AUSTIN BEHAVIORAL HEALTH CENTER, L.C.
Gary G.F. Yorke, Ph.D.
Jane M. Yorke, M.A.
3355 Bee Cave Road., Suite 610
Austin, Texas 78746
512-347-7666

EARLY CHILDHOOD ASSESSMENT PROGRAM

INSTRUCTIONS:

1) PLEASE COMPLETE THIS PAGE AND HAVE YOUR PHYSICIAN COMPLETE PAGE 2.

2) COMPLETE THE REMAINDER OF THIS QUESTIONNAIRE (DO NOT SEPARATE FROM PAGE 2).

NAME:_____ TODAY'S DATE_____

SEX: ____M _____F DATE OF BIRTH:_____ AGE_____

DAYCARE OR PRESCHOOL ATTENDING:_____

TEACHER OR DIRECTOR'S NAME:_____

PARENT/GUARDIAN 1 NAME:_____

PARENT/GUARDIAN 2 NAME:_____

STEPMOTHER'S NAME (if applicable):_____

STEPFATHER'S NAME (if applicable):_____

PLEASE DO NOT TEAR THIS PAGE OUT TO MAIL. GIVE IT BACK TO PARENTS TO HAND CARRY. THANK YOU.

PHYSICIAN'S FORM

REASON FOR REFERRAL:_____

_____

Height: _____ Percentile: _____ Weight: _____ Percentile: _____

Head Circumference: _____ Percentile: _____

Blood Pressure: _____/_____ General Appearance: _____

Vision (Specify Test _____)_____

Hearing (Specify Method_____)_____

(Place an "X" to the right of any abnormal findings. Cross out items not performed.)

_____

Hair and Scalp	Neck--Palpation	Extremities--Muscles
Skin	Chest--Appearance	Extremities--Other
Eyes--Fundoscopic	Lungs--Auscultation	Vertebral Column
Eyes--Oculomotor	Heart--Rhythm, Rate	Cranial Nerves
Eyes--Other	Heart--Murmurs	Reflex Intensity
Ears--Tympanic Membranes	Abdomen--Appearance	Reflex Symmetry
Ears--Canals	Abdomen--Masses	Pathological Reflexes
Ears--Other	Genitalia--Hernia	Gait
Nasopharynx	Genitalia--Other	Sensation
Oropharynx	Anorectal	Other Neurological
Mouth--Teeth, Gums	Lymph Nodes	Urinalysis
Mouth--Other	Extremities--Joints	Hemoglobin/Hematocrit
		Other Items, Tests:

Immunizations (Date completed)

DT	Polio
Measles	Mumps
Rubella	TB
Other(s)	

_____

Summary statement on findings and overall health:_____

_____

_____

_____

Describe abnormal findings:_____

_____

_____

_____

PARENT'S FORM

1. Please identify the reason you are seeking this assessment:_____

2. When did the problem(s) begin?_____

3. List anything you did to improve the problem:_____

PLEASE LIST THE NAMES OF ALL FAMILY MEMBERS WITH WHOM THE CHILD LIVES:

NAME	AGE	RELATION TO THE CHILD

FAMILY/ENVIRONMENTAL FACTORS

Are the biological parents divorced? _____ separated? _____widowed?_____

If so, at what age was the child when these events occurred?_____

If biological parents are divorced, who has legal custody?_____

Does the child visit the non-custodial parent?_____ If so, how often?_____

Who cared for the child during the first two years? Describe changes in caretakers:_____

_____

_____

_____

Was English the child's first language? If not, what was the first language and when did the child learn to speak English?_____

Did the child attend daycare?_____yes _____no If so, at what ages?_____

Did the child attend preschool? _____yes _____no If so, at what ages?_____

Were both parents involved in the child's care?_____

Who stays with the child when the child is ill?_____

What forms of discipline do you use?_____

_____

Who usually disciplines the child?_____

_____

Do both parents agree on discipline? If no, please elaborate:_____

_____

_____

Do you have extended family in the area to help the with the child? Describe:_____

_____

_____

Does the child have a close relationship with an adult not presently living at home (e.g., grandparent, relative, family friend) If so, who?_____

_____

What other support systems do you have?_____

_____

Where do you turn for suggestions and information regarding parenting and child development?

