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Serving Children, Adolescents and Families

Comprehensive Neurodevelopmental History Interview

The information you provide on these pages is an extremely valuable part of this child's evaluation and treatment. Please complete each item with careful consideration before the next appointment. This information will be part of the child's medical record and is protected under Privacy Acts. Thank you for your assistance.

General Information

Child's Name _____ Date _____

Mother's Name _____ Father's Name _____

Who is completing this form? _____

Child's Current Address _____

City _____ County _____ State _____ Zip _____

Phone Numbers _____

Date of Birth _____ Age _____ Ethnicity _____ Sex: Female Male

School _____ Grade level _____

Special school placement? _____

Who has legal custody to make medical/legal decisions for the child?

Both parents (joint legal custody) Mother only Father only Other (guardian ad litem, etc.)

If you checked "Other" above, please explain _____

If parents are divorced or separated, please explain the child's living arrangements. _____

Please list any psychiatrists, social workers, therapists, school staff, or other professionals currently involved in the child's welfare. _____

What are your main concerns? _____

What are some of this child's strengths, positive points, abilities, etc.? _____

Prenatal History

Do Not Write In This Area

1. Is the child adopted? No If yes, at what age? _____
2. Mother's health during this pregnancy was: Good Fair Poor Unknown
3. Please explain any complications or accidents during this pregnancy (e.g., high blood pressure, swelling, injuries, infections, diabetes, etc.). _____

4. Please note any medication or substances used during this pregnancy, even if they were stopped after the mother learned she was pregnant.
Alcohol: None Once or twice total _____ times per _____
Quit drinking at what month of the pregnancy? _____
Cigarettes: None _____ cigarettes/day OR _____ packs/day
Quit smoking at what month of the pregnancy? _____
Coffee None Once or twice total _____ times per _____
Other caffeinated drinks (soda, tea, energy drinks, etc.)
 None Once or twice total _____ times per _____
Marijuana or other drugs: which ones? _____
 Never Once or twice total _____ times per _____
List any medications or supplements taken during pregnancy (e.g., herbal supplements, antibiotics, valium, pre-natal vitamins, etc.):

Labor and Birth Information

1. The baby was born: on time _____ weeks early _____ weeks late
2. The baby's weight and length were: normal below normal above normal
Weight if known: _____ lbs. _____ oz. Length if known: _____
3. Describe any complications or dangers to the mother or baby during labor/delivery?
(etc. very long labor, breech birth, C-section, umbilical cord around neck, etc.)

4. Describe any special care required after the delivery (e.g., oxygen, intensive care, heart monitoring, drug withdrawal, etc.). _____

Early Childhood Health and Development

Birth to 18 months

1. What was the baby's usual temperament or personality?

- Easy - didn't cry much, slept and ate on schedule, cuddly, easy to sooth, etc.
- Average - usually somewhere between easy and difficult
- Difficult - hard to satisfy, fussy, did not eat/sleep on schedule, colicky, etc.
- Sensitive - easily upset, best with a fixed schedule, but cuddly, easy to soothe
- Easy OR Difficult until _____ months, then _____

Do Not Write In This Area

2. Describe the child as an infant.

	Not at all	A little	Pretty much	Very much
Enjoyed being held	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good eye contact, smiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babbling to or with you by 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing baby games with you by 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Describe the child as a toddler.

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playful and confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Happy and got along well with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentle, non-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy to satisfy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adaptable – could take him/her anywhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy to soothe after being upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shy and cautious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually irritable or negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destructive or aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily frustrated, frequent tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upset by transitions and changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with new places, people, food, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Very busy or active - always into something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. When did the child meet the following milestones?

	On time	Early	Late	Don't know
Crawled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sat without support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stood alone, holding on to furniture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked without holding on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pointed at things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scribbled on paper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turned to look at the source of a sound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoke first words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used 2 words together ("Me go," etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoke in sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used scissors to cut things out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tied shoe laces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rode a bike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Was toilet training difficult for the child? No Yes

If yes, please explain _____

Medical Overview

1. The child's health is: Excellent Good Fair Problematic

2. Who is the child's medical doctor? _____

Where does he/she work? _____

3. Approximate date of the last physical exam or wellness check-up: _____

Approximate date of last eye exam: _____

Approximate date of last hearing exam: _____

4. Does the child have any ongoing medical problems (e.g., asthma, anemia, diabetes, heart condition, chronic illnesses, seizures, etc.)? No If yes, what?

