**Early Childhood Questionnaire**

<table>
<thead>
<tr>
<th>Child’s name</th>
<th>Child’s date of birth</th>
<th>Child’s age</th>
<th>Form completed by</th>
<th>Date form completed</th>
</tr>
</thead>
</table>

### FAMILY INFORMATION

<table>
<thead>
<tr>
<th>Parent</th>
<th>Parent</th>
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<tbody>
<tr>
<td>Name</td>
<td>Name</td>
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<tr>
<td>Street address</td>
<td>Street address</td>
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<tr>
<td>City, State, ZIP</td>
<td>City, State, ZIP</td>
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<tr>
<td>Home phone</td>
<td>Home phone</td>
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<tr>
<td>Work phone</td>
<td>Work phone</td>
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<tr>
<td>Education</td>
<td>Education</td>
</tr>
<tr>
<td>Occupation</td>
<td>Occupation</td>
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</tbody>
</table>

**Family status:**
- [ ] Married
- [ ] Separated (in ______ / ________)
- [ ] Divorced (in ______ / ________)
- [ ] Never married

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

<table>
<thead>
<tr>
<th>Stepparent</th>
<th>Stepparent</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
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<tr>
<td>Street address</td>
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<td>City, State, ZIP</td>
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<td>Home phone</td>
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<td>Education</td>
<td>Education</td>
</tr>
<tr>
<td>Occupation</td>
<td>Occupation</td>
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</tbody>
</table>

Is your child adopted? [ ] No  [ ] Yes. If yes, how old was the 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 parents’ address ______________________

### PRESCHOOL INFORMATION

<table>
<thead>
<tr>
<th>School name</th>
<th>Homeroom teacher</th>
<th>Grade</th>
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<tr>
<td>Address</td>
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</table>

Contact person _____________________

Phone _____________________

Fax _____________________

*please complete the reverse side*
REFERRAL INFORMATION

<table>
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<tr>
<th>Primary physician</th>
<th>Primary physician phone</th>
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<thead>
<tr>
<th>Referring physician</th>
<th>Referring physician phone</th>
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| Referring physician address | |
|-----------------------------| |

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<tr>
<th>Insurance company</th>
<th>Will insurance company cover this evaluation?</th>
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<tr>
<td></td>
<td>☐ No ☐ Yes ☐ Don't know</td>
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</table>

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?

________________________________________________________________________
________________________________________________________________________

CHILD CARE

If primary caregivers work outside the home, please provide the following information ☐ Not applicable

Name of child-care provider

________________________________________________________________________

Hours (such as 3:30 to 6 p.m.) ____________________ Number of children in center__

THIS SPACE RESERVED FOR INTAKE INTERVIEWER
SOCIAL HISTORY

Please draw the family constellation at the child's primary residence and at the residence of the child's other parent (if living separately). Include ages of all children and adults living in the home. Use the following illustration as an example.

(father) George (45) (mother) Mary (46)

(children) Tom (12) Joe (10) Sue (8)

1. □ Yes □ No Have other adults or children lived in the home currently or in the past? If yes, what is their relationship with your child?

2. □ Yes □ No Has your child experienced any parental separations or the death of any family member? If yes, please describe circumstances (for example, child's age or event)

3. □ Yes □ No Is either parent away from home for several days at a time on a regular basis?

4. □ Yes □ No Does your cultural heritage play a significant role in your daily life?

5. If parents are divorced/separated, how often does the child visit with the other parent?

SIBLINGS

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to child</th>
<th>Where living?</th>
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FAMILY MEDICAL HISTORY

Please indicate all medical conditions that have occurred in the child's biological relatives. Indicate which relative in the space provided. Under sibling, 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."

