Dear Parent/Guardian,

Welcome to ***Developmental and Behavioral Pediatrics of the Carolinas***. We would like to introduce you to your future care team. At your first evaluation you and your child will meet your child's Developmental and Behavioral Pediatrician. At your future visit, you will meet your child's Developmental and Behavioral Advanced Practice Provider. This care team will collectively develop a treatment plan specific to the needs of your child and provide access to the best Pediatrics Developmental and Behavioral Services.

Concord Provider Team
Joseph Stegman, MD
Mark Clayton, MD
Shruti Mittal, MD
George "Wes" Hatley, PA-C
Angela Noone, MSN, CPNP

Charlotte Provider Team
Yasmin Senturias, MD
Tsehaiwork "Sunny" Fenikile, MD
Shruti Mittal, MD
Monique Sutton, MSN, CPNP
Ryan Grimes, MSN, CPNP

Enclosed you will find our new patient information and assessment inventories that must be completed and returned prior to an appointment being scheduled. Please be sure to thoroughly read and complete the contents of this packet. A checklist is enclosed for your convenience. Some pages may be double-sided. If you need help completing the packet, please contact your PCP or our clinic.

Please note, if we do not receive a completed packet this will delay the packet review and scheduling process. With the increased needs for our services and the large number of referrals we receive monthly, please note a fully completed packet, once received by the practice, will take an additional 4-6 weeks to review. At that time, you will be contacted by one of our teammates to schedule your appointment.

Please mail, fax, or drop off your completed packet to our Concord Office:

301 Medical Park Drive
Ste 202B
Concord, NC 28025
Office (704) 403-2626
Fax: (704) 403-2699

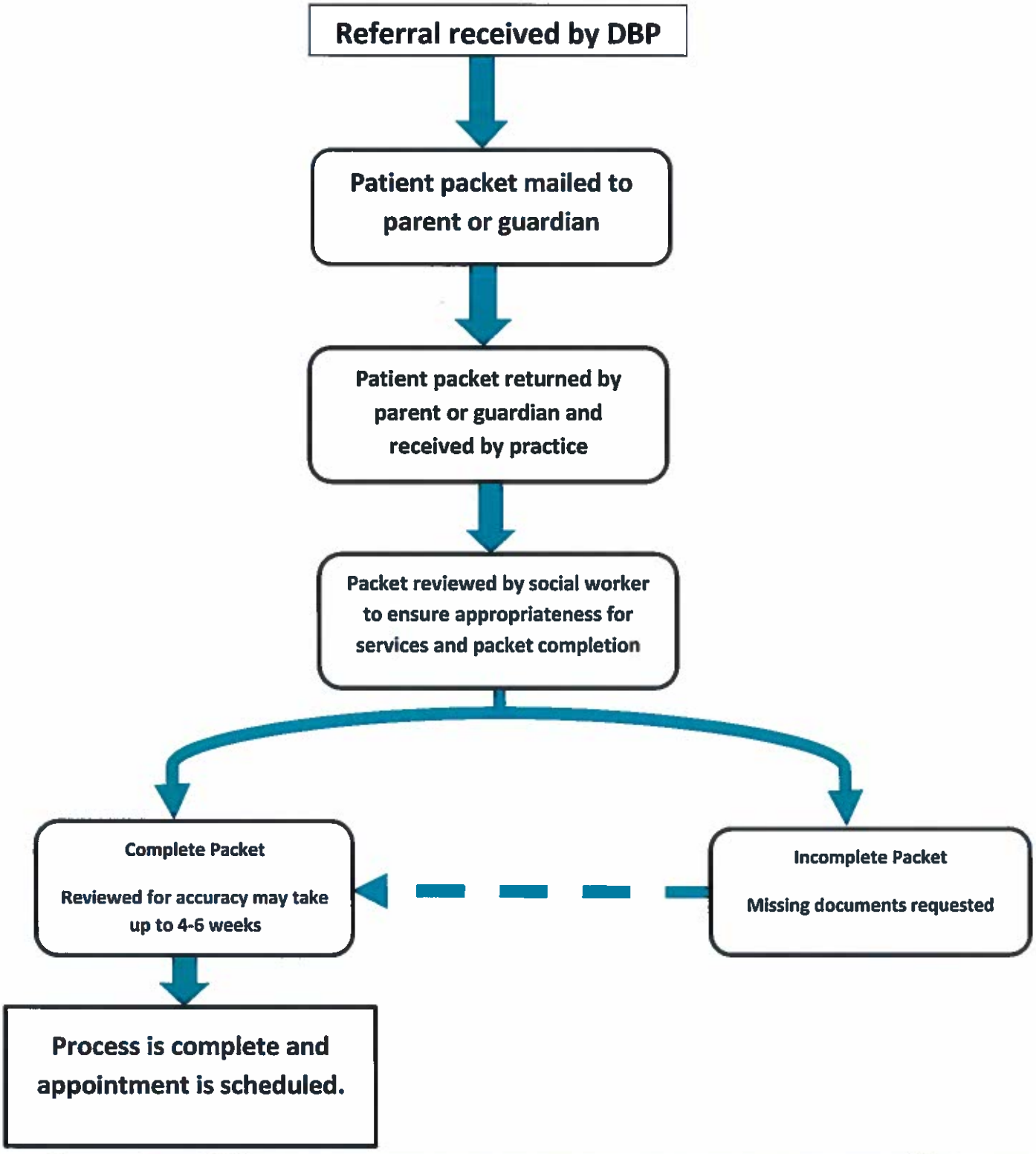
All referrals are time sensitive. Please return as soon as possible. The sooner we receive a completed packet the sooner we can place it in review. If you need assistance completing the packet, please call our office at 704-403-1653.