_____

_____

Is mother employed outside of the home? _____yes _____no

If so, where? _____ How many hours per week?_____

Is father employed outside of the home? _____yes _____no

If so, where? _____ How many hours per week?_____

Mother's educational level:_____

Father's educational level:_____

Who watches your child after school hours?_____

Does the child play outside in the neighborhood?_____

What activities does your child enjoy?_____

_____

What kinds of jobs or household responsibilities does your child have?_____

_____

Does he/she do them willingly? _____ Without prompting? _____

What kinds of activities do you do together as a family?_____

_____

Describe your child's strengths:_____

_____

Has your child ever had a psychological or psychiatric evaluation?_____

If so, when and by whom?_____

Has your child ever been hospitalized for emotional reasons?_____

_____

_____

Is there anything else you would like us to know about your child?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The following checklists help us decide whether there are any medical factors that might be important. The checklist entitled "Possible Pregnancy Problems" concerns pregnancy with the child, except for the last two items, which refer to previous pregnancies. The "Newborn Infant Problems" checklist is about the baby's first month of life. Please read each list; then put an X in the appropriate column following each item.

POSSIBLE PREGNANCY PROBLEMS	**TRUE**	**NOT TRUE**	**NOT SURE**
Had bleeding during first 3 months			
Had bleeding during second 3 months			
Had bleeding during the last 3 months			
Gained 30 or more pounds (specify:_____)			
Had toxemia			
Had to take medications*			
Vomited often			
Got hurt or injured			
Gained less then 15 pounds (specify:_____)			
Took narcotic drugs			
Drank much alcohol			
Had an infection			
Smoked one (or more) packs of cigarettes a day			
Labor lasted longer than 12 hours (specify:_____)			
Had a cesarean section			
Had a difficult delivery			
Was put to sleep for delivery			
Had previous miscarriages			
Had previous premature baby(ies)			

Length of this pregnancy _____months _____ weeks

*Specify any medications:_____

_____

Other pregnancy problems/illnesses:_____

_____

NEWBORN INFANT PROBLEMS	TRUE	NOT TRUE	NOT SURE
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Turned yellow (jaundice)			
Turned blue (cyanosis)			
Was a twin or triplet			
Had an infection			
Was given medications			
Had seizures (fits, convulsions)			
Had diarrhea			
Needed oxygen			
Was in hospital for more than 7 days			
Gagged often			
Vomited often			
Born with heart defect			
Had trouble sucking			
Had skin problems			
Was very jittery			

Baby's birth weight _____ lbs. _____ oz.

Please list any other problems:_____

_____

_____

Was child breast-fed? _____ No _____ Yes (until age _____ months)

Following are two checklists about problems parents sometimes have with very young children. The checklist entitled "Health Problems" is about any medical problems the child may have had during the first two years of life. The "Functional Problems" checklist includes personality or behavioral problems that child may have had. In both lists, if the child has had any of these problems, please put an X. Please note when the problem occurred.

HEALTH PROBLEMS	**X**	**Age(s) problem occurred**
Ear infections		
Rashes or skin problems		
Meningitis		
Seizures (convulsions) or spells		
High fevers(over103)		
Pneumonia		
Asthma		
Slow weight gain		
Trouble with ears or hearing		
Trouble with eyes or vision		
Diarrhea		
Hospitalization		
Surgery (operations)		
Serious injuries		
Food allergies		
Other allergies		
Anemia (low blood count)		
Lead poisoning		
Other poisoning or overdose		
Heart problems		
Got sick after a shot (immunization)		
Other important illness(specify):		
Medications used over a long period of time		

FUNCTIONAL PROBLEMS	X	Age(s) problem occurred
Feeding difficulty		
Poor appetite		
Unwillingness to try new foods		
Very unpredictable appetite		
Extreme hunger		
Colic		
Constipation		
Stomach aches		
Trouble falling asleep		
Trouble staying asleep		
Very unpredictable length of sleep		
Very heavy sleeping		
Overactivity		
Head banging		
Temper tantrums		
Self-destructive behavior (hurt self)		
Difficulty in being comforted or consoled		
Stiffness or rigidity		
Looseness or floppiness		
Crying often and easily		
Shyness with strangers		
Bashfulness with new children		
Irritability		
Extreme reaction to noise or sudden movement		
Difficulty in keeping to a schedule		
Difficulty getting satisfied		
Desire to be held too often		
Failure to be affectionate toward parents		
Unwillingness to go along with change in daily routine		

Following is a checklist of early accomplishments of children. Please put an "X" next to each item under the column giving the age at which this milestone first occurred. If there are items the child still cannot do, please put an "X" in the "Not Yet" column.

