College of Public Health and Health Professions
Department of Clinical and Health Psychology
Psychology Clinic

1600 SW Archer Rd, Room G-901
PO Box 100165
Gainesville, FL 32610-0165
Phone: (352) 265-0294
Fax: (352) 265-0096

APPOINTMENT INFORMATION - Developmental Neuropsychology Service

Appointment Date _____ **Appointment Time_____**

Appointment Location: Shands Hospital Psychology Clinic

Your child has been referred to the UF Developmental Psychology Clinic for an evaluation. Your child's appointment has been scheduled with **Dr. Cynthia Johnson.** Since UF Health at Shands is a teaching hospital, Dr. Johnson typically has doctoral trainees assisting her with the assessments. The testing typically involves discussing concerns with the parents and one-on-one testing with your child to evaluate their developmental, emotional/behavioral and social, abilities. It is important to have a caregiver (i.e., parent) present throughout the evaluation. **To ensure that your child can do their best on these tests, be sure your child is well-rested and fed, bring any necessary hearing aids/glasses/medication, and have your child take their regular medication as prescribed**.

In most cases, this appointment will last approximately 2 hours. In most cases, your child will complete the tests in a private room under Dr. Johnson's supervision while you complete questionnaires regarding the child's behaviors and development.

Enclosed are forms for you to complete *prior* to your child's appointment. Please bring these forms, as well as any school or medical records, medication information (types and doses), or reports from prior evaluations to your child's appointment.

If you are a new patient to UF Health/Shands, it will be necessary to register prior to your appointment. For further information, contact the Psychology Clinic at (352) 265-0294. **Patients that have a Shands medical record number** will need to update registration and insurance information at the time of service. If you have updated your record within the last 60 days, it will not be necessary to do so again, unless there are changes that need to be reported.

Should you need to cancel or reschedule, please contact us no later than two days prior to your appointment. If you should have any questions, please contact the clinic at (352) 265-0294. Please see enclosed map for directions.

We look forward to meeting you and your child at the upcoming appointment with us!

Department of Clinical and Health Psychology
P. O. Box 100165
Gainesville, FL 32610-0165
352-265-0294

University of Florida Psychology Clinic

INSURANCE INFORMATION REQUEST

****PLEASE COMPLETE THIS FORM CORRECTLY OR YOUR INSURANCE COMPANY WILL NOT BE BILLED APPROPRIATELY AND THE BALANCE WILL BECOME YOUR RESPONSIBILITY****

Date_____

Patient Name_____

Date of Birth _____

Primary Insurance	Secondary Insurance
1. Name of Insurance Company_____	1. Name of Insurance Company_____
Address _____	Address _____
Insurance Phone Number_____ (see back of card)	Insurance Phone Number_____ (see back of card)
2. Subscriber/Policy/Member/Contract ID #	2. Subscriber/Policy/Member/Contract ID #
3. Name of Policy Holder _____	3. Name of Policy Holder _____
4. Policy Holder's Date of Birth _____	4. Policy Holder's Date of Birth _____
5. Relationship of Policy Holder to Patient _____	5. Relationship of Policy Holder to Patient _____
6. Is this group or individual insurance? Group____ Individual ___	6. Is this group or individual insurance? Group____ Individual ___
IF GROUP, PLEASE COMPLETE:	**IF GROUP, PLEASE COMPLETE:**
Group Number _____	Group Number _____
Employer Name _____	Employer Name _____
Address _____	Address _____
Phone_____	Phone_____

7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY INSURANCE BENEFITS:

I hereby authorize Clinical and Health Psychology to release information related to all psychological care, attention and treatment to the above listed carrier. I also hereby authorize and request payment directly to Florida Health Professions Association, Inc. for bills covering this period of treatment, by all Insurance carriers with whom I have coverage. I further agree to pay all charges connected with this treatment not covered by any insurance I may have, and understand insurance coverage does not release me of obligation to begin payment upon initial visit. (Copies of this agreement shall be valid as the original)

_____ _____
Signature - Patient or Guardian Date

_____ _____
Signature - Policy Holder or Guarantor (if other than patient/guardian) Date

UF UNIVERSITY of FLORIDA

The Foundation for The Gator Nation

Patient Information Form

Thank you for choosing the University of Florida Psychology Clinic for your healthcare needs. Please complete this form to ensure we have the most accurate and current information. We may ask you to review this information from time to time to make sure it stays up-to-date.

