**Beyond the Spectrum Initial Intake Packet**

Thank you for your interest in Beyond the Spectrum! If you would like to schedule a tour and assessment for possible placement in our school, please complete the intake packet and return to Beyond the Spectrum by

**email:** **info@beyondthespectrum.org, fax: 941-527-0526 or mail: 7333 International Place, Sarasota, Fl 34240.**

You will then receive a call or email to schedule a tour and assessment.

**INTAKE PACKETS REMAIN ON FILE FOR 12 MONTHS FROM DATE OF SUBMISSION**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enrolling School Year**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# General Information (PLEASE PRINT)

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_ Present Grade\_\_\_\_\_\_\_\_\_\_ Enrolling Grade\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_

Current School (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Address and Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the child have an IEP? \_\_\_\_\_yes \_\_\_\_\_ no

**Funding Information**

**Please contact Peggy Caruso, Finance Director, at 941-447-8400 / peggy.caruso@beyond thespectrum.org**

**for assistance or information regarding funding**

Family Empowerment Scholarship – Unique Abilities (FES-UA) \_\_\_\_\_\_\_\_yes \_\_\_\_\_\_\_\_ no

A.A.A. Scholarship \_\_\_\_\_\_\_\_yes \_\_\_\_\_\_\_\_ no

**Parent/Guardian(s) Requesting Information, Tour, or Placement (PLEASE PRINT ALL INFORMATION)**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

# Intake Questionnaire

At Beyond the Spectrum, we offer three specialized educational programs. Please note, some questions may not be relevant to your child. Please answer all applicable questions thoroughly and to the best of your ability so that we may better understand your child’s individual circumstances, needs, and goals. Thank you.

**CHILD DIAGNOSES**

The diagnoses listed below are divided into categories. Please circle all diagnoses that apply to your child.

**Developmental or Neurological-Related Diagnoses**

|  |  |  |
| --- | --- | --- |
| Autism  | Asperger’s  | Down’s Syndrome  |
| Seizure Disorder  **Sensory or Motor Diagnoses**  | Fetal Alcohol Syndrome  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Apraxia  | Gross Motor Delay  | Fine Motor Delay  |
| Cerebral Palsy **Learning-Related Diagnoses**  | Sensory Integration Disorder  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Dyslexia  **Mood or Anxiety-Related Diagnoses**  | Dysgraphia  | Dyscalculia  |
| General Anxiety Disorder  | Separation Anxiety  | Obsesses Compulsive (OCD)  |
| Panic Disorder  | Social Phobia  | Tourette’s Syndrome  |
| Depression  | Bipolar Disorder  | PTSD  |

Other(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior, Attention, or Personality-Related Diagnoses**

|  |  |
| --- | --- |
| Attention Deficit – Hyperactive (ADD-H)  | Attention Deficit – Inattentive Attention Deficit – Combined (ADD-I) (ADD-H/I)  |
| Oppositional Defiance Disorder (ODD)  |  Other(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

If your child has any diagnoses, does he/she know it? \_\_\_yes \_\_\_ no

If yes, what do you call it or refer to it as? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROFILE: Please identify all medical conditions your child currently has or has had in the past.**

Asthma: \_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_ Diabetes: \_\_\_\_\_\_ Heart Condition: \_\_\_\_\_ Other(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **FOOD allergies** that your child has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **NON-FOOD allergies** your child has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child has allergies, what are the signs and symptoms of an allergic reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have an Epi-Pen in case of severe allergic reaction? \_\_\_\_\_yes \_\_\_\_\_ no

Any other medical conditions or health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Dietary Restrictions or Needs

Is your child on a special or limited diet, or does your child have specific feeding needs? \_\_\_yes \_\_\_ no

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medications - Please list all medications that your child takes regularly

 Name of Medication/Dose/Frequency Prescribing Physician

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any that your child experiences regularly**

Headaches

Sensitive to sound

Dark under eye circles

Frequent constipation

Frequent diarrhea

Mood swings

Refusal to eat

Hyperactivity

Acid reflux

Eczema

Tires easily

Frequent ear infections

Chronic congestions

Seasonal allergies

Bruises easily

 Any additional notes or concerns regarding your child’s health or medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SERVICES AND THERAPIES**

Please indicate which services and/or therapies your child currently receives.

|  |  |  |  |
| --- | --- | --- | --- |
| **Service**  | **Child Receives (circle)**  | **Provider**  | **Hours per Week**  |
| ABA Therapy  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Music Therapy  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Occupational Therapy (OT)  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Physical Therapy (PT)  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Speech/Language Therapy  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Yes No  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_  |

Any additional notes regarding services or therapies that your child receives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ACADEMIC PROFILE**

To the best of your knowledge, please circle what your child can do *independently*. Please note, this is not a comprehensive list of all academic skills, but rather a way for us to have an idea of your child’s academic abilities.