5. Please list all medicines the child is taking now, including medicines for medical problems, psychiatric problems, vitamins, herbs, or dietary supplements:

Medication

Prescribed By

To Control

6. Allergies to medications, foods, pollen, animals, etc.:

7. Has the family ever lived in an area known for potential problems with lead poisoning or other chemical exposure? No Yes

8. Has the youth ever used or been suspected of using cigarettes, alcohol, or drugs? No If yes, describe _____

9. Child's Sleep:

Difficulty falling asleep, staying asleep, or awakening too early? No Yes

If yes, describe _____

Check all that describe the child during the day on average:

Gets up and going easily

Gets up groggy and wakens slowly

Difficult to awaken even if the child has had enough sleep

Falls asleep in class or is excessively tired during the day

Seems energetic even though he/she slept very little

Do Not Write In This Area

10. Describe any other problems that occur during the night (e.g., afraid of the dark, snoring, nightmares, won't sleep alone, talking in sleep, etc.):

11. Please check all that describe the child's level of activity:

- Athletic, regular sports practice
- Physical education classes in school several days each week
- Walks, bikes, skateboards, or other activities 4 or more days per week
- Actively plays outside 2 or more times per week
- Fairly sedentary - doesn't get active unless encouraged

12. Please list any surgeries the child has had, at what age, and the outcome, including tubes in ears?

Do Not Write In This Area

Approximate Age	Reason for Surgery	Outcome
------------------------	---------------------------	----------------

13. Ear infections? Frequently in the past Gets them regularly Rarely to none

14. Please describe any other ailments, head injuries, broken bones, other injuries, or accidents the child has had, at what age, and the current status:

Approximate Age	Injury/Ailment	Current Status
------------------------	-----------------------	-----------------------

15. Any other health concerns: _____

Evaluation and Treatment History

1. List any previous evaluations/testing the child has had (e.g. for learning disabilities, ADHD, developmental delays, behavior, emotional problems, etc.):

Approximate age	Where	Results
------------------------	--------------	----------------

2. List any psychiatric hospitalizations the child has had:

Approximate age	Where	Why	Length of stay
------------------------	--------------	------------	-----------------------

3. List past counselors, psychologists, therapists, psychiatrists, etc.

Approximate age	Why	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have parents had any counseling or training for help with the child's behavior?
 No If yes, describe: _____

5. Check the box for reasons medication has ever been prescribed to the child.
 ADD/ADHD Depression Anxiety Sleep Tantrums Psychosis
Was it helpful? No Yes
Problems/Side effects _____

Do Not Write In This Area

Please, double-check that all **current** medications are listed on page 4, number 5.

School & Education History

1. Please list the grade and any important experiences (positive and negative) the child has had in school (e.g., diagnosed with a learning disability, repeated grades, report card changes, behavior changes, teacher problems, etc.)

Grade	Situation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Areas of difficulty:

<input type="checkbox"/> Reading	<input type="checkbox"/> Math calculations (number problems)
<input type="checkbox"/> Copying from the board	<input type="checkbox"/> Math word problems
<input type="checkbox"/> Expressing ideas in writing	<input type="checkbox"/> Working on homework independently
<input type="checkbox"/> Spelling	<input type="checkbox"/> Organization
<input type="checkbox"/> Messy writing	<input type="checkbox"/> Turning assignments in on time

3. Child's strengths or best areas in school: _____

4. Please list any special assistance with schoolwork or homework (tutoring, special education, IEP, 504 Plan, teacher modifications, etc)?

5. In the past 12 months, how many in-school suspensions? _____
Cause _____
How many out-of-school suspensions? _____
Cause _____

6. Has the child been expelled from school? No If yes, why? _____

Social Environment

1. Child's current dwelling?
 House Apartment Mobile home Temporary housing
 Other _____
Location?
 Rural Inner city Suburbs in the city Small town outside of city
 Other _____

Do Not Write In This Area

2. With whom does the child live now? If the child has more than one home where he/she regularly lives, please list the members of that household also.

Name	Relationship	Age

List any pets that live with the child.

3. Please list siblings not living in the home:

Name	Relationship	Age	Living where

4. The child's biological parents are: Married Separated Divorced Not living

5. Family interests or hobbies (camping, science fiction, sports, hunting, reading, etc.):

6. Does the family attend church, temple, or other place of worship?
 Occasionally Regularly No

7. Has the child ever experienced:

- | | |
|---------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Emotional or verbal abuse | <input type="checkbox"/> Harassment/Bullying at school |
| <input type="checkbox"/> Victim of a crime | <input type="checkbox"/> Encouraged by caregivers to break the law |
| <input type="checkbox"/> Witnessed violence in the home | <input type="checkbox"/> Witnessed crime in the community |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Not sure |

8. Check any of the following events that have occurred in the past 12 months:

- | | |
|--------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Parents divorced or separated | <input type="checkbox"/> Absence of a parent for a week or more |
| <input type="checkbox"/> Family member ill or injured | <input type="checkbox"/> Death in the family |
| <input type="checkbox"/> Family moved | <input type="checkbox"/> Death of a pet or acquired a new pet |
| <input type="checkbox"/> Tension in the home | <input type="checkbox"/> Parent changed jobs or lost a job |
| <input type="checkbox"/> Legal or financial problems | <input type="checkbox"/> Child changed schools or daycare |
| <input type="checkbox"/> Loss of a close friend | <input type="checkbox"/> House fire, natural disaster |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Family member was a crime victim |
| <input type="checkbox"/> Someone new in the household | <input type="checkbox"/> Child saw abuse or sexual situation |