EARLY DEVELOPMENT	**X**	**Age**	**Not Yet**
Sat up without help			
Crawled			
Walked alone (10-15 steps)			
Walked up stairs			
Rode a tricycle			
Caught a big ball			
Spoke first words (Mama, Dada, etc.)			
Put words together			
Spoke 2-3 word sentence			
Spoke clearly so strangers understood			
Used fingers to feed self			
Used a spoon			
Fully bowel trained			
Fully bladder trained			
Able to separate easily from mother			

Following is a checklist of eight school problems. We are interested in whether anyone in the family other than this child has or has had any of these. Please put an "X" in the column of the family member(s) who have or have had each problem. If more than one brother or sister has or has had one of these difficulties, put an "X" for each one in the appropriate column. (For example, if there were two brothers who had trouble learning how to read, you would put two "X's" under the column "Child's Brother's). The "Other" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Child's Mother	Child's Father	Child's Sister(s)	Child's Brother(s)	Other Specify
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Speech problems					
Behavior problems in childhood					
In trouble as a teenager					
Kept back in school					

In this section there is a list of sentences that parents use to describe their children. Please read each of these statements and place an "X" in the appropriate column.

KEY

Definitely applies = Is much more frequent and/or extreme than in others of the same age
Applies somewhat = Is sometimes more extreme than in others of the same age
Does not apply = Is usually appropriate or better than average for his or her age

ACTIVITY-ATTENTION PROBLEMS	Definitely Applies	Applies Somewhat	Does Not Apply
His/her body is in constant motion			
His/her body is underactive			
His/her mind seems overactive			
He/she has trouble sitting through a meal			
He/she does things without thinking			
He/she starts things, but doesn't finish them			
At times, he/she doesn't seem to hear what you say			
He/she does things in the wrong order			
He/she doesn't realize when he/she has made a mistake			
He/she has trouble falling asleep at night			
He/she has trouble staying asleep at night			
He/she yawns often during the day			
He/she breaks things around the home			
He/she seems to do things the hard way			
He/she stares at things for long periods			
He/she listens to outside noises for long periods			
He/she get s distracted easily			
He/she likes to keep changing games			
He/she is hard to control on a car trip			
He/she can't keep his/her hands to themselves			
He/she seems to want things all the time			

Following is a list of behaviors and characteristics. All children show some of these at some time during their lives. To the right of each item, please put an "X" in the column which best describes this child during the past six months. If a particular item does not describe the child, put an "X" in the column "Does Not Apply".

KEY

Definitely applies = Is much more frequent and/or extreme than in others of the same age
Applies somewhat = Is sometimes more extreme than in others of the same age
Does not apply = Is usually appropriate or better than average for his or her age

ASSOCIATED BEHAVIORS	**Definitely Applies**	**Applies Somewhat**	**Does Not Apply**
Is moody			
Has a bad temper			
Cries easily			
Is a worrier			
Has bad dreams			
Sleeps or tries to sleep with parents			
Is often sad			
Is often very quiet			
Whines often			
Is fearful of being alone			
Is fearful of new situations, people, places			
Is often tired			
Has stomach aches or headaches often			
Wets bed or pants often			
Soils underwear or has accidents with bowel movements			
Overeats often			
Bites nails or sucks thumb			
Often complains of pains in arms or legs			
Has nervous twitches or tic			

ASSOCIATED BEHAVIORS CONT'D.	Definifely Applies	Applies Somewhat	Does Not Apply
Complains of feeling ill often			
Has constipation			
Is often too concerned about cleanliness & neatness			
Tell lies			
Often takes things from parents/sibling without permission			
Starts fights with other children			
Bullies other children			
If fresh, rude to grownups			
Destroys objects at home			
Is fearless			
Is mean			
Deliberately tries to make parents angry			
Gets in trouble with neighbors			
Is cruel to animals			
Is a "loner"			
Has no real friends			
Loses friends easily			
Has mostly younger friends			
Has mostly older friends			
Gets bossed by other children			
Clings to adults			
Is slow to trust adults			
Gets picked on			
Demands to be the center of attention			
Is not liked by other children			

Below is list of positive or good behaviors. Please indicate which of these pertain to you child by putting "X" in the appropriate column to the right of each item.

ASSOCIATED STRENGTHS	**Definitely Applies**	**Applies Somewhat**	**Does Not Apply**
Has an even disposition, is easy to live with			
Usually seems happy			
Enjoys new experiences			
Easily becomes involved in many activities			
Takes pleasure in many activities			
Is affectionate			
Is kind or sympathetic if someone is sad or hurt			
Is friendly and outgoing			
Plays well with other children			
Shares toys with others			
Accepts rules easily			
Plays gently with smaller children or animals			
Enjoys playing with other children			
Takes turns well			
Tolerates minor bumps and scratches without much complaint			
Tolerates criticism well			
Handles frustrations well			
Is forgiving			
Stands up for himself/herself when necessary			
Recovers easily after disappointments			

Please add any information which you feel may help us better understand your child:

Please attach a recent photograph of the child, if available, in the space below. This will help us remember him or her if there is an inquiry from you after the evaluation. It is not essential, but it can be very useful. Any size is acceptable.

ATTACH PHOTOGRAPH HERE