For more information about our practice, please visit our website:
https://atriumhealth.org/locations/developmental-and-behavioral-pediatrics-of-the-carolinas
Thank you for allowing us to participate in your child's health care needs. We look forward to meeting you.

Yours in Health Care,
Physicians and Care Team of
Developmental and Behavioral Pediatrics of the Carolinas

Developmental and Behavioral Pediatrics of the Carolinas

Referral Process



Developmental & Behavioral Pediatrics of the Carolinas.

Making the Most of Your Visit

To ensure a thorough and productive evaluation of your child, we request to you bring only your child scheduled for the visit. Please refrain from bringing the patient's siblings or other children to the appointment. If you must bring siblings, we kindly ask that you bring a responsible adult to accompany them in the waiting room during this time. This limits distractions and allows us to focus on your concerns for your child.

Due to the high volume of patients requiring our specialized services, our clinic has established the following guidelines regarding cancellations, no shows, and late arrivals. The policy is as follows:

Cancellations & No Shows

1. Please contact us for cancellations within 24 hours of the scheduled appointment time. This allows the office to schedule another patient in need of an appointment.

2. Appointments not cancelled within 24 hours or failure to attend a schedule appointment will be considered a ***"no show"***

3. Patients with **Three (3) no show** appointments within a 12-month period are subject to dismissal from the practice.

4. Patients with **Two 2 no show** appointments for initial evaluations (consults) will result in the dismissal of the patient's referral.

Late Arrivals

1. Patients who arrive ***10 minutes*** after their scheduled appointment time will be considered late. As the discretions of the provider, patients may be seen with a reduced visit time or may be required to reschedule their appointment.

We appreciate your cooperation and look forward to meeting you and your child.

704-403-2626

PAPERWORK CHECKLIST

We have enclosed this paperwork checklist to help you with your packet. To avoid delays in scheduling an appointment, please submit **ALL** items on the list that is relevant to your child. The below items are requested so that our providers may complete a thorough evaluation of your child. Please be aware that the provider may request additional evaluations before or after the initial consult for diagnostic clarification.

Please review front and back of each document to ensure they are complete.

- ☐ **Family Information Sheet**
- ☐ **Patient History Forms**
- ☐ **PHQ – 9**
- ☐ **BASC 3** (parent and teacher/daycare provider)
- ☐ **ASRS** (parent and teacher/daycare provider)

Please disregard teacher forms if your child is not enrolled in school, preschool, or daycare program

- ☐ **Full IEP and accompanying testing that was used to generate the IEP** (ex. Evaluations Intervention Evaluation, IQ Testing, Achievement Testing, Psychoeducational Evaluation, Speech Evaluation)
- ☐ **Full Psychoeducational Evaluation**
- ☐ **504 Plan** (if applicable)
- ☐ **Previous Evaluations and Records of Treatment:**
  - Speech, Occupational (OT), and/or Physical (PT) Therapy
  - Psychological/Psychoeducation Evaluation (IQ, Academic Testing, Speech, OT and PT Evaluations)
  - Psychiatry
  - Neurology
  - Early Childhood Evaluations (CDSA or Babynet)
  - Previous Developmental & Behavioral Pediatrician Records
  - Behavioral Therapy
  - Medication History (Prescribing Physician and Medication List)
- ☐ **Legal Documentation** if you are a foster parent, grandparent, or guardian, we will need copies of legal custody paperwork

*****MAIL ALL FORMS TO THE CONCORD LOCATION*****

Please note any other special needs: _____

If interpreter is required, please specify language: _____

Please select the location you would like your appointment scheduled:

☐ **Concord**
301 Medical Park Drive
Ste 202B
Concord, NC 28025

Physicians at Location
Joseph C. Stegman, MD
Mark C. Clayton, MD
Shruti Mittal, MD

☐ **Charlotte**
2608 East 7th Street
Charlotte, NC 28203

Physicians at Location
Yasmin S. Senturias, MD FAAP
Tsehaiwork "Sunny" Fenikile, MD
Shruti Mittal, MD

Developmental & Behavioral Pediatrics of the Carolinas
Family Information

Patient Information

Last Name	First	Middle	Sex ☐ Male ☐ Female
Date of Birth	Social Security No	*SS # needed for ALL Medicaid patients*	
Address	City	State	Zip Code
Primary Language ☐ English ☐ Spanish ☐ Other	Race		

Primary Custody/ Guardianship (Guardians will need to send copy of legal Documents)

☐ Parents ☐ Father ☐ Mother ☐ Grandparent ☐ Foster Care

Father/ Guardian Information

Last Name	First	
Date of Birth	Social Security No	
Address ☐Same as above		
Street	City	Zip Code
Home Phone No.	Mobile No.	
Employer	Work No.	

Mother/Guardian Information

Last Name	First	
Date of Birth	Social Security No	
Address ☐Same as above		
Street	City	Zip Code
Home Phone No.	Mobile No.	
Employer	Work No.	

