

Please read each question carefully and

1. Check the box  that best describes your child's behavior *and*
2. Check the circle 0 if this behavior is a concern

MOST OF TIME	RARELY OR SOMETIMES NEVER	CHECK IF THIS IS A CONCERN
--------------------	---------------------------------	----------------------------------

- |   |                            |                            |                            |                                    |
|---|----------------------------|----------------------------|----------------------------|------------------------------------|
| 1. Does your child look at you when you talk to him?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0                                  |
| 2. Does your child like to be hugged or cuddled?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0                                  |
| 3. Does your child cling to you more than you expect?   | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0                                  |
| 4. Does your child greet or say hello to familiar adults?   | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0                                  |
| 5. Does your child seem happy?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0                                  |
| 6. Does your child like to hear stories and sing songs?   | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> 0 |
| 7. Does your child seem too friendly with strangers?  | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input checked="" type="radio"/> 0 |
| 8. Does your child seem more active than other children her age?  | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0                                  |
| 9. Can your child settle himself down after periods of exciting activity?   | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0                                  |
| 10. Does your child cry, scream, or have tantrums for long periods of time?   | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0                                  |
| 11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____<br>(You may write in something else.) | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0                                  |

Name \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_ TOTALPOINTS\_ON PAGE \_\_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
12. Can your child stay with activities she enjoys for at least 3 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
13. Does your child do what you ask him to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
14. 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
15. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
16. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ (You may write in another	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
17. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
18. 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
19. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
20. Does your child let you know how he is feeling with either words or gestures? For example, does he let you know when he is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0

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

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK THIS IS CONCERN
.....				
21. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
22. 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
23. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
24. Does your child stay away from dangerous	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
26. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	0
27. Does your child play alongside other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	0
28. 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
.....				
TOTALPOINTS				ONYAGE

1

MOST  
OF THE  
TIME

RARELY  
OR  
SOMETIMES NEVER

CHECK IF  
THIS IS A  
CONCERN

29. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

x

v

z

0

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

30. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training? If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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