breathing problems
- Respirator How long?
- Bleeding in the brain
- Difficulty sucking/feeding
- Heart problems

9. Yes No Were there any congenital defects/anomalies? (e.g., cleft palate)

DEVELOPMENTAL HISTORY

1. Please describe your child's temperament at the following ages:

- | | | | | |
|--------------------------|---|--------------------------------|----------------------------------|--------------------------------------|
| Infancy (birth - 12 mo.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |
| Toddler (12 - 36 mo.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |
| Preschool (36 - 60 mo.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |

2. Was there anything unusual about how your child developed? (e.g., didn't like to be held, very early interest in numbers?)

BIRTH TO ONE YEAR

1. Yes No In the first year, did your infant experience any of the following problems?

- | | |
|--|--|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Weight loss or poor weight gain | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Other infections |
| <input type="checkbox"/> Sleep problems | |

ONE TO THREE YEARS

1. Yes No From age one to three, did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Ear tubes inserted | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Separation problems | |

THREE TO FIVE YEARS

1. Yes No From age three to five, did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Separation problems | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Toileting problems | <input type="checkbox"/> Ear tubes inserted |
| <input type="checkbox"/> Difficulty with structured activity | <input type="checkbox"/> High activity level |
| <input type="checkbox"/> Difficulty with transitions | <input type="checkbox"/> Short attention span |

2. Yes No Did preschool teachers/daycare providers or other caregivers observe difficulty with any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Structured activity | <input type="checkbox"/> Group activity |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Transitions |

EDUCATIONAL HISTORY

1. Yes No Do you have any specific concerns regarding your child's school progress?
 Academics Social Teacher Peer relationships
2. Yes No Are your concerns related to achievement for: (check all that apply)
 Reading Math Language
3. Yes No Do you have concerns related to:
 Off task behavior Organization Attention Concentration
4. Yes No Has your child had a school evaluation? If yes, date of last complete evaluation: _____
5. Yes No Does your child have an: Individualized Education Plan (IEP)?
 Individualized Education Plan (IEP)
 504 Plan
Last updated: _____
6. Yes No Are you satisfied with the services your child has received at school?
7. Yes No Has your child been involved in any of the following educational programs?
 Early Childhood Special Ed. Autism services
 Title 1 or Chapter 1 Friendship Group/Social Skills Group
 Assurance of Mastery - Reading Counseling
 Assurance of Master - Math Mental retardation/Mental impairment
 Learning Disabilities program Home tutoring
 Emotional/Behavioral Disorder program Private tutoring
 Program for other health impaired Home bound instruction
 Speech/Language Therapy Gifted and talented programming
 Occupational Therapy Multiply handicapped
 Physical Therapy Some program but I don't know what
8. Yes No Currently or in the past, has your child's teacher discussed any of these problems?
 Getting along with peers Turning in assigned work
 Disrupting classroom Rushing to complete work
 Getting along with teachers Staying on task during work periods
 Difficulty waiting turn Making frequent careless errors
 Excessive socializing Completing large or long-term projects
 Following rules (classrooms, bus, recess, lunch) Organization of work materials
 Competing work on time
 Following directions
 Forgetting to bring homework materials home
or to return completed work
9. Yes No Has your child ever experienced any of the following?
 Delayed Kindergarten entry
 Retained in grade _____
 In school suspension, reason: _____ in grade: _____
 Suspended for _____ days, reason: _____ in grade: _____
 Expelled, reason: _____ in grade: _____

10. Please summarize your child's progress in each grade level. A) Were grades average, below average or above average? B) Did teachers raise any specific concerns at conferences or list concern on report cards? C) Were there difficulties with not understanding or completing homework/school assignments? D) Did the child receive any special services?

