Childhood New Patient Initial Intake Paperwork

Note: In this questionnaire "you" is used as if the child were answering questions, avoiding repetition of him/her. If questions do not apply to your child, leave those blank.

First Name:_____Middle:_____Last Name:_____

Birthdate:_____/_____/_____ Birth Order:_____Age : _____

☐Male ☐Female Eye Color:_____Hair Color: _____Height: _____Weight:_____

Blood Type: ☐Not known ☐A ☐B ☐AB ☐Rh+ ☐Rh-

Address: _____

City:_____Country_____

Postal Code: _____Parent(s) Email Address:_____

Home Telephone: (_____)_____ Mobile Number:_____

Referred By: _____

Mothers Name:_____Occupation_____Work #_____

Fathers Name:_____Occupation_____Work #_____

Person(s) filling out this questionnaire:_____Date:_____

What is the main problem that led to the child being brought here?_____

☐Child had no problems ☐Depression ☐Anxiety

☐Suicidal Thoughts ☐Suicidal Actions ☐Problems thinking clearly

☐Arguments with Parents ☐Adjustment to Parents Divorce

☐Academic Problems ☐Behavior Problems in School ☐Refusal to go to School

☐Behavior Problems at Home ☐Other:

How severe is this problem?

☐ Does not apply ☐ Mild ☐ Moderate ☐ Severe

How long has the child had this problem?

☐ Does not apply ☐ For the past several years ☐ For the past several days

☐ For past several months ☐ For the past year ☐ For the past two years

☐ For the past several years ☐ Other: _____

Which of the following has this problem affected?

☐ Does not apply ☐ None ☐ The child's academic performance

☐ The child's relationship with peers ☐ The child's relationships with family

☐ The child's physical health ☐ The child's emotional health

☐ The child's behavior ☐ Other: _____

Has the child been treated for this problem?

☐ Does not apply ☐ No ☐ Yes, but with only partial success ☐ Yes, but without success ☐ Yes, with success

What other problems is the child having?

☐ None ☐ Depression ☐ Anxiety

☐ Suicidal Thoughts ☐ Suicidal Actions ☐ Problems thinking clearly

☐ Arguments with Parents ☐ Adjustment to Parents Divorce

☐ Academic Problems ☐ Behavior Problems in School ☐ Refusal to go to School

☐ Behavior Problems at Home ☐ Health Problems ☐ Physical Abuse ☐ Sexual Abuse

☐ Neglect by Parents ☐ Bed-Wetting ☐ Stealing ☐ Fears ☐ Other: _____

What is the child's status in school?

☐ Has not started school

☐ Full-time, regular classes ☐ Full-time, special education classes

☐ Part-time, regular classes ☐ Part-time, special education classes

☐ Suspended from school ☐ Expelled from school

☐ Being Tutored at Home ☐ Other: _____

What grade is the child in now (or when school starts again in the fall)?

☐ Not in school, will not be in school ☐

Preschool ☐ Kindergarten ☐ First ☐ Second

☐ Third

☐ Fourth ☐ Fifth ☐ Sixth ☐ Seventh ☐ Other: _____

How many children are in the child's family including the child?

☐ Only child ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ More than 10

How old was the child's natural father at the time of the child's birth?

☐ Do not know ☐ 15-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50 or older

How old was the child's natural mother at the time of the child's birth?

☐ Do not know ☐ 15-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50 or older

What was the child's physical condition immediately after birth?

☐ Do not know ☐ Normal, no unusual problems ☐ Injured at birth

☐ Difficult breathing ☐ Problems with heart ☐ Problems with bones

☐ Low birth weight ☐ Problems with digestion ☐ Infection

☐ Jaundice ☐ Had blood transfusion ☐ Had seizures

☐ Fever ☐ Place in intensive care ☐ Placed in incubator

☐ Other: _____

Approximately how much did the child weigh when born?_____

How many days did the child spend in the hospital after birth?

☐ Do not know ☐ 5 days or less ☐ More than 5 days

☐ More than 10 days ☐ More than 20 days ☐ More than 30 days

Describe the child's temperament before age 2?