In Case of Emergency

Name	Relationship to patient	Phone No.
Name	Relationship to patient	Phone No.

Insurance Information (send copy of front and back of card)

Primary Insurance Company Name		
Subscriber Information		
Name	Date of Birth	Social Security No.
Secondary Insurance Company Name		
Subscriber Information		
Name	Date of Birth	Social Security NO.
NC Medicaid ID No.	Social Security No.	

Permission for child to receive medical treatment

If I can't come with my child, I agree to let (person name)

I give permission to the above person to give permission for any treatment. Please Initial _____

Care Team Provider prefers a Parent to be present at all visits. This is for (in case of an emergency).

Signature of person completing form _____ **Date** _____

Atrium Health

Today's Date: _____

DEVELOPMENTAL & BEHAVIORAL PEDIATRICS FORM- PLEASE COMPLETE ENTIRE FORM

Child's Name: _____ Date of Birth: _____

Name Child wants to be called: _____

PATIENT HISTORY FORM

Name of person completing this Form: _____ Relationship to Child: _____

PURPOSE OF THE VISIT

Describe what concerns you have about your child: _____

_____

Previous Evaluations for these concerns: (Examples: School, CDSA, Psychiatrists, Psychologists, Neurologists, Genetics, Speech, OT, PT) _____

_____

What would you most like to happen with this this visit: _____

What questions do you have for the doctor?: _____

_____

Does he/she currently have an Individualized Education Program (IEP)? Yes/No OR Section 504 Plan? Yes/No

List any services your child is currently receiving: _____

(Speech/Occupational Therapy/Physical Therapy, ABA, special services through the school, 504, behavioral therapy)

CHILD'S HISTORY (fill out or encircle Yes/No items)

Describe your child's overall health/growth: _____

Describe Your Child's Growth: _____

Describe Your Child's Temperament: _____

Birth Weight: _____pounds _____ounces

Circle which of these describe your pregnancy: Full term / Premature (____ weeks) / Induced / vaginal delivery / C-section.

Were there any complications while you were pregnant or during birth? _____

_____

Hospitalizations/surgeries/chronic illnesses: _____

_____

Head injuries: _____ Seizures? Yes/No _____

ALLERGIES/ DRUG ALLERGIES: _____

When did your child begin school or preschool: _____ Repeated Grade: _____

Current School: _____ Grade: _____

PAST MEDICATIONS: If your child has been on any medications in the past, list with dose and reactions: (ex. Vyvanse: decreased appetite):

_____ _____

_____ _____

CURRENT MEDICATIONS (Name + Dose + When/how often):

_____ _____

_____ _____

_____ _____

DEVELOPMENTAL AND EDUCATIONAL HISTORY:

Describe concerns about your child's development: _____

_____

_____

At age did you first suspect difficulties? _____

Did your child lose any developmental skills at any point in time? _____

By what age did your child begin to do the following activities listed below?

MOTOR

Crawl: _____

Sit without support: _____

Walk alone: _____

Ride a bicycle without training wheels: _____

Walk up and down stairs: _____

LANGUAGE

Respond to name: _____

Said first word (with meaning) _____

Put 2 words together: _____

Talk about his/her day: _____

Pretend play with others: _____

SOCIAL/SELF HELP

Smile in response to others: _____

Use a spoon to feed self: _____

Bladder/bowel trained: _____

Play with others: _____

Able to separate from parent/caregiver: _____

Able to dress oneself: _____

When did your child begin school or preschool: _____ Repeated Grade: _____

CURRENT SCHOOL: _____ Grade: _____

Learning challenges (all subjects/list) _____

_____

In the list below, please circle one or more of the following behaviors your child has:

Self-regulatory: Feeding Problems (eating too much or too little/ no variety) / sleep problems (with or without snoring) / eating non-foods, hyperactive.

Social: Shyness with strangers/ bashfulness with other children/ poor eye contact/ failure to be affectionate.

Emotional: Temper tantrums/ irritability/ crying often and easily/ tendency to be overexcited/ difficulty getting consoled.

Sensory: High threshold for pain/ oversensitive to noises/ oversensitive to textures of food, clothing or light.

Aggression/self-injurious: head banging/ hurting self/ physical aggression to others.

Motor behaviors: repetitive movements/ motor tics/ vocal tics.

Others: problems with changes in routine, fixation on items, refusal to go to school.

REVIEW OF SYSTEMS

In the list below, please circle any problems your child has or has had in the past:

Chronic Pain	Unexplained Fevers
Weight Loss	Cancer
High Cholesterol	Cataracts
Crossed Eyes	Chronic Ear infections
Chronic Sinus Infections	Chronic Allergic symptoms
Heart Murmur	Other Heart Problems
Asthma	Bronchiolitis
RSV	High Blood Pressure
Chronic Bronchitis	Cystic Fibrosis
Other Lung Disorders	Chronic Diarrhea
Chronic Constipation	Reflux
Ulcer	Other stomach or bowel problem
Joint problems	Muscle Problems
Skin Problems	Chronic Eczema
ADHD	Learning Disabilities
Intellectual Disability	Autism
Seizures	Cerebral Palsy
Depression	Anxiety
Kidney or Bladder infections	Other kidney disease
Diabetes	Thyroid problems
Other glandular problems	Sickle Cell Anemia
Anemia	Other blood disease

Other(s) (please list): _____

FAMILY HISTORY:

Who in the family has any of the following difficulties? (only include biological family)
(This would include child's father, mother, brothers, sisters, grandparents, aunts, uncles and first cousins.)
Please indicate the family member related to the appropriate items below:

ADHD:	Autism spectrum Asperger:
Trouble learning:	Bipolar Disorder:
Intellectual Disability:	Schizophrenia:
Repeated a grade in school:	Seizures:
Speech problems:	Drinking or drug abuse:
Behavior problems in school:	Birth Defects/died as infant or child:
Anxiety:	Tics or Tourette's syndrome:
Depression:	Vision Impairment/ Hearing Impairment:

SOCIAL HISTORY:

PARENTS: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other _____

Who does the child live with? _____

Child's Relationship with Mother: _____

Child's Relationship with Father: _____

Siblings, names and ages: _____

Family circumstances: _____

Biological Father:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

Biological Mother:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

ADOPTION INFORMATION (IF APPLICABLE):

Is the child adopted? _____ At what age? _____

Circumstances of Adoption: _____

Adoptive Father:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

Adoptive Mother:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health _____

Has this child been in Foster Care? _____

Circumstances of Foster Care: _____

Foster Parents: _____

Total Number of foster placements? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

SEND TO SCHOOL

Parent/Guardian:

Please **complete** and send to school with your child. We will need **all** available documents **before** we can schedule an appointment for your child.

THE FOLLOWING INFORMATION IS REQUESTED:

- Full Psychoeducational Evaluation Results
- IQ and Achievement Testing
- Full Psychological/Psychiatric Evaluation, including Treatment Records
- Full Individualized Education Program (IEP)
- 504 Plan
- Speech/Occupational/Physical Therapy Records

Informed consent has been explained to me and I understand the contents to be released; the reason for the required information, and that there are statutes and regulations protecting the confidentiality of authorized information. I acknowledge that I may revoke this consent at any time, with the exception that the authorization within this consent has been initiated. I hereby consent to the release of confidential information contained in the records of:

Full Name of Student	**School Name**	**Date of Birth**
Parents Signature	**Relationship to Student**	**Date**

Please Fax Information Requested to: 704-403-2699

Developmental & Behavioral Pediatrics of the Carolinas

301 Medical Park Drive, Ste 202B

Concord, NC 28025

Office Number: 704-403-2626

BASC3

Parent Rating Scales PRS–P

Preschool Ages 2–5

Cecil R. Reynolds, PhD • Randy W. Kamphaus, PhD

Child's Name _____ (First / Middle / Last)

Date _____ (Month / Day / Year) Birth Date _____ (Month / Day / Year)

School _____ Grade _____

Child's Gender ☐ Male ☐ Female Age _____

Your Name _____ (First / MI / Last)

Your Gender ☐ Male ☐ Female

Your Relationship to Child ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Do you have concerns about this child's:

(a) Vision? Y N _____

(b) Hearing? Y N _____

(c) Eating habits? Y N _____

Instructions

This form contains phrases that describe how children may act. Please read each phrase and select the response that describes how this child has behaved recently (in the last several months).

Select **N** if the behavior **never** occurs.

Select **S** if the behavior **sometimes** occurs.

Select **O** if the behavior **often** occurs.

Select **A** if the behavior **almost always** occurs.

Please mark every item. If you don't know or are unsure of your response to an item, give your best estimate. A "Never" response does not mean that the child "never" engages in a behavior, only that you have no knowledge of it occurring.

How to Mark Your Responses

Be certain to circle completely the letter you choose:

N S (O) A

If you wish to change a response, mark an X through it and circle your new choice, like this:

N (S) ⊗ A

Before starting, be sure to complete the information above these instructions.