Patient **First** Name: _____
Patient **Last** Name: _____

Address: _____
_____
City: _____
State: _____ Zip Code: _____

Home Phone: (___ _) _____
Work Phone: (___ _) _____
Cell Phone: (_____) _____
Parent/ Guardian's Name: (if applicable)
_____

May we contact you at home? Yes/ No
May we contact you at work? Yes/ No
If yes, what time(s) would be good for contacting you? _____
Can a message be left at home? Yes/ No

Social Security #:_____

Date of Birth: _____
Age: _____

Marital Status: (**circle one**) Single Married Divorced Widow(er) Other

Religion: _____

Ethnic/Racial Background: (**circle one**)
African-American Asian
Caucasian Hispanic/Latino
Native American Multiracial
Other: (explain)

Employer: _____

Emergency contact person: _____ Relationship: _____
Emergency Contact Phone #: (_____) _____
Who referred you to us? _____

************DO NOT WRITE BELOW THIS LINE************

OFFICE USE ONLY

Primary Insurance: _____ Phone: _____ Other Notes:
Address_____ Fax: _____
_____
Policy Holder: _____ Policy #:_____
Group #:_____

Secondary Insurance: _____ Phone: _____
Address: _____ Fax: _____
Policy Holder: _____ Policy #:_____
Group #:_____
Provisions: Authorization Needed? Yes/ No Date Obtained: _____
Authorization #:_____
Deductible Amount: _____ Amount Satisfied: _____
Co-pay Amount: _____
Co-Insurance Amount: _____ Self-pay Amount: _____
Visits Authorized: _____ Terms: _____
Testing Authorization: _____ _____

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Informational Handout

The Psychology Clinic in Shands Hospital at the University of Florida provides assessment and treatment services for children, adolescents, adults, older adults, couples, and families. Our clinic provides services for emotional problems and those with a range of medical illnesses. Licensed and board certified faculty psychologists are responsible for all services in our clinic. Like Shands Hospital and the University of Florida Clinics, the psychology clinic is a training site. Therefore, trainees are likely to be involved in your care. In all cases, these trainees work under the direction of a faculty member. This may involve the faculty member watching the trainee through a one-way mirror or taped recording. Our trainees are bound by the same ethical and legal standards as our licensed psychologists. Please discuss with your provider any questions or concerns you might have about this or any issue related to our clinic.

Hours of Operation

The Psychology Clinic schedules patient appointments between 8AM-5PM Monday, Wednesday, Thursday, and Friday. Appointments are scheduled between the hours of 8AM –7PM on Tuesday's.

What to Expect

The Licensed Psychologist and trainee assigned to you work as a team. Your team will likely start with an assessment. This assessment gathers information to answer questions about your particular case. This information is also helpful in planning effective treatment if needed. Your team conducts this assessment through an interview with you and/or family and friends. In addition, testing may be appropriate. This may include paper and pencil testing of your thinking and learning abilities, memory, emotions and/or behaviors.
You should be sure and understand the purpose (purposes) of this testing by talking with either the licensed psychologist or trainee. In all cases, all procedures will be explained to you. This evaluation may take from 2-8 hours.

Following your assessment, it may be suggested to you that you begin treatment in our clinic. We attempt to provide the most helpful treatment possible for your situation based on our own research and the research of others. Previous research studies indicate that many patients are helped by therapy. However, treatment benefits cannot be guaranteed. Your therapist will be happy to discuss any questions you may have. These therapy sessions can last as little as 30 minutes or as long 80 minutes. Your therapist will discuss the length of your sessions before you begin treatment.