☐ Do not know ☐ Calm ☐ Active ☐ Sociable

☐ Withdrawn ☐ Happy ☐ Unhappy ☐ Alert

☐ Sleepy ☐ Affectionate ☐ Crying ☐ Difficult

☐ Irritable ☐ Hypersensitive ☐ Angry ☐ Regular

☐ Irregular ☐ Fearful ☐ Cranky ☐ Curious

☐ Playful ☐ Other: _____

How was the child fed before age 2?

☐ Do not know ☐ Bottle ☐ Breast ☐ Bottle and Breast

From birth to age 2, when did the child develop physical skills such as sitting and crawling?

☐ Do not know ☐ Earlier than most ☐ At about the time as most children

☐ Later than most children ☐ Other _____

When did the child learn to walk?

☐ Do not know ☐ Before 1 year ☐ 1 to 1 ½ years ☐ 1 ½ to 2

years ☐ After 2 years ☐ Other: _____

When did the child learn to talk?

☐ Do not know ☐ Before 1 year ☐ 1 to 1 ½ years ☐ 1 ½ to 2

years ☐ After 2 years ☐ Other: _____

When did toilet training begin?

☐ Do not know ☐ Before 1 year ☐ 1 year ☐ 1 ½ years

☐ 2 years ☐ 2 ½ years ☐ 3 years ☐ 3 ½ years

☐ 4 years ☐ After 4 years ☐ Other:_____

Where there problems in toilet training?

☐ Do not know ☐ No ☐ Severe problems ☐ Moderate ☐ Mild

☐ Other: _____

Describe the child's motor development (running, jumping, throwing, etc) from ages 2-5.

☐ Do not know ☐ Advanced in comparison to other children

☐ Average in comparison to other children ☐ Slow in comparison to other children ☐ Other: _____

Describe the child's language development (talking in sentences, vocabulary) from ages 2-5.

☐ Do not know ☐ Advanced in comparison to other children

☐ Average in comparison to other children ☐ Slow in comparison to other children ☐ Other: _____

Describe the child's social development (development of friendships, relationships with peers, relationships with adults, etc.) from ages 2 – 5.

☐ Do not know ☐ Advanced in comparison to other children

☐ Average in comparison to other children ☐ Slow in comparison to other children ☐ Other: _____

Describe the child's mental development (counting, knowledge of alphabet, doing puzzles, understanding concepts, etc.) from ages 2 – 5.

☐ Do not know ☐ Advanced in comparison to other children

☐ Average in comparison to other children ☐ Slow in comparison to other children ☐ Other: _____

Describe the child's temperament from ages 2 – 5.

☐ Do not know	☐ Calm	☐ Active	☐ Sociable
☐ Withdrawn	☐ Happy	☐ Unhappy	☐ Alert
☐ Sleepy	☐ Affectionate	☐ Crying	☐ Difficult
☐ Irritable	☐ Hypersensitive	☐ Angry	☐ Regular
☐ Irregular	☐ Fearful	☐ Cranky	☐ Curious
☐ Playful	☐ Other: _____		

Which of the following school has the child attended?

☐ None ☐ Infant day care ☐ Preschool ☐ Kindergarten

At what age did the child start kindergarten?

☐ Has not attended ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Older than 7 years old

Did the child have any problems when starting kindergarten?

☐ Does not apply ☐ No ☐ Was afraid

☐ Complained of being ill to avoid going to school ☐ Had to be punished to go to school ☐ Other: _____

Which of the following describes the child's experience in kindergarten?

☐ Does not apply ☐ Enjoyed school ☐ Felt neutral about school ☐ Disliked school

Which of the following describe the child's behavior in kindergarten?

☐ Does not apply ☐ None ☐ Fearful ☐ Withdrawn

☐ Aggressive ☐ Disobedient ☐ Distractive ☐ Active

☐ Other: _____

Describe the child's academic performance in kindergarten?

☐ Does not apply ☐ Slow ☐ Average ☐ Advanced

At what age did the child start the first grade?

☐ Has not attended ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ More than 8 years old

Which of the following describes the child's experience in the first grade?

☐ Does not apply ☐ Enjoyed school ☐ Felt neutral about school ☐ Disliked school

Describe the child's academic performance in first grade?

☐ Does not apply ☐ Excellent grades ☐ Good grades

☐ Average grades ☐ Poor grades ☐ Other _____

Describe the child's experiences in the first grade.