#  Reading/ Writing Mathematics

 Approximate grade level: \_\_\_\_\_\_\_\_ Approximate grade level: \_\_\_\_\_\_\_\_

 Identify letters Identify numbers

 Read sight words Count to 10

 Read sentences Count to 100

 Read short books Basic addition

 Read chapter books Basic subtraction

 Write his/her name Basic multiplication

 Write complete sentences Basic division

 Any additional comments regarding your child’s academic progress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD’S PERSONALITY Please circle all words that best describe your child**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AnxiousConfidentTalkativeQuietLeaderFollowerIndependentDependentSensitiveAggressiveActiveNon-ActiveOutgoingShyMoodyEven-temperedPlayfulSeriousAnalyticalImpulsive |  |  |  |  |

 Any additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL SKILLS AND TENDENCIES** Please select which of the following your child *enjoys*.

Does your child usually prefer to be alone or with others? \_\_\_ Alone \_\_\_ With others \_\_\_ No preference

Does your child initiate interaction with parents/guardians? \_\_\_yes \_\_\_ no \_\_\_Only if he/she wants something

Does your child initiate interactions with other adults? \_\_\_yes \_\_\_ no \_\_\_Only if he/she wants something

Does your child initiate interactions with siblings? \_\_\_yes \_\_\_ no \_\_\_Only if he/she wants something

Does your child initiate interactions with peers? \_\_\_yes \_\_\_ no \_\_\_Only if he/she wants something

 What does your child like to do alone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does your child like to do with others? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **COMMUNICATION AND HEARING -** Does your child have difficulty with any of the following? (Please circle all that apply):

Articulation

Fluency of Speech

Voice Disorder

Apraxia

Stuttering

Auditory Processing Disorder

Deaf / Hearing Loss

Scripting or Echolalia

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Check all that are true for your child

Has no verbal language

Has limited verbal language

Can answer basic questions

Is conversational

Communicates in full sentences

Is difficult to understand

Uses PECs to communicate

Uses device to communicate

Uses sign language

Points to what he/she wants

Uses gestures (head shake)

Does not voluntarily speak

# EXECUTIVE FUNCTIONING

 Does your child have difficulty with organization skills? \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never

Does your child have difficulty with maintaining attention? \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never

Does your child have difficulty with transitions? \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never

|  |  |
| --- | --- |
| Does your child get “stuck” on certain tasks or ideas?   |  \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never  |
| Would you consider your child to be flexible?   |  \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never  |
| Is your child forgetful?   |  \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never  |
| Is your child able to learn from his/her mistakes?  |  \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never  |

Does your child require assistance to stay on task? \_\_\_Always \_\_\_ Often \_\_\_Rarely \_\_\_Never

Does your child have a one-on-one aide or shadow at school? \_\_\_\_\_ Yes, full-time \_\_\_\_\_ Yes, part-time \_\_\_\_\_ No

 Any additional comments or concerns regarding your child’s executive functioning skills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**BEHAVIOR PROFILE**

Does your child have a current behavior plan at school? \_\_\_ yes \_\_\_ no

Does your child receive behavior services at home or in a clinic? \_\_\_ yes \_\_\_ no

Can you alone take your child and another child into the community without problems? \_\_\_ yes \_\_\_ no

Has your child ever been asked to leave a program, or not come back the following session? \_\_\_ yes \_\_\_ no

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**In the past year, has your child displayed any of the following? Check all that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
| Hit– open hand  | Hit- closed fist  | Kicking  | Biting  |
| Throwing items  | Stealing items  | Excessive lying  | Scratching  |
| Spitting  | Pinching  | Head banging  | Scratching  |
| Tantrum  | Running away  | Damage property  | Refuse to do tasks  |

Any additional behaviors of concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When your child acts out, what do you think usually causes it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When your child acts out, what does it usually look like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When your child acts out, how long does it usually take until he/she calms down? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When your child acts out, what usually helps to calm him/her down? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What behavioral interventions work best for your child? (such as ignoring, time-out, redirection, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Any additional comments or information regarding your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_