If you have any concerns about your assessment or treatment, you should discuss them with the supervising licensed psychologist or trainee. As we mentioned earlier, this is a training clinic and you may be observed during your assessment or treatment. If your psychologist or trainee wishes to tape record your assessment or treatment for use in supervision of your care, they will ask you to sign a separate form. This form grants them permission for taping before it occurs. You also may be offered the opportunity to participate in a research study. Participation in our research is voluntary. If you agree to participate, you will be informed about the particular study and will be asked to sign a separate permission form.

About Privacy

The information you provide at these sessions will be treated with great care and kept private according to state law and the rule of our profession. In a few rare circumstances, your privacy cannot be protected. Here are the most common examples:

1) if a court has ordered you to seek evaluation and treatment here, then the court has a right to this information
2) if a court orders release of your records for a legal proceeding
3) if you make a serious threat to harm yourself or another person
4) if your provider believes that either a child or an elderly person is being abused or neglected

There are other times when your information may be released. If you have concerns, please discuss these concerns with your provider.

My signature below indicates that I have read the above statements.

Please read, sign, and bring with you to your visit.

_____ _____

Signature of patient, parent or guardian Date

Consent and Authorization

Section A: Notice of Limited Liability

I, on behalf of myself, my child, and/or my ward, hereby acknowledge I have been informed that: Care and treatment that I/we receive at this and other Florida Health Professional Association clinics/facilities, associated with the Department of Clinical and Health Psychology, will be provided by University of Florida employees and/or agents. I understand that these health-care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida statutes 726.28). Effective October 1, 2011 the amounts will be adjusted to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence.

Section B: Treatment Authorization, Assignments of Proceeds, Authorization to Release Information and Guarantor Agreement

1. Authorization for Routine Diagnostic Procedure and Psychological Treatment-I hereby consent to such diagnostic procedures which in the judgment of my healthcare provider may be considered necessary or advisable while a client at a Florida Health Professionals Association (FHPA) clinics/facility. I recognize that the FHPA providers are employees of a healthcare teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision.

2. Assignment of Benefits-I hereby assign to the FHPA payment from all third-party payers* and with whom I have coverage or from whom benefits are or may become payable to me, for the charges of health care services I receive for, related to, my treatment (past, present, or future). I agree to be personally responsible for payment of any healthcare services that are not covered by my third-party payers*, including, but not limited to, not covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

3. Release of Medical Information by the Florida Health Professionals Association-By signing in the space below as Patient/Guardian, I hereby authorize the FHPA providing services during my outpatient clinical care, to release information from and/or copies of my psychological records and other information as may be required for my psychological care and to secure payment for charges incurred by me or on my behalf, to any other FHPA clinic/facility, my physician, to my referring physician, the guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that the

FHPA may later obtain to contribute payments for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to the outpatient clinics to maintain its licensure and accredited status.

4. Guarantor Agreement- By signing in the space below as Patient/Guardian or guarantor, or as patient's/guardian's spouse or guarantor's spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third-party coverage I may have are due and payable by me at the time of the visit or discontinuation of treatment or in a pre-arranged payment plan agreeable to FHPA. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due. The charges I agree to pay are those listed in the master billing charge manual, which are available for inspection upon request and incorporated herein by reference. I hereby acknowledge that, unless the FHPA and my insurance company or third-party carrier have agreed that I will not be billed, if the FHPA has agreed to bill my insurance or other third-party carrier it has agreed to do so as a courtesy and that the FHPA has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

*Third-party payers include, but are not limited to, coverage available from: Medicare, Tri-care, or governmental programs; health, accident, automobile, or other insurance; workers compensation; HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/ Guardian Signature: _____
Patient's/ Guardian's Spouse Signature: _____
Guarantor Signature (if other than patient/ guardian): _____
Guarantor's Spouse Signature: _____
Name of Insured (if other than patient): _____
Witness (Adult 18yrs and over): _____ Date: _____

