Child’s Name: 

Parent(s): 

School: 

Date of Request: 

1) In the space below, please provide a brief description of the type of school or classroom the child attends (e.g., day care, developmental preschool, public school, etc.): **If the child is in special education, please attach a copy of their IEP and any other relevant test data that may be helpful in our evaluation process.**

2) Please describe the composition of the classroom (e.g., total number of children, number of children with disabilities, type(s) of disabilities).

3) When did this child begin your program? 

4) Please describe the child’s performance in each area:
   a) Cognitive/Pre-academic Skills:
      (e.g., object naming, colors, numbers, letters, etc.)
   b) Self-help Skills:
      (e.g., feeding, dressing, toilet training)
   c) Socialization Skills:
      (e.g., peer relationships, interest in other people, play skills, interpersonal skills)
   d) Gross Motor Skills:
      (e.g., walking, running, coordination)
   e) Fine Motor Skills:
      (e.g., use of fingers to manipulate objects, coloring, drawing, etc.)
   f) Listening Skills:
(e.g., ability to understand instructions, ability to follow discussion topics)

g) Expressive Language Skills:
(e.g., ability to express needs and ideas, articulation)

h) General Knowledge:
(e.g., understanding of social norms, common sense reasoning, common fairy tales)

5) What do you see as the child’s strengths?

6) What do you see as the child’s areas of need?

7) Please describe the child’s behavior in the classroom:
(e.g., following directions, attention and concentration, independent work behavior, etc.)

8) Please describe any behavior which concerns you.

9) Are there specific situations in which behavior is problematic? What triggers behaviors?

10) What types of activities have you worked on individually with the child?

11) What do you perceive as the source of the child’s difficulties?

12) Please describe the type of contact you have with the child’s parents:

13) Has the child been tested by a resource teacher or psychologist, or referred for school testing? If so, please indicate when and, if possible, attach copies.

14) If this child is currently certified for special education, what is/are the handicapping condition(s)?
15) What services does the child receive (e.g. speech-language therapy, physical therapy, etc.)

16) For each item, please check the box that best describes this child’s behavior:

<table>
<thead>
<tr>
<th>Observation</th>
<th>Not at All</th>
<th>Just a Little</th>
<th>Pretty Much</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Restless or overactive</td>
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<tr>
<td>2. Excitable</td>
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<td>3. Disturbs other children</td>
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<td>4. Fails to finish things he/she starts</td>
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<td>5. Short attention span</td>
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<td>6. Constant fidgeting</td>
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<td>7. Inattentive, easily distracted</td>
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<td>8. Demands must be met immediately</td>
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<td>9. Easily frustrated</td>
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<td>10. Cries often and easily</td>
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<td>11. Mood changes quickly and drastically</td>
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<tr>
<td>12. Temper outbursts, explosive and unpredictable behavior</td>
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</table>

17) Additional comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for taking the time to complete this form. Please call at 615-936-0249 if you have any questions or further information regarding this child.

________________________________________  ________________________________
Signature                                      Date

__________________________
Relationship to child

Please return form in the self-addressed, stamped envelope:

Intake Office
Division of Developmental Medicine
9120 Doctors’ Office Tower
Nashville, TN 37232-9003

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