Preschool

Kindergarten

Grades 1-3

Grades 4-6

Grades 7-9

Grades 10-12

THIS SPACE RESERVED FOR INTAKE INTERVIEWER

SPEECH AND LANGUAGE HISTORY

- 1. Yes No Do you have any current concerns regarding your child's speech or language?
- 2. Yes No Is your child currently receiving speech or language therapy?
- 3. Yes No Does your child have a history of speech or language problems?
- 4. Yes No Has your child received speech therapy in the past? If yes, please complete the following:
Nature of problem (e.g., language delay) _____ Dates of Service/Facility _____
- 5. Yes No Does your child have a current IEP/IFSP in speech/language? If yes, which of the following services are included:
 Expressive language Voice therapy Articulation
 Receptive language Fluency (e.g., stuttering)
 Other _____

RECEPTIVE / EXPRESSIVE LANGUAGE

- 1. Yes No Does your child have any of the following problems understanding language?
 Following single part directions Understanding age appropriate jokes
 Following multi-part directions Understanding idioms (e.g., You missed the boat)
 Understanding questions Understanding vocabulary
- 2. Yes No Does your child have any problems with expressive language?
 Grammar/syntax Initiating conversation
 Maintaining topic of conversation Adjusting to listener's needs
 Sequencing story from start to finish Using appropriate vocabulary
 Other _____

ARTICULATION

- 1. Yes No Does your child have any problems saying sounds correctly?
 Specific sound errors, describe: _____
 Difficulty sequencing long words

FLUENCY

- 1. Yes No Does your child have any difficulty with speech fluency?
 Frequently stutters or stammers
 Say "um" or "uh" a lot

VOICE

- 1. Yes No Does your child have any problems with his/her voice?
 Frequent screaming Voice quality (e.g., harsh, hoarse, breathy, nasal)
 Loud talker Frequent laryngitis

Check the column that best describes your/this child.

Not at all	Just a little	Pretty much	Very much	Don't know	
A1, AS1					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	1. Has difficulty using eye contact, facial expressions and gestures to interact with others
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	2. Fails to develop peer relationships that are appropriate to the child's developmental level
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	3. Does not show interest in the enjoyment or activities of others (e.g., does not show, bring, or point out toys or other objects of interest)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	4. Has a hard time understanding the "give & take" of social interactions
A2					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	5. Has delayed, or total lack of development of spoken language
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	6. Is unable to start or keep a conversation going with others but is able to speak adequately
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	7. Uses unusual and/or repetitive language
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	8. Lacks spontaneous make-believe play or interactive play with peers appropriate to his/her developmental level
A3, AS2					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	9. Is preoccupied with one or more unusual and restricted areas of interest (e.g., dinosaurs, trains, baseball statistics, etc.) that is unusual either in intensity or focus
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	10. Engages in nonfunctional routines or rituals
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	11. Displays stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	12. Has persistent preoccupations with parts of objects (e.g., the wheels on a toy car)
CDD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	13. Has lost previously acquired expressive or receptive language
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	14. Has lost previously acquired social skills or adaptive behavior
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	15. Has lost previously acquired bowel or bladder control
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	16. Has stopped playing
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	17. Has lost previously acquired motor skills
SA					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	18. Is excessively distressed when separated from home or major attachment figures or when separation is anticipated
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	19. Worries persistently and excessively about losing a parent, caregiver or other important attachment figure or about harm befalling them
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	20. Worries persistently and excessively that a future event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	21. Is reluctant or refused to go to school or elsewhere due to fear of separation
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	22. Has persistent and excessive fear or reluctance to be alone or without major attachment figures at home or in other settings
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	23. Is reluctant or refuses to go to sleep without being near a major attachment figure or to sleep away from home
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	24. Reports repeated nightmares involving the theme of separation
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	25. Repeatedly complains of physical symptoms (e.g., headaches, stomachaches, nausea or vomiting) when separation from major attachment figure occurs or is anticipated.

Check the column that best describes your/this child.