UF UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI)

Patient's Name	Date of Birth	Verification of Identity Driver's License
Patient's Address	Medical Record Number	Other:

** Complete the following only if the **person authorizing** the use or disclosure is **not the patient**:

Representative's Name	Relationship to Patient Parent	Legal Authority Parent and Legal Repr.
Representative's Address	Verification of Identity Driver's License	Verification of Authority Person known to facility

By signing this form, I authorize the following:

Disclosure of the patient's PHI **from**:		Disclosure of the patient's PHI **to**: Patient/Parent Name & Address	
Person, class of persons, or organization Shands Teaching Hospital		*Person, class of persons, or organization*	
Address P.O. Box 100165, University of Florida		*Address*	
Gainesville, FL 32610-0165			
Attn:	*Phone* 352-265-0294	Attn:	*Phone*

The following protected health information may be disclosed *(describe in detail)*:

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Check all that are approved.*)

☐ Mental Health	☐ Substance Abuse	☐ HIV/AIDS	☐ Records created by non-UF/Shands providers

The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified:	*Expiration Date or Event*
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative:	*Date*

Complete all parts of the form, print out and sign and date. Patient or representative should keep a copy. Give, fax, or mail the original form to the person or organization releasing the information.

UF UNIVERSITY of FLORIDA
College of Public Health & Health Professions

Child & Family Questionnaire

Child's Name:	Date:	MR #: (Clinician use)
Birthdate:	Age:	Sex:
Check One Biological / Adopted	Foster care	If yes, name of agency:
Person completing form:	Relationship to child:	
Street address:		
City:	State:	Zip:
Parent Names:		
Who referred your child and why?		

When did your child begin to show these abilities?	**Age**	**Any concern?**
Sat without support:		
Crawled:		
Walked alone:		
Used a single word to name something or someone, e.g. "ball", "dog"		
Used simple sentences		
Was able to have a conversation with two or more exchanges on the same topic		
Toilet training - urine		
Toilet training - bowel		
Toilet training - night		
Used utensils to feed self		

Please indicate if any of the following behaviors are problems for your child. As you answer the questions, consider if the behaviors are more problematic than you would expect for your child's age. We will be using this list of concerns to help us as we evaluate your child.			
Check the behaviors that are problems for your child:			
	Difficulty with following directions at home		Is withdrawn
	Difficulty with following directions at school		Feels badly about him/herself
	Difficulty paying attention at school		Worries that bad things may happen
	Difficulty paying attention in other activities		Wakes up frequently or early in the morning
	Being easily distracted		Is not able to separate from parent in a familiar place
	Does not complete tasks		Talks about hurting him/herself
	Hyperactive, always on the go		Hurts him/herself
	Restless, fidgety		Is not interested in children of the same age
	Difficulty sitting still		Is interested in other children, but doesn't interact
	Impulsive, does things without thinking		Does not show enjoyment in interacting with peers
	Works independently		Is not able to share toys and play space
	Does not follow rules		Can not take turns in play
	Argues a lot		Can not have a conversation with a child
	Frequently angry, loses temper a lot		Does not imitate action in games such as clapping hands
	Fights with other children		Does not play with toys as intended, e.g. builds with blocks
	Frequently defiant, says no to adults		Does not do pretend play, e.g. talking on phone
	Uncooperative		Has interests that are intense and take up much time
	Hurts others (people or animals)		Has unusual movements, e.g. rocking, twitching
	Whines or complains frequently		Makes noises such as clearing throat, grunting
			Can not tolerate changes in routine
	Is sad or unhappy		Is bothered by touch, smell, taste, sounds
	Has temper tantrums		Has many fears
If yes, indicate frequency of tantrums:		If yes, name the specific fears:	