<table>
<thead>
<tr>
<th>Learning disability</th>
<th>Father</th>
<th>Sibling</th>
<th>Aunt</th>
<th>Uncle</th>
<th>Cousin</th>
<th>Grandparent</th>
<th>Other</th>
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<tr>
<td>Attention deficit disorder</td>
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<td>Chronic illness (please list: such as asthma, arthritis, diabetes, lupus)</td>
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<td>Depression</td>
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<td>Manic/depressive (bipolar)</td>
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<td>Suicide attempt</td>
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<td>Anxiety</td>
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<tr>
<td>Other</td>
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</table>
The pregnancy was mother’s __________ of __________ pregnancies with ________ live births.

1. □ Yes  □ No  Did any of the following occur before the pregnancy?
   - Fertility medications
   - Miscarriages

2. □ 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 (such as work hours, death of a relative)
   - Prenatal testing (such as CMV, HIV, TORCH)
   - Don’t know
   - Alcohol use: amount per day:
   - Cigarette use: amount per day:
   - Medication use: describe, which months:
   - Drugs (such as cocaine, marijuana), which months:

3. □ 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, ________ hours
   - Multiple birth
   - Other
MEDICAL HISTORY
5. □ Yes □ No Has your child had any of the following health problems?
   □ Seizures □ Asthma □ Chronic ear infections
   □ Ear tubes, age ______ □ Broken bones □ Head injury
   □ Meningitis □ Diabetes □ Lead poisoning
   □ Allergies, please list:
   □ Vision problems, (wears glasses ...) since age ________________
   □ Special diet or nutritional supplements
   □ Hearing problems – hearing loss □ Left ear □ Right ear

6. Hospitalizations (reason) Dates Surgery Date
   ____________________________________________
   ____________________________________________
   ____________________________________________

7. Are any issues seriously affecting your family of which you would like us to be aware?
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

CURRENT ILLNESS AND BEHAVIOR
1. What is the current health status of the 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 medications on a daily basis? If yes, please complete the table below.
   Name of medication Dosage and how often How long child has 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 (such as neurology, occupational therapy or physical therapy)? If yes, provide name.

10. **Yes** [ ]  **No** [ ]  Does your child experience any of the following difficulties with sleep?
- [ ] Difficulty falling asleep
- [ ] Waking in the night
- [ ] Night terrors
- [ ] Early morning waking
- [ ] Difficulty sitting at the table
- [ ] Falls asleep during day (other than age-appropriate naps)
- [ ] Night wets
- [ ] Wakes in the night
- [ ] Snoring
- [ ] Muscle tremors
- [ ] Sleeps too much
- [ ] Sleeps too long
- [ ] Apnea
- [ ] Other

11. **Yes** [ ]  **No** [ ]  Does your child have any of the following difficulties with eating?
- [ ] Difficulty sitting at the table
- [ ] Overeats
- [ ] Picky eater
- [ ] Avoids foods due to texture
- [ ] Odd eating behavior/habits
- [ ] Poor food choices
- [ ] Other

12. **Yes** [ ]  **No** [ ]  Does your child have any of the following difficulties with elimination?
- [ ] Daytime wetting
- [ ] Night wetting
- [ ] Toilet refusal
- [ ] Diarrhea
- [ ] Constipation
- [ ] Soiling
- [ ] Other

13. **Yes** [ ]  **No** [ ]  Does your child frequently complain of physical symptoms not related to a medical problem?
- [ ] Stomachaches
- [ ] Headaches
- [ ] Joint aches
- [ ] Fatigue
- [ ] Dizziness
- [ ] Heart palpitations
- [ ] Breathing problems
- [ ] Tremors/shakes
- [ ] 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 ...)