☐ Does not apply ☐ None ☐ Suspended ☐ Expelled

☐ Frequently Absent ☐ Placed in Full-time special education ☐ Placed in Part-time special education ☐ Placed in accelerated academic program ☐ Counseled ☐ Evaluated by psychologist

☐ Other: _____

Describe the child's academic performance since the first grade?

☐ Does not apply ☐ Excellent grades ☐ Good grades

☐ Average grades ☐ Poor grades ☐ Other _____

Describe the child's experiences since the first grade.

☐ Does not apply ☐ None ☐ Suspended ☐ Expelled

☐ Frequently Absent ☐ Placed in Full-time special education ☐ Placed in Part-time special education ☐ Placed in accelerated academic program ☐ Counseled ☐ Evaluated by psychologist

☐ Other: _____

Describe the child's current subject strengths in school.

☐ Does not apply ☐ None ☐ Art ☐ Music ☐ Reading

☐ Math ☐ Spelling ☐ English ☐ Science ☐ History

☐ Social Studies ☐ Other: _____

Describe the child's current subject weaknesses in school.

☐ Does not apply ☐ None ☐ Art ☐ Music ☐ Reading

☐ Math ☐ Spelling ☐ English ☐ Science ☐ History

☐ Social Studies ☐ Other: _____

Describe the child's current skill strengths in school.

☐ Does not apply ☐ None ☐ Concentration ☐ Organization

☐ Test preparation ☐ Paper and Reports ☐ Handwriting ☐ Memorizing

☐ Playing attention in class ☐ Getting assignments done on time

☐ Being careful and checking work ☐ Vocabulary and expression

☐ Understanding concepts ☐ Pleasing the teacher

☐ Behaving correctly ☐ Taking tests ☐ Reading speed

☐ Reading comprehension ☐ Spelling ☐ Working hard

☐ Intelligence ☐ Other: _____

Describe the child's current skill weaknesses in school.

☐ Does not apply ☐ None ☐ Concentration ☐ Organization

☐ Test preparation ☐ Paper and Reports ☐ Handwriting ☐ Memorizing

☐ Playing attention in class ☐ Getting assignments done on time

☐ Being careful and checking work ☐ Vocabulary and expression

☐ Understanding concepts ☐ Pleasing the teacher

☐ Behaving correctly ☐ Taking tests ☐ Reading speed

☐ Reading comprehension ☐ Spelling ☐ Working hard

☐ Intelligence ☐ Other: _____

Does the child currently have behavior problems in the classroom?

☐ Does not apply ☐ No ☐ Required to sit near teacher

☐ Required to sit in an isolated area ☐ Has been sent to the principal's office

☐ Often reprimanded ☐ Talks out of turn

☐ Can't wait until turn ☐ Other _____

Does the child currently have problems with attention and concentration in the classroom?

☐ Does not apply ☐ No ☐ Daydreaming

☐ Not getting assignments done ☐ Material disorganized or messy

☐ Forgets teacher's instructions ☐ Acts without deliberation ☐ Difficulty sitting still ☐ Difficulty being quiet

☐ Other: _____

How is the child described by current teacher(s)?

☐ Does not apply ☐ None of the following

☐ Fidgety ☐ Has problem remaining seated

☐ Distractible ☐ Doesn't wait turn in games

☐ Answers questions before completed ☐ Fails to finish assignments

☐ Has problem maintaining attention ☐ Switches from one unfinished task to another ☐ Has problem playing quietly ☐ Talks excessively

☐ Interrupts ☐ Doesn't listen

☐ Other _____

Which of the following are true?

☐ Do not know ☐ None ☐ Child has had regular medical checkups

☐ Child has had regular hearing tests ☐ Child has had regular vision tests

☐ Child has had regular dental checkups

Which of the following are true?

☐ None ☐ Child wears glasses ☐ Child wears a hearing aid

☐ Child wears an orthopedic brace ☐ Child wears orthopedic/corrective shoes ☐ Child uses crutches for walking ☐ Other: _____

What problems does the child have with sleep?

☐ None ☐ Trouble getting to sleep ☐ Waking up a lot at night ☐ Not getting enough sleep ☐ Sleeping too much

☐ Restlessness in bed ☐ Waking up too early in the morning

☐ Sleeping enough, but still tired ☐ Falling asleep in school

☐ Refusing to go to bed at night ☐ Refusing to get up in the morning

☐ Sleepwalking ☐ Nightmares or Night Tremors

☐ Other: _____

What problems does the child have with eating?

