

Please read each question carefully and

1. Check the box  that best describes your child's behavior *and*

MOST  
OF THE  
TIME

SOMETIMES  
RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to him?

z  v  x  O

2. Does your child seem too friendly with strangers?

x  v  z  O

3. Does your child laugh or smile when you play with her?

z  v  x  O

4. Is your child's body relaxed?

z  v  x  O

5. When you leave, does your child remain upset and cry for more than an hour?

x  v  z  O

6. Does your child greet or say hello to familiar adults

z  v  x  O

7. Does your child like to be hugged or cuddled?

z  v  x  O

8. When upset, can your child calm down within 15 minutes?

z  v  x  O

9. Does your child stiffen and arch his back when picked up?

i  v  z  O

Name \_\_\_\_\_ DO \_\_\_\_\_ MR \_\_\_\_\_ TOTAL POINTS ON PAGE \_\_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
11. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/> v	<input type="checkbox"/> z	0
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
13. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
14. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
15. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
16. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
17. Does your child get constipated or have diarrhea?	X	V	Z	0
18. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
TOTAL POINTS ON PAGE				___

	MOST OF THE TIME	RARELY OR	CHECK IF THIS IS A
19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x    0
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x    0
21. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z    0
22. Does your child like to hear stories or sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x    0
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z    0
24. Does your child like to be around other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x    0
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z    0

Name \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_ TOTAL POINTS ON PAGE \_\_\_\_\_



MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
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26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

x       v       z       O

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

28. Is there anything that worries you about your child? If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

29. What things do you enjoy most about your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person filling out form \_\_\_\_\_  
 Relationship to child \_\_\_\_\_

TOTAL POINTS ON PAGE \_\_\_\_\_