

ADAPTIVE BEHAVIOR

CIRCLE ONE

- | | | |
|------------|---|--------|
| 1. | Does this child use a spoon or fork to feed him/herself? | Yes No |
| 2. | Can this child remove any of his/her clothing such as coat, shoes? | Yes No |
| 3. | Does this child wash and dry his/her own hands? | Yes No |
| 4. | Is this child able to separate from the parents? | Yes No |
| 5. | Does this child get along well with other children? | Yes No |
| <u>6.</u> | Does this child know how to care for his/her own toilet needs without help?
This means that he/she must undress, wipe, and dress him/herself. The child does not have to be able to fasten back buttons or tie bows. | Yes No |
| 7. | Do you feel this child is at ease with other children/adults and therefore is not unusually shy? | Yes No |
| 8. | Does this child generally have both daytime and nighttime bowel and bladder control? | Yes No |
| 9. | Could this child fix a bowl of dry cereal for him/herself? OR could your child fix a sandwich for him/herself? | Yes No |
| 10. | Does this child put on any piece of clothing, such as underpants, socks, shoes? | Yes No |
| 11. | Does this child help in the house by doing simple things like putting toys away or getting something for a parent when asked? | Yes No |
| 12. | Can this child button any piece of clothing? | Yes No |
| <u>13.</u> | Does this child have an enthusiastic approach to learning? | Yes No |
| 14. | Does this child play games in which he/she takes turns with other children?
(Example: hide and seek, tag) | Yes No |
| 15. | Can this child dress him/herself completely and correctly without help?
She/he may have help only for tying shoelaces and buttoning or zipping in the back. | Yes No |
| 16. | Does this child know what things belong to him/her or to others, and most of the time will ask before playing with another child's toy? | Yes No |

Has this child ever had a developmental or speech screening? _____

If yes, when? _____

Where? _____

Is this child now receiving speech therapy? _____

If yes, when? _____

Where? _____

BHASED PRESCHOOL SCREENING QUESTIONNAIRE

Child's Name: _____ Birthdate: _____ Sex: M F

Circle one: American Indian/Alaska Native African American Asian Hispanic White Other

Child's Physician: _____ Today's Date: _____

- | | | (Circle One) | |
|-----|---|--------------|----|
| | | Yes | No |
| 1. | Did the mother have any injuries or diseases or use alcohol or drugs (prescription or non-prescription) while pregnant with this child? | | |
| 2. | Was the mother 18 years of age or younger at the birth of this child? | | |
| 3. | Did this child weigh under 5 ½ pounds (5 pounds 8 oz.) at birth? | | |
| 4. | Did this child have any birth problems, diseases, or injuries requiring medical attention at birth? | | |
| 5. | Has this child ever had any illness or injuries requiring hospitalization? | | |
| 6. | Has this child ever had convulsions associated with a high fever? | | |
| 7. | Has this child had <u>many</u> ear infections, earaches, and/or runny ears? | | |
| 8. | Does this child have hearing loss? Or does either parent have a history of childhood deafness or hearing loss? | | |
| 9. | Has this child ever had an <u>elevated</u> lead screening (over 10 ug/dL)? | | |
| 10. | Have you noticed any signs which indicate eye difficulty in this child such as crossed eyes, lazy eye, etc.? Or does this child wear glasses? | | |
| 11. | Is this child currently on daily medication for anything other than a short illness? | | |
| 12. | Does this child appear clumsier than other children his/her age? | | |
| 13. | Does this child suffer from dizzy spells or headaches other than when ill? | | |

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", PLEASE EXPLAIN BRIEFLY:

- | | | | |
|-----|---|-----|----|
| 14. | Did this child walk alone by approximately 14 months? | Yes | No |
| 15. | Did this child put at least two words together to make a thought by two years of age? | Yes | No |
| 16. | Is this child's current speech understandable to people outside the immediate family? | Yes | No |

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "NO", PLEASE EXPLAIN BRIEFLY:

Do you have any specific concerns about this child's development or behavior? Or has there been a recent family crisis which could have a negative impact on your child? If yes, please explain. _____

Please check how often your child shows the following behaviors using the column indicated for your child's current age.	3 Years			4 Years			5 Years			
	Often	Sometimes	Seldom Or Never	Often	Sometimes	Seldom Or Never	Often	Sometimes	Seldom Or Never	
Tantrums (kicks, hits, or bites When angry)										2 2 3
Head banging (against bed or wall)										4 4 4
Thumb sucking										1 2 3
Nightmares										2 2 3
Nail biting										2 2 2
Sits alone and rocks (not in rocking chair)										3 4 4
Defiant/resistant										1 2 3
Overly active (constantly moving)										2 2 3
Short attention span (Gets restless in quiet activity such as reading or drawing after 5 minutes.)										2 3 4
Sets fires										4 4 4
Prefers to be alone (rather than playing with other children)										3 3 3
Gets upset easily unnecessarily										1 2 3
Cries easily unnecessarily										1 2 3
Destroys own or other's belongings										2 3 3
Mean to animals										2 3 4

Do you feel that your child's behavior is out of control and requires professional intervention? Yes No

If you are interested in qualifying for a free preschool program through your local school district (where available) please answer the following questions.

ARE ANY OF YOUR CHILDREN NOW ENROLLED IN ANY OF THE FOLLOWING:

Reduced/Free School Lunch Yes No
WIC Yes No
Public Aid Yes No
Child's Medicaid # _____

CIRCLE ANY OF THE FOLLOWING AGENCIES YOUR FAMILY HAS BEEN INVOLVED WITH:

Social Services Homeless Shelter
Children's Therapy Center Alcohol/Drug Services
Mental Health Center Civil Court
Dept. Children/Family Services
Special Education