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 the room, fails to react to noise
- [ ] Echoes or repeats words or phrases over and over
- [ ] High pain tolerance
- [ ] Repeats same behavior
- [ ] Becomes agitated if not permitted to perform ritual or routine behavior
- [ ] Sensory sensitivities (such as textures of food, smells, upset by bright lights, excessive reaction to noise, overreaction to touch)
- [ ] Seems unafraid of dangerous activity (such as 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 thoughts/attempts
- [ ] Unusual thinking
- [ ] Physical abuse
- [ ] Anxiety
- [ ] Sexual abuse
- [ ] Other
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 (such as sensitive, happy, compassionate, stubborn, angry, easygoing, 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?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

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 (such as cleft palate)?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
DEVELOPMENTAL HISTORY

1. Please describe your child's temperament at the following ages:
   - Infancy (birth to 12 mos.): □ Pleasant/happy □ Fussy □ Colicky □ Other ______________________
   - Toddler (13 to 36 mos.): □ Pleasant/happy □ Fussy □ Colicky □ Other ______________________
   - Preschool (36 to 60 mos.): □ Pleasant/happy □ Fussy □ Colicky □ Other ______________________

2. Was there anything unusual about how your child developed (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?
   - □ Breathing problems □ Ear infections
   - □ Feeding problems □ Injury
   - □ Weight loss or poor weight gain □ Developmental delay
   - □ Irritability □ Other infections
   - □ Sleep problems

ONE TO THREE YEARS

1. □ Yes □ No From age one to three, did any of the following occur?
   - □ Excessive temper tantrums □ Recurrent ear infections
   - □ Developmental delay □ Sleep problems
   - □ Ear tubes inserted □ Behavior problems
   - □ Separation problems

THREE TO FIVE YEARS

1. □ Yes □ No From age three to five, did any of the following occur?
   - □ Excessive temper tantrums □ Recurrent ear infections
   - □ Developmental delay □ Sleep problems
   - □ Separation problems □ Behavior problems
   - □ Toilet training problems □ Ear tubes inserted
   - □ Difficulty with structured activity □ High activity level
   - □ Difficulty with transitions □ Short attention span
   - □ Separation problems

2. □ Yes □ No Did preschool teachers, day-care providers or other caregivers observe difficulty with any of the following?
   - □ Structured activity □ Group activity
   - □ Behavior □ Attention
   - □ Peer relationships □ Transitions

DEVELOPMENTAL MILESTONES

1. At what age did your child first do the following? Please indicate age in months (such as 16 mos.)
   - Turn over
   - Sit alone
   - Crawl
   - Walk alone
   - Ride a bike
   - Feed self with spoon
   - Bowel trained
   - Bladder trained
   - Dry at night
   - Speak first words
   - Use two-word to three-word combinations
   - Begin to read
   - Write name

2. Has your child shown any loss of previous abilities (such as he was speaking in two-word sentences, then stopped talking or began using one word only). Please describe.

3. □ Yes □ No Has your child ever been diagnosed with a behavior or emotional problem? If yes, please complete below.
   - Diagnosis
   - Age
   - Clinician or facility
   - Treatment
Does your child have any of the following symptoms of worrying?

1. No  Yes
   - Unrealistic worry about future events
   - Easily fatigued
   - Overly high personal standards and expectations
   - Very self-conscious
   - Difficulty tolerating normal errors
   - Excessive need for reassurance
   - Unrealistic and persistent fears about well-being of caregivers or other important people
   - Obsessive thoughts, such as fear of germs
   - Compulsions, such as handwashing, counting, checking, ordering, lining up objects
   - Repeated nightmares

2. No  Yes
   - Diminished pleasure in activities
   - Self-critical statements
   - Sad, depressed or irritable mood most of the day
   - Sleeps too much
   - Early morning waking
   - Cries easily or often

3. No  Yes
   - Has your child ever experienced a period of days or weeks when his or her mood was more elevated or irritable than usual?
   - Highly distractible
   - Decreased need for sleep
   - More talkative than usual
   - Increased activity level

Has your child ever received psychological or psychiatric assessment, treatment or hospitalization, including for drug and alcohol abuse? If yes, please complete below.

<table>
<thead>
<tr>
<th>Family member</th>
<th>Age</th>
<th>Clinician or facility</th>
<th>Reason for treatment</th>
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<tbody>
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Mood

Has your child have any of the following symptoms of worrying?