Other distressing events _____

9. Has the child ever had a life-threatening experience (house fire, mugged, etc.)?

- No If yes, describe _____

Do Not Write In This Area

10. Prior to age 4, was the child separated from Mom or Dad for more than a week due to:

- | | |
|--------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Child hospitalized | <input type="checkbox"/> Parent hospitalized |
| <input type="checkbox"/> Camp | <input type="checkbox"/> Business trip |
| <input type="checkbox"/> Visiting relative or friend | <input type="checkbox"/> Parent went away to care for someone |
| <input type="checkbox"/> Any other reason for the separation _____ | |
| <input type="checkbox"/> No separation during that time | |

11. Describe any special needs or health problems of family members (chronic illness, handicap, etc.). _____

12. How easily does the child make friends?

- Doesn't have any Worse than average Average Better than average

13. How long does the child usually keep friendships?

- Less than 6 months 6 months to a year More than a year Unknown

14. How many close friends does he/she have?

- None 1 2 or 3 4 or 5 More

How often each week does he/she do things with friends outside of school? _____

These friends are: "Good kids" Bad influences

15. How well does this child get along with:

- | | | | |
|-------------------------|-------------------------------|----------------------------------|---------------------------------|
| Brothers, sisters | <input type="checkbox"/> Well | <input type="checkbox"/> Average | <input type="checkbox"/> Poorly |
| Other kids the same age | <input type="checkbox"/> Well | <input type="checkbox"/> Average | <input type="checkbox"/> Poorly |
| Parents | <input type="checkbox"/> Well | <input type="checkbox"/> Average | <input type="checkbox"/> Poorly |

16. Any areas of extreme interest (dinosaurs, sports, weapons, trains, insects, etc.)?

Describe _____

This interest seems: Over-focused/excessive Positive/productive

Caretaker Concerns

1. Check the ways that parents or caretakers deal with behavior problems:

	Mother	Father	Other (who?)
Talking to, scolding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Yelling, screaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spanking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Time out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Taking away privileges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Grounding, restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Rewards for good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Giving in to the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Avoiding the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

2. Are these methods effective in changing the child's behavior?

No Yes Temporarily Only partly

Do Not Write In This Area

3. How well does the child go along with the parents' first-time commands?

Mother: Never Rarely Usually Always

Father: Never Rarely Usually Always

4. Does the child eventually go along with the parents' wishes?

Mother: Never Rarely Usually Always

Father: Never Rarely Usually Always

5. Do parents have difficulty with being consistent with the child?

Mother: Never Rarely Usually Always

Father: Never Rarely Usually Always

6. Indicate any parenting concerns you have.

Child doesn't seem to care what discipline is used

Nothing seems to work

Worry about being too strict or too forceful

Worry about losing control

Worry about being too lax

Worry about being too protective

Worry about having had poor parent role models

Other _____

Family History

Indicate any **blood relatives** of the child with the following issues.

	Brothers Sisters	Bio Mother	Mother's Relatives	Bio Father	Father's Relatives
Learning disabilities, dyslexia, speech or special education classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention deficit or hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism, Asperger's Disorder or other developmental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional-defiant, breaks rules, annoys others on purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal problems, arrests, jail/prison time, court probation, or "always in trouble"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger problems, rageful outbursts, aggressive, or abusive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar, manic-depressive, or moody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxieties, fears, phobias, or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive, compulsive, or fussy habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression for more than 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy alcohol use or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis, schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics, other nervous habits, or Tourette's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling, shopping, or other compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Victim of physical or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems (over- or under-active)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic medical problems (heart problems, diabetes, cancer, deafness, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do Not Write In This Area

Neurodevelopmental Screening

Please check the boxes to describe the child's abilities in the following areas:

	Not good	Okay	Good	Very good
Attention Control				
Able to start and finish a task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can decide what's important to focus on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stays focused on a task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses a planner without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporal-Sequential				
Does things efficiently that require a series of steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes letters of words in correct order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manages time well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spatial Awareness				
Runs into things, knocks things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finds her/his way around without getting lost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can copy complex geometrical figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can figure out how things work, builds things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penmanship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working Memory				
Keeps things in mind while doing something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can organize information in her/his mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to follow multiple-step commands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can work out math problems in his/her mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language				
Understands what she/he reads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understands what others say	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expresses ideas in writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expresses ideas with talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pronounces letters and words clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a large vocabulary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Skills				
Coordination and balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye-hand coordination (writing, drawing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger control (tying shoes, threading needle, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills				
Can interpret others' feelings correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resolves conflicts with friends appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stays on topic of conversation appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows when it is time to change topic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is accepted by other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Higher Order Thinking				
Can solve her/his own problems appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Logical thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considers consequences before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can apply what she/he knows to new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do Not Write In This Area