PEARSON

PsychCorp

3 4 5 6 7 8 9 10 11 12 A B C D E

Product Number 30807

Remember: N = Never S = Sometimes O = Often A = Almost always

1.	Is easy to please	N	S	O	A
2.	Begins conversations appropriately	N	S	O	A
3.	Is in constant motion	N	S	O	A
4.	Says, "please" and "thank you."	N	S	O	A
5.	Is a picky eater	N	S	O	A
6.	Gets sick	N	S	O	A
7.	Will seek help when he or she needs it	N	S	O	A
8.	Adjusts well to changes in family plans	N	S	O	A
9.	Breaks other children's things	N	S	O	A
10.	Is easily stressed	N	S	O	A
11.	Congratulates others when good things happen to them	N	S	O	A
12.	Provides full name when asked	N	S	O	A
13.	Interrupts parents when they are talking on the phone	N	S	O	A
14.	Is sad	N	S	O	A
15.	Needs help putting on clothes	N	S	O	A
16.	Pays attention	N	S	O	A
17.	Adjusts well to changes in routine	N	S	O	A
18.	Complains about health	N	S	O	A
19.	Shows fear of strangers	N	S	O	A
20.	Disrupts the play of other children	N	S	O	A
21.	Worries about what parents think	N	S	O	A
22.	Offers help to other children	N	S	O	A
23.	Whines	N	S	O	A
24.	Vomits	N	S	O	A
25.	Acts without thinking	N	S	O	A
26.	Worries about things that cannot be changed	N	S	O	A
27.	Loses control when angry	N	S	O	A
28.	Has a short attention span	N	S	O	A
29.	Engages in repetitive movements	N	S	O	A
30.	Is easily upset	N	S	O	A
31.	Isolates self from others	N	S	O	A
32.	Shares toys or possessions with other children	N	S	O	A
33.	Needs help tying shoes	N	S	O	A
34.	Seems odd	N	S	O	A
35.	Changes moods quickly	N	S	O	A
36.	Cannot wait to take turn	N	S	O	A
37.	Worries about parents	N	S	O	A
38.	Listens to directions	N	S	O	A
39.	Needs help using zippers	N	S	O	A
40.	Is shy with other children	N	S	O	A
41.	Seems unaware of others	N	S	O	A
42.	Is easily calmed when angry	N	S	O	A
43.	Teases others	N	S	O	A
44.	Eats things that are not food	N	S	O	A
45.	Needs help bathing self	N	S	O	A
46.	Worries about what other children think	N	S	O	A
47.	Has trouble eating with a fork	N	S	O	A
48.	Gets colds	N	S	O	A
49.	Is mean	N	S	O	A
50.	Avoids eye contact	N	S	O	A
51.	Answers telephone properly	N	S	O	A
52.	Is easily frustrated	N	S	O	A
53.	Politely asks for help	N	S	O	A
54.	Has trouble fastening buttons on clothing	N	S	O	A
55.	Is cruel to animals	N	S	O	A
56.	Has sore throats	N	S	O	A
57.	Needs to be reminded to brush teeth	N	S	O	A
58.	Bangs head	N	S	O	A
59.	Pays attention when being spoken to	N	S	O	A
60.	Tries to be perfect	N	S	O	A
61.	Falls down or trips over things easily	N	S	O	A
62.	Tries new things	N	S	O	A
63.	Threatens to hurt others	N	S	O	A
64.	Provides home address when asked	N	S	O	A
65.	Sleeps with parents	N	S	O	A
66.	Communicates clearly	N	S	O	A
67.	Compliments others	N	S	O	A
68.	Has headaches	N	S	O	A
69.	Reacts negatively	N	S	O	A
70.	Wets bed	N	S	O	A
71.	Holds a grudge	N	S	O	A
72.	Pouts	N	S	O	A
73.	Responds appropriately when asked a question	N	S	O	A
74.	Fiddles with things while at meals	N	S	O	A
75.	Quickly joins group activities	N	S	O	A
76.	Stares blankly	N	S	O	A
77.	Sets fires	N	S	O	A
78.	Is easily distracted	N	S	O	A
79.	Recovers quickly after a setback	N	S	O	A
80.	Cries easily	N	S	O	A
81.	Is unclear when presenting ideas	N	S	O	A
82.	Avoids other children	N	S	O	A
83.	Finds ways to solve problems	N	S	O	A
84.	Hits other children	N	S	O	A
85.	Is overly emotional	N	S	O	A
86.	Is shy with adults	N	S	O	A
87.	Has fevers	N	S	O	A
88.	Adjusts easily to new surroundings	N	S	O	A
89.	Avoids exercise or other physical activity	N	S	O	A
90.	Is negative about things	N	S	O	A

Remember: N = Never S = Sometimes O = Often A = Almost always

91.	Has trouble making new friends.	N	S	O	A
92.	Has trouble concentrating.	N	S	O	A
93.	Says, "I'm not very good at this."	N	S	O	A
94.	Does strange things	N	S	O	A
95.	Starts conversations	N	S	O	A
96.	Bullies others	N	S	O	A
97.	Complains of physical problems	N	S	O	A
98.	Is irritable.	N	S	O	A
99.	Argues when denied own way	N	S	O	A
100.	Volunteers to help with things	N	S	O	A
101.	Says things that make no sense.	N	S	O	A
102.	Is overly active	N	S	O	A
103.	Says all letters of the alphabet when asked.	N	S	O	A
104.	Worries about making mistakes.	N	S	O	A
105.	Says, "Nobody likes me."	N	S	O	A
106.	Misses school or daycare because of sickness	N	S	O	A
107.	Uses appropriate table manners.	N	S	O	A
108.	Readily starts up conversations with new people.	N	S	O	A
109.	Gets angry easily	N	S	O	A
110.	Complains of being cold	N	S	O	A
111.	Has poor self-control.	N	S	O	A
112.	Has toileting accidents.	N	S	O	A
113.	Shows basic emotions clearly.	N	S	O	A
114.	Has seizures.	N	S	O	A
115.	Listens carefully.	N	S	O	A
116.	Adjusts well to new teachers or caregivers	N	S	O	A
117.	Needs too much supervision	N	S	O	A
118.	Acts strangely	N	S	O	A
119.	Is overly aggressive	N	S	O	A
120.	Is clear when telling about personal experiences.	N	S	O	A
121.	Interrupts others when they are speaking	N	S	O	A
122.	Complains of pain.	N	S	O	A
123.	Encourages others to do their best	N	S	O	A
124.	Speaks in short phrases that are hard to understand.	N	S	O	A
125.	Avoids making friends	N	S	O	A
126.	Makes frequent visits to the doctor	N	S	O	A
127.	Babbles to self.	N	S	O	A
128.	Worries	N	S	O	A
129.	Says, "I'm afraid I will make a mistake."	N	S	O	A
130.	Makes friends easily	N	S	O	A
131.	Shows feelings that do not fit the situation.	N	S	O	A
132.	Complains of stomach pain	N	S	O	A
133.	Acts out of control	N	S	O	A
134.	Prefers to play alone.	N	S	O	A
135.	Does weird things.	N	S	O	A
136.	Clings to parent in strange surroundings	N	S	O	A
137.	Is unable to slow down.	N	S	O	A
138.	Is nervous.	N	S	O	A
139.	Is able to describe feelings accurately.	N	S	O	A

General Comments

What are the behavioral and/or emotional strengths of this child?