Not at all	Just a little	Pretty much	Very much	Don't know	
SM					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	26. Fails to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite displaying the ability to speak in other situations
RAD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	27. Fails to initiate or respond in most social situations
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	28. Is excessively inhibited in most social situations
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	29. Appears to have increased awareness and vigilance in most social interactions
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	30. Is highly ambivalent and shows contradictory responses in most social interactions (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting.)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	31. Displays excessive familiarity with relative strangers
MDD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	32. Has a depressed mood most of the day, nearly every day. This is indicated by either subjective report (e.g., feeling sad or empty) or observation made by others (e.g., appears tearful or displays an irritable mood)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	33. Has markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	34. Shows a significant loss of weight while not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or has increase or decreases in appetite nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	35. Sleeps too much or too little nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	36. Appears to be excessively inactive or overactive nearly every day which can be observed by others
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	37. Reports feelings of fatigue or loss of energy nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	38. Has feelings of worthlessness or excessive or inappropriate guilt nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	39. Has diminished ability to think or concentrate, or is indecisive, nearly every day
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	40. Has recurrent thoughts of death (not just fear of dying), has recurrent suicidal ideation with a specific plan, has attempted suicide, or has a specific plan for committing suicide.
DD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	41. Consistently displays poor appetite or overeating
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	42. Consistently displays low energy or fatigue
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	43. Has low self-esteem
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	44. Consistently has feeling of hopelessness
ME					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	45. Displays inflated self-esteem or grandiosity
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	46. Has a decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	47. Is more talkative than usual or seems pressured to keep talking
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	48. Changes topics in conversation rapidly (flight of ideas) and appears as though thoughts are racing
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	49. Is distractible (e.g., attention is easily drawn to unimportant or irrelevant external objects or events)

Check the column that best describes your/this child.

Not at all	Just a little	Pretty much	Very much	Don't know	
ME cont'd					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	50. Shows an increase in goal-directed activity (either socially or at school), or shows psychomotor agitation
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	51. Is excessively involved in pleasurable activities that have a high potential for painful consequences
AGR					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	52. Has recurrent unexpected panic attacks
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	53. Has anxiety about being in places or situations from which escape might be difficult (or embarrassing) and avoids this situation or requires the presence of a companion
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	54. Fears being outside of the home alone and avoids it or requires the presence of a companion
SAD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	55. Fears social or performance situations in which he/she is exposed to unfamiliar people or may be scrutinized by others and exposure to these situations provokes anxiety and perhaps a panic attack.
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	56. Fears social situations and these situations almost invariably provoke anxiety which may be expressed by crying, tantrums, freezing, or shrinking from situations with unfamiliar people
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	57. Recognizes that his/her fear of social situations is excessive or unreasonable
OCD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	58. Reports having recurrent and persistent thoughts, impulses, or images that cause marked anxiety or distress
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	59. Reports having persistent and recurrent thoughts, impulses, or images that are not simply excessive worries about real life problems
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	60. Displays repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that he/she feels driven to perform
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	61. Displays repetitive behaviors or thoughts that cause distress, are time consuming (take more than one hour a day) or significantly interfere with normal daily routines
GAD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	62. Has excessive anxiety and worry about a number of events and activities
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	63. Finds it difficult to control his/her worrying
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	64. Is restless or feels keyed up or on edge
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	65. Is easily fatigued
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	66. Has difficulty concentrating or his/her mind often goes blank
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	67. Is irritable
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	68. Reports muscle tension
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	69. Had difficulty falling or staying asleep or has restless sleep
NLD					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	70. Has trouble interpreting body language, gestures and/or facial expressions
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	71. Had difficulty understanding and interpreting changes in tone of voice, mood and emotional cues
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	72. Has difficulty comprehending information not immediately contained in words, such as nuances, humor, sarcasm, metaphor and imagery
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	73. Has trouble knowing what another person knows or needs to know while in conversation

Check the column that best describes your/this child.

Not at all	Just a little	Pretty much	Very much	Don't know	
NLD cont'd					
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	74. Has trouble knowing what is and what is not appropriate to say in various situations
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	75. Has trouble knowing when and how to initiate and maintain conversations
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	76. Has trouble knowing when and how to terminate communication
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	77. Is unable to break down a complex task into simpler parts allowing him/her to work through the steps in order to complete the task
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	78. Has difficulty comprehending concepts such as time, space or quantity
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	79. Is unable to understand spatial relationships (e.g., solve puzzles, build models)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	80. Has impaired sense of space, orientation, and directionality (e.g., has trouble using birds-eye-view maps or following complex verbal directions)
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	81. Has impaired visual pattern recognition and memory
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>	82. Has impaired hand-eye coordination and fine motor control

Please attach a picture of your child in the space below

Thank you very much for completing this questionnaire. This information will help us evaluate your child.

Alexander Center Staff

Please return this form to:

Park Nicollet Clinic—Alexander Center
 11455 Viking Drive
 Eden Prairie, MN 55344