

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 THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
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- | | | | | |
|---|----------------------------|----------------------------|----------------------------|---|
| 1. Does your child look at you when you talk to her? | <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 talk and/or play with adults he knows well? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | C |
| 4. Does your child cling to you more than you expect? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0 |
| 5. When upset, can your child calm down within 15 minutes? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0 |
| 6. Does your child seem too friendly with strangers? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | 0 |
| 7. Can your child settle herself down after periods of exciting activity? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | 0 |
| 8. 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 | C |
| 9. Does your child seem happy? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | C |

Nam _____ DOB _____ MR# _____ TOTAL POINTS ON PAGE _____

	MOS OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK THIS IS A CONCERN
10. Is your child interested in things around him, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	O
11. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	O
12. Does your child seem more active than other children her age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	O
13. Can your child stay with activities she enjoys for at least 5 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	O
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	O
15. 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	O
16. 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	O
17. Does your child use words to tell you what he wants or needs?	z	<input type="checkbox"/> v	<input type="checkbox"/> x	O
TOTAL POINTS ON _____				

MOST OF TIME RAREL OR NEVER CHECK IF THIS IS A CONCER

18. Does your child follow routine directions?

For example, does she come to the table or help clean up her toys when asked?

z v X 0

19. Does your child cry, scream, or have tantrums for long periods of time?

X v z 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?

z v 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.)

X v z 0

22. Does your child hurt himself on purpose?

 0

23. Does your child stay away from dangerous things, such as fire and moving cars?

z v X 0

24. Does your child destroy or damage things on purpose?

x v z 0

25. Does your child use words to describe her feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?

z v x 0

Name _____ DOB _____ MR# _____ TOTAL POINTS ON _____

	MOST OF TIME	SOMETIMES	RAREL OR NEVER	CHECK IF THIS IS CONCER
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26. Can your child name a friend?

z v x 0

27. Do *other* children like to play with your child?

z v x 0

28. Does *your child* like to play with other children?

z v x 0

29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

x v z 0

30. Does your child show an interest in or knowledge of adult sexual language and

x v z 0

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

x v z 0

32. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, explain

TOTAL POINTS ON PAGE _____

CHP Health Center for children ages 33 through 41 months

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

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

Person filling out form _____
Relationship to child _____

Name _____ DOB _____ MR# _____