Please list any specific behavioral and/or emotional concerns you have about this child.

PsychCorp is an imprint of Pearson Clinical Assessment.

Pearson Executive Office 5601 Green Valley Drive Bloomington, MN 55437
800.627.7271 www.PearsonClinical.com

BASC-3

Cecil R. Reynolds, PhD • Randy W. Kamphaus, PhD

Teacher Rating Scales

TRS–P

Preschool Ages 2–5

Child's Name _____ (First / Middle / Last)

Date _____ (Month / Day / Year) Birth Date _____ (Month / Day / Year)

School _____ Grade _____

Gender ☐ Male ☐ Female Age _____

Your Name _____ (First / MI / Last)

Your Position ☐ Regular-education teacher ☐ Special-education teacher ☐ Other _____

How long have you known this child?

☐ Less than 1 month ☐ 1–2 months ☐ 3–5 months ☐ 6–11 months ☐ 12 months or more

Do you have concerns about this child's:

(a) Vision? Y N _____

(b) Hearing? Y N _____

Instructions

This form contains phrases that describe how children may act. Please read each phrase and select the response that describes how this child has behaved recently (in the last several months).

Select **N** if the behavior **never** occurs.
Select **S** if the behavior **sometimes** occurs.
Select **O** if the behavior **often** occurs.
Select **A** if the behavior **almost always** occurs.

Please mark every item. If you don't know or are unsure of your response to an item, give your best estimate. A "Never" response does not mean that the child "never" engages in a behavior, only that you have not observed the child behaving that way.

How to Mark Your Responses

Be certain to circle completely the letter you choose:

N S (O) A

If you wish to change a response, mark an X through it and circle your new choice, like this:

N (S) ~~O~~ A

Before starting, be sure to complete the information above.

Remember: N = Never S = Sometimes O = Often A = Almost always

1.	Pays attention.	N	S	O	A	31.	Loses control when angry.	N	S	O	A
2.	Worries.	N	S	O	A	32.	Listens attentively.	N	S	O	A
3.	Transitions well.	N	S	O	A	33.	Is overly aggressive.	N	S	O	A
4.	Says all letters of the alphabet when asked.	N	S	O	A	34.	Has trouble staying seated.	N	S	O	A
5.	Recovers quickly after a setback.	N	S	O	A	35.	Complains of pain.	N	S	O	A
6.	Is irritable.	N	S	O	A	36.	Seems to take setbacks in stride.	N	S	O	A
7.	Encourages others to do their best.	N	S	O	A	37.	Avoids other children.	N	S	O	A
8.	Seems out of touch with reality.	N	S	O	A	38.	Has a short attention span.	N	S	O	A
9.	Gets colds.	N	S	O	A	39.	Misses school or daycare because of sickness.	N	S	O	A
10.	Provides full name when asked.	N	S	O	A	40.	Adjusts well to changes in routine.	N	S	O	A
11.	Is easily distracted.	N	S	O	A	41.	Is sad.	N	S	O	A
12.	Congratulates others when good things happen to them.	N	S	O	A	42.	Offers help to other children.	N	S	O	A
13.	Is mean.	N	S	O	A	43.	Shares toys or possessions with other children.	N	S	O	A
14.	Is pessimistic.	N	S	O	A	44.	Reacts negatively.	N	S	O	A
15.	Communicates clearly.	N	S	O	A	45.	Does strange things.	N	S	O	A
16.	Controls emotions.	N	S	O	A	46.	Annoys others on purpose.	N	S	O	A
17.	Listens carefully.	N	S	O	A	47.	Refuses to talk.	N	S	O	A
18.	Avoids making friends.	N	S	O	A	48.	Adjusts well to new teachers or caregivers.	N	S	O	A
19.	Is easily stressed.	N	S	O	A	49.	Is clear when telling about personal experiences.	N	S	O	A
20.	Finds ways to solve problems.	N	S	O	A	50.	Has toileting accidents.	N	S	O	A
21.	Seems odd.	N	S	O	A	51.	Loses temper too easily.	N	S	O	A
22.	Is overly active.	N	S	O	A	52.	Has trouble making new friends.	N	S	O	A
23.	Has fevers.	N	S	O	A	53.	Acts strangely.	N	S	O	A
24.	Disrupts the play of other children.	N	S	O	A	54.	Starts conversations.	N	S	O	A
25.	Will seek help when he or she needs it.	N	S	O	A	55.	Threatens to hurt others.	N	S	O	A
26.	Says, "please" and "thank you."	N	S	O	A	56.	Is easily frustrated.	N	S	O	A
27.	Is unclear when presenting ideas.	N	S	O	A	57.	Listens to directions.	N	S	O	A
28.	Complains about health.	N	S	O	A	58.	Engages in repetitive movements.	N	S	O	A
29.	Says, "Nobody likes me."	N	S	O	A	59.	Breaks other children's things.	N	S	O	A
30.	Is overly emotional.	N	S	O	A	60.	Responds appropriately when asked a question.	N	S	O	A