CHILD HEALTH HISTORY			
Circle One: Was the pregnancy	Full Term?	Premature?	# of weeks?
Circle One: What type of delivery?	Vaginal?	Ceasarian?	Birth Weight
Check for each problem the mother had during pregnancy:			
Bleeding:	Infections:	Accidents:	Medicine:
Alcohol:	Other drugs:	Other:	
Check for each problem the baby had during labor, delivery, or at birth:			
Breathing:	Turned blue:	Jaundice:	Feeding:
Infection:	Swallowing:	Seizures:	Incubator:
Fetal Distress:			
How long was your baby in the hospital after delivery?			
Has your child been diagnosed with any medical or genetic conditions?			Yes or No?
If yes, describe:			
Provide information below about hospital visits: Emergency Room (ER), Outpatient (OP) and Inpatient (IP):			
Date	ER, OP, or IP	Hospital	Reason
Has the child's vision ever been checked?			Yes or No?
Results:			Date:
Has the child's hearing ever been checked?			Yes or No?
Results:			Date:
List any medication your child takes now: (include dose, frequency and reason for medication)			
List supplements/vitamins/alternative treatments:			

Check any concerns about the child:	Current	Past	Tell us more
Headaches			
Stomach aches			
Other pain			
Poor growth			
Eating			
Elevated lead levels			
Ear Infections			
Staring spells			
Seizures			
Unusual Movements			
Breathing			
Sleeping			
Mouthing of objects			
Food allergies			
Drug allergies			
Environmental allergies			
Sensitivity to latex			

FAMILY HISTORY		
Is there any family history of illness, psychiatric problems or learning difficulties that might be important for us to know?		
	Mother's Family	Father's Family
	List family members or relatives with conditions listed in left column.	
Developmental delays or concerns:		
School or learning difficulty:		
Hyperactivity/ADHD:		
Seizures:		
Tics/Tourette's:		
Mental Retardation:		
Autism or PDD:		
Anxiety:		
Depression:		
Nervous Problems:		
Other Mental Health Conditions:		
EDUCATION AND SERVICES		
Current school:		**Grade level:**
What early intervention programs, therapies, pre-schools or schools has the child attended in the past?		
Name	**Year**	**Program Type/Grade**
Does your child attend/receive?	**Yes or No**	**Specify**
Special Education		
School or Community Activities		

Speech Therapy		
Occupational Therapy		
Physical Therapy		
Sensory Integration Therapy		
Psychiatric Services		

UF UNIVERSITY of FLORIDA
College of Public Health & Health Professions

TEACHER/CAREGIVER THERAPIST FORM

Patient Name

Medical Record Number

Birthdate

Dear Parents/Guardians: Please do not fill out this form. Please complete "Release Section" only.

1. Ask your child's teacher, caregiver, or therapist to complete the questionnaire and rating forms.
2. Ask your child's teacher or therapist to attach a copy of any recent educational and/or psychological forms.
3. Complete and sign the release section below so that school officials can send information about your child.
4. Ask the child's teacher or therapist to return the questionnaire, rating forms and reports to the following address:

Mailing Address: Psychology Clinic
1600 SW Archer Rd, Room G-901, P.O. Box 100165, Gainesville, FL 32601-0165

RELEASE SECTION (TO BE FILLED OUT BY PARIENT/GUARDIAN)

I hereby give my permission to (name of person releasing information): _____

of (SCHOOL/AGENCY): _____

to release information requested (completed questionnaires and ratings, educational and psychological reports) regarding the following CHILD: _____ /Date of Birth: _____

to THE UNIVERSITY OF FLORIDA.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO CHILD: _____

QUESTIONNAIRE (TO BE FILLED OUT BY TEACHER/CAREGIVER/THERAPIST

Child's name: _____

Birthdate: _____ Age: _____ Sex: _____

Preschool/School/Agency: _____ School Phone #: _____

School Address: _____

City: _____ State: _____ Zip: _____

Teacher/Therapist: _____

Person Completing Form: _____ Date Completed: _____

In what type of program/service/school is this child enrolled? Please check appropriate box.