1. No  Yes
   - Unrealistic worry about future events
   - Easily fatigued
   - Overly high personal standards and expectations
   - Very self-conscious
   - Difficulty tolerating normal errors
   - Excessive need for reassurance
   - Unrealistic and persistent fears about well-being of caregivers or other important people
   - Obsessive thoughts, such as fear of germs
   - Compulsions, such as handwashing, counting, checking, ordering, lining up objects
   - Repeated nightmares

2. No  Yes
   - Sad, depressed or irritable mood most of the day
   - Self-critical statements
   - Diminished pleasure in activities
   - Sleeps too much
   - Early morning waking
   - Cries easily or often

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THIS SPACE RESERVED FOR INTAKE INTERVIEWER
1. Who is in charge of disciplining your child?

2. ☐ Yes ☐ No  Do all caregivers agree on discipline?

3. Which of the following discipline techniques are used with your child? (check all that apply)
   - ☐ Time out in room
   - ☐ Time out in chair
   - ☐ Spanking
   - ☐ Other
   - ☐ Privileges removed
   - ☐ Reward for appropriate behavior
   - ☐ Taking away toys or television time

4. Which of the above discipline techniques have you found most effective?

5. Please describe other concerns you have about disciplining your child.

---

**EDUCATIONAL HISTORY**

1. ☐ Yes ☐ No  Do you have specific concerns about 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)
   - ☐ 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 Mastery–Math     □ Mental retardation/mental impairment
   □ Learning disabilities program     □ Home tutoring
   □ Emotional/behavioral disorder program     □ Private tutoring
   □ Program for other health-impairment     □ Homebound instruction
   □ Speech-language therapy     □ Gifted and talented programming
   □ Occupational therapy     □ Multiple handicaps
   □ Physical therapy     □ I don’t know the program’s name
   □ Friendship group/social skills group
   □ Counseling
   □ Mental retardation/mental impairment
   □ Home tutoring
   □ Private tutoring
   □ Homebound instruction
   □ Gifted and talented programming
   □ Multiple handicaps
   □ I don’t know the program’s name

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
   □ Completing 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 __________

SPEECH AND LANGUAGE HISTORY

1. □ Yes □ No  Do you have any current concerns about 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 (language delay ...)     Dates of service/facility

5. □ Yes □ No  Does your child have a current IEP/IFSP in speech or language? If yes, which of the following services are included.
   □ Expressive language
   □ Voice therapy
   □ Articulation
   □ Receptive language
   □ Fluency (such as 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 multipart directions
   □ Understanding idioms (such as “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
### County Resources

1. ☐ Yes  ☐ No  Do you or your child have been involved with any of the following resources?
   - ☐ PCA (Personal Care Assistance)
   - ☐ Foster care
   - ☐ County social worker
   - ☐ Respite care
   - ☐ Other

### Fluency

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

### Voice

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

### Hearing/Listening

1. ☐ Yes  ☐ No  Do you have any specific concerns about your child's hearing or listening?
   - ☐ Turns volume up on TV or radio
   - ☐ Distracted by background noise
   - ☐ Says "what?" a lot
   - ☐ Complains of ringing in ears
   - ☐ Misunderstands speech frequently
   - ☐ Answers questions incorrectly
   - ☐ Complains of dizziness
   - ☐ Problems with balance
2. ☐ Yes  ☐ No  Does your child have any difficulty using or understanding nonverbal cues?
   - ☐ Body language
   - ☐ Facial expressions
   - ☐ Tone of voice
   - ☐ Rate of speech
   - ☐ Don't know
3. ☐ Yes  ☐ No  Does your child struggle with sounding appropriate in social situations?
   - ☐ Facial expressions
   - ☐ Body language
   - ☐ Tone of voice
   - ☐ Rate of speech
   - ☐ Don't know

### This Space Reserved for Intake Interviewer

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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.

Please return this form to:
Park Nicollet Alexander Center
8455 Flying Cloud Drive, Suite 205
Eden Prairie, MN  55344