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PsychCorp

Product Number 30801

Remember: N = Never S = Sometimes O = Often A = Almost always

61.	Hits other children.	N	S	O	A
62.	Provides home address when asked.	N	S	O	A
63.	Prefers to play alone.	N	S	O	A
64.	Has poor self-control.	N	S	O	A
65.	Says, "I'm afraid I will make a mistake."	N	S	O	A
66.	Politely asks for help.	N	S	O	A
67.	Falls down or trips over things easily.	N	S	O	A
68.	Defies teachers or caregivers.	N	S	O	A
69.	Worries about things that cannot be changed.	N	S	O	A
70.	Gets sick.	N	S	O	A
71.	Quickly joins group activities.	N	S	O	A
72.	Gets angry easily.	N	S	O	A
73.	Acts as if other children are not there.	N	S	O	A
74.	Is negative about things.	N	S	O	A
75.	Worries about parents.	N	S	O	A
76.	Has headaches.	N	S	O	A
77.	Bothers other children when they are working.	N	S	O	A
78.	Avoids eye contact.	N	S	O	A
79.	Is easily upset.	N	S	O	A
80.	Has trouble concentrating.	N	S	O	A
81.	Compliments others.	N	S	O	A
82.	Has trouble keeping hands or feet to self.	N	S	O	A
83.	Shows feelings that do not fit the situation.	N	S	O	A
84.	Appears tense.	N	S	O	A
85.	Complains of stomach pain.	N	S	O	A
86.	Cannot wait to take turn.	N	S	O	A
87.	Cries easily.	N	S	O	A
88.	Has sore throats.	N	S	O	A
89.	Pouts.	N	S	O	A
90.	Speaks out of turn during class.	N	S	O	A
91.	Is nervous around new people.	N	S	O	A
92.	Bullies others.	N	S	O	A
93.	Eats things that are not food.	N	S	O	A
94.	Argues when denied own way.	N	S	O	A
95.	Is nervous.	N	S	O	A
96.	Says things that make no sense.	N	S	O	A
97.	Acts out of control.	N	S	O	A
98.	Is easily calmed when angry.	N	S	O	A
99.	Is able to describe feelings accurately.	N	S	O	A
100.	Complains of physical problems.	N	S	O	A
101.	Babbles to self.	N	S	O	A
102.	Gets very upset when things are lost.	N	S	O	A
103.	Isolates self from others.	N	S	O	A
104.	Shows basic emotions clearly.	N	S	O	A
105.	Is in constant motion.	N	S	O	A

General Comments

What are the behavioral and/or emotional strengths of this child?

Please list any specific behavioral and/or emotional concerns you have about this child.

ASRS® (2–5 Years) PARENT RATINGS

Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.

Response Form

Child's Name/ID: _____ Gender: M F (Circle One) Today's Date: ____/____/____ (Year / Month / Day)

Parent's Name/ID: _____ Childcare Setting: _____ Birth Date: ____/____/____ (Year / Month / Day)

Did your child acquire language before age 3? Yes No Don't Know Not applicable (child is under age 3)

If Yes, did your child speak in 3 word sentences by age 3? Yes No Don't Know Not applicable (child is under age 3)

Age: ____/____/____ (Years / Months / Days)

Instructions: Read each statement that follows the phrase, "***During the past four weeks, how often did the child...,***" then circle the number under the word that tells how often you saw the behavior. Read each question carefully, then mark how often you saw the behavior in the **past four weeks.** Answer every question without skipping any. If you want to change your answer, put an X through it and circle your new choice. Be sure to answer every question.

During the past four weeks, how often did the child...	Never	Rarely	Occasionally	Frequently	Very Frequently
1. smile appropriately?	0	1	2	3	4
2. become bothered by some fabrics or tags in clothes?	0	1	2	3	4
3. understand how someone else felt?	0	1	2	3	4
4. play with others?	0	1	2	3	4
5. look at others when talking with them?	0	1	2	3	4
6. ask questions that were off-topic?	0	1	2	3	4
7. point to objects when asked to?	0	1	2	3	4
8. insist on doing things the same way each time?	0	1	2	3	4
9. need things to happen just as expected?	0	1	2	3	4
10. have a strong reaction to any change in routine?	0	1	2	3	4
11. line up objects in a row?	0	1	2	3	4
12. overreact to common smells?	0	1	2	3	4
13. look at others when interacting with them?	0	1	2	3	4
14. understand the point of view of others?	0	1	2	3	4
15. have trouble talking with other children?	0	1	2	3	4
16. share fun activities with others?	0	1	2	3	4
17. appear disorganized?	0	1	2	3	4
18. use make believe play?	0	1	2	3	4
19. care about what other people think or feel?	0	1	2	3	4
20. become upset if routines were changed?	0	1	2	3	4
21. respond when spoken to by adults?	0	1	2	3	4
22. use language that was immature for his/her age?	0	1	2	3	4
23. avoid looking at an adult when there was a problem?	0	1	2	3	4
24. choose to play alone?	0	1	2	3	4
25. listen when spoken to?	0	1	2	3	4
26. talk too much about things that other children don't care about?	0	1	2	3	4
27. focus too much on details?	0	1	2	3	4
28. start conversations with others?	0	1	2	3	4
29. keep a conversation going?	0	1	2	3	4
30. play next to, but not with, other children?	0	1	2	3	4

Please flip this form over to answer statements 31 to 70.