PRESCHOOL ☐
Please check all that apply:

- ☐ Daycare/Preschool
- ☐ Headstart
- ☐ Special Preschool Program
- ☐ Home-Based Early Intervention
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech/Language Services
- ☐ Other: _____

For above program, number of days per week? _____
For above program number of hours per week? _____

K-12 ☐ Grade: _____
What kind of a classroom?

_____

_____

_____

_____

_____

What questions do you have about the child's development? _____

_____

_____

_____

_____

_____

What are the child's strengths? _____

_____

_____

_____

_____

_____

What are the child's most significant problems? _____

_____

_____

_____

_____

_____

Has the child been assessed previously by your program or intermediate unit? ☐ Yes ☐ No

If yes, by whom? _____

With what results? _____

_____

Does the child have a diagnosis that highlights educational, developmental, or behavioral needs? If yes, what is the diagnosis?_____

_____

_____

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TEACHER/CAREGIVER THERAPIST FORM

Patient Name

Medical Record Number

Birthdate

Please use the tables below to list the date and results of any assessments that have been administered

List the assessment instruments that were used: _____

_____

_____

_____

_____

_____

_____

FOR PRESCHOOLERS

Domain	Date	Chronological Age	Developmental Age
Cognitive			
Expressive Language			
Receptive Language			
Perceptual/Fine Motor			
Gross Motor			
Social-Emotional			
Other _____			

For K-12

Domain	Date	Score	
Cognitive			
Expressive Language			
Receptive Language			
Perceptual/Fine Motor			
Gross Motor			
Social-Emotional			
Other _____			

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College of Public Health & Health Professions

TEACHER/CAREGIVER THERAPIST FORM

Patient Name

Medical Record Number

Birthdate

Please indicate if any of the following behaviors are problems for this child. As you answer the questions, consider if the behaviors are more problematic than you would expect for the child's age. We will be using this list of concerns to help us as we evaluate this child.

Check the behaviors that are a problem for this child:

- ☐ Difficulty with following directions at school
- ☐ Difficulty paying attention at school
- ☐ Difficulty paying attention in other activities
- ☐ Being easily distracted
- ☐ Does not complete tasks
- ☐ Hyperactive, always on the go
- ☐ Restless, fidgety
- ☐ Difficulty staying still
- ☐ Impulsive, does things without thinking
- ☐ Works independently
- ☐ Does not follow rules
- ☐ Argues a lot
- ☐ Frequently angry, loses temper a lot
- ☐ Fights with other children
- ☐ Frequently defiant, says no to adults
- ☐ Uncooperative
- ☐ Hurts others (people or animals
- ☐ Whines or complains frequently
- ☐ "tunes out", seems to be in own world
- ☐ Is sad or unhappy
- ☐ Lacks understanding of "social cues"
- ☐ Has temper tantrums

  If yes, indicate frequency of tantrums:

  _____
  _____
  _____
  _____

- ☐ Feels bad about him/herself
- ☐ Worries that bad things may happen
- ☐ Is withdrawn
- ☐ Is not able to separate from parent at school
- ☐ Talks about hurting him/herself
- ☐ Hurts him/herself
- ☐ Is not interested in children of same age
- ☐ Is interested in other children, but doesn't interact
- ☐ Does not show enjoyment in interacting with peers
- ☐ Is not able to share toys and play space
- ☐ Cannot take turns in play
- ☐ Cannot have a conversation with a child
- ☐ Does not imitate action in games such as clapping hands
- ☐ Does not play with toys as intended, e.g. builds with blocks
- ☐ Does not pretend play, e.g. talking on phone
- ☐ Has interests that are intense and take up much time
- ☐ Has unusual movements, e.g. rocking, twitching
- ☐ Makes noises such as clearing throat, grunting
- ☐ Cannot tolerate changes in routine
- ☐ Is bothered by touch, smell, taste, touch, sounds
- ☐ Only interacts on own terms
- ☐ Has many fears

  If yes, name specific fears:

  _____
  _____
  _____
  _____