ASRS® (2–5 Years) PARENT RATINGS

Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.

Response Form

During the past four weeks, how often did the child...	Never	Rarely	Occasionally	Frequently	Very frequently
31. get into trouble with adults?	0	1	2	3	4
32. fail to complete tasks?	0	1	2	3	4
33. have social problems with adults?	0	1	2	3	4
34. have problems waiting his/her turn?	0	1	2	3	4
35. play with toys appropriately?	0	1	2	3	4
36. show little emotion?	0	1	2	3	4
37. learn simple tasks but then forget them quickly?	0	1	2	3	4
38. notice social cues?	0	1	2	3	4
39. become fascinated with parts of objects?	0	1	2	3	4
40. respond when spoken to by other children?	0	1	2	3	4
41. talk too much about things that adults don't care about?	0	1	2	3	4
42. use an odd way of speaking?	0	1	2	3	4
43. avoid looking at people who spoke to him/her?	0	1	2	3	4
44. have trouble talking with adults?	0	1	2	3	4
45. resist being touched or held?	0	1	2	3	4
46. overreact to loud noises?	0	1	2	3	4
47. focus on one subject for too much time?	0	1	2	3	4
48. insist on keeping certain objects with him/her at all times?	0	1	2	3	4
49. seek the company of other children?	0	1	2	3	4
50. show an interest in the ideas of others?	0	1	2	3	4
51. have social problems with children of the same age?	0	1	2	3	4
52. understand age-appropriate humor or jokes?	0	1	2	3	4
53. repeat certain words or phrases out of context?	0	1	2	3	4
54. share his/her enjoyment with others?	0	1	2	3	4
55. have problems paying attention to fun tasks?	0	1	2	3	4
56. insist on certain routines?	0	1	2	3	4
57. follow instructions that he/she understood?	0	1	2	3	4
58. interrupt or intrude on others?	0	1	2	3	4
59. reverse pronouns (e.g., you for me)?	0	1	2	3	4
60. become obsessed with details?	0	1	2	3	4
61. show good peer interactions?	0	1	2	3	4
62. appear fidgety when asked to sit still?	0	1	2	3	4
63. become distracted?	0	1	2	3	4
64. flap his/her hands when excited?	0	1	2	3	4
65. twirl, spin, or bang objects?	0	1	2	3	4
66. smell, taste, or eat inedible objects?	0	1	2	3	4
67. fail to make his/her needs known?	0	1	2	3	4
68. hurt him/herself (e.g., banged own head) when upset?	0	1	2	3	4
69. overreact to touch?	0	1	2	3	4
70. repeat or echo what others said?	0	1	2	3	4

ASRS®

(2–5 Years) TEACHER CHILD/CARE PROVIDER RATINGS
Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.

Response Form

Child's Name/ID: _____ Gender: M F (Circle One)

Today's Date: ____/____/____ (Year / Month / Day)

Teacher's Name/ID: _____

Birth Date: ____/____/____ (Year / Month / Day)

Time Known Child: ____ (Years) ____ (Months)

Childcare Setting: _____

Age: ____/____/____ (Years / Months / Days)

Instructions: Read each statement that follows the phrase, "***During the past four weeks, how often did the child...,***" then circle the number under the word that tells how often you saw the behavior. Read each question carefully, then mark how often you saw the behavior **in the past four weeks.** Answer every question without skipping any. If you want to change your answer, put an X through it and circle your new choice. Be sure to answer every question.

During the past four weeks, how often did the child...	Never	Rarely	Occasionally	Frequently	Very Frequently
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2. become bothered by some fabrics or tags in clothes?	0	1	2	3	4
3. understand how someone else felt?	0	1	2	3	4
4. play with others?	0	1	2	3	4
5. look at others when talking with them?	0	1	2	3	4
6. ask questions that were off-topic?	0	1	2	3	4
7. point to objects when asked to?	0	1	2	3	4
8. insist on doing things the same way each time?	0	1	2	3	4
9. need things to happen just as expected?	0	1	2	3	4
10. have a strong reaction to any change in routine?	0	1	2	3	4
11. line up objects in a row?	0	1	2	3	4
12. overreact to common smells?	0	1	2	3	4
13. look at others when interacting with them?	0	1	2	3	4
14. understand the point of view of others?	0	1	2	3	4
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17. appear disorganized?	0	1	2	3	4
18. use make believe play?	0	1	2	3	4
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23. avoid looking at an adult when there was a problem?	0	1	2	3	4
24. choose to play alone?	0	1	2	3	4
25. listen when spoken to?	0	1	2	3	4
26. talk too much about things that other children don't care about?	0	1	2	3	4
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Please flip this form over to answer statements 31 to 70.

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Response Form

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39. become fascinated with parts of objects?	0	1	2	3	4
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42. use an odd way of speaking?	0	1	2	3	4
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66. smell, taste, or eat inedible objects?	0	1	2	3	4
67. fail to make his/her needs known?	0	1	2	3	4
68. hurt him/herself (e.g., banged own head) when upset?	0	1	2	3	4
69. overreact to touch?	0	1	2	3	4
70. repeat or echo what others said?	0	1	2	3	4