☐ None ☐ Refuse to eat balanced diet ☐ Eating too many snacks

☐ Finicky about food ☐ Has a poor appetite ☐ Overeats

☐ Other _____

Does the child have problems with wetting or soiling?

☐ No ☐ Occasionally wets bed ☐ Frequently wets bed

☐ Frequently soils bed ☐ Occasionally wets pants ☐ Frequently wets pants ☐ Occasionally soils pants

☐ Other: _____

What kinds of discipline do the child's parents (or caretakers) use?

☐ Does not apply ☐ Do not know ☐ None

☐ Yelling ☐ Lectures ☐ Physical Punishment

☐ Grounding ☐ Loss of allowance ☐ Withdrawal of privileges

How strict are the child's parents (or caretakers)?

☐ Does not apply ☐ Do not know ☐ Very strict

☐ Strict ☐ Average ☐ Permissive ☐ Very permissive

Which of the following describes the child now?

☐ Has many close friends ☐ Has several close friends

☐ Has few close friends ☐ Has no close friends

How does the child perceive his or her level of acceptance?

☐ Good ☐ Mixed ☐ Poor

Which problems does the child have with peers?

☐ None ☐ Being teased ☐ Being physically attacked

☐ Having frequent arguments ☐ Being rejected by peer group

☐ Being jealous of peers ☐ Peers who have delinquent behavior

☐ Having peers get poor grades ☐ Other _____

How does the child participate in games with others?

☐ Does not participate ☐ Actively participates

☐ Passively participates ☐ Cheats occasionally

☐ Cheats regularly ☐ Has a strong drive to win

☐ Has no interest in winning ☐ Other _____

Does the child have imaginary playmates?

☐ Never has had ☐ Has had in the past, but not now ☐ Has currently

Developmental History

Please indicate the approximate age in months for the following milestones

Sitting up	_____months	☐Never
Crawl	_____months	☐Never
Pulled to stand	_____months	☐Never
Potty trained	_____months	☐Never
Walked alone	_____months	☐Never
Dry at night	_____months	☐Never
First words	_____months	☐Never
Spoke clearly	_____months	☐Never
Lost language	_____months	☐Never
Lost eye contact	_____months	☐Never

PAST EVALUATIONS

Please indicate if you have had any of the following evaluations, treatment, or consultations by placing a check mark in the appropriate columns. Please attach any copies of reports or provide the addresses where the evaluations took place. Add comments (to the back or attach sheet if needed).

Check If Yes	Check If Abnormal	Date	Evaluation / Test
☐	☐		Psychological Evaluations
☐	☐		Wechsler Preschool & Primary Scale of Intelligence
☐	☐		Speech and Language Evaluations
☐	☐		Genetic Evaluations
☐	☐		Neurological Evaluations
☐	☐		Gastroenterology Evaluations
☐	☐		Celiac/Gluten Testing
☐	☐		Allergy Evaluation
☐	☐		Nutritional Evaluation
☐	☐		Auditory Evaluation
☐	☐		Vision Evaluation
☐	☐		Osteopathic
☐	☐		Acupuncture
☐	☐		Physical Therapy

☐	☐		Occupational Therapy
☐	☐		Sensory Integration Therapy
☐	☐		Language Classes
☐	☐		Sign Language
☐	☐		Homeopathic
☐	☐		Naturopathic
☐	☐		Chiropractic
☐	☐		Other (Be Specific):

Hospitalizations

Age	Reason for hospitalization

Child Perinatal Information - Please a check mark if applicable for the following questions for the child.

Very active before birth	☐ Yes	☐ No
Hospital / Birthing Center	☐ Yes	☐ No
Needed Newborn Special Care	☐ Yes	☐ No
Appeared Healthy	☐ Yes	☐ No
Easily consoled during first month	☐ Yes	☐ No
Antibiotics first month	☐ Yes	☐ No
Experienced no complication first month of life	☐ Yes	☐ No

Birth Weight and Apgar

Weight at birth:_____lbs Length: _____

Apgar score at 1 minute_____Apgar score at 5 minutes_____

Early Childhood Illnesses

Number of earaches in the first two years _____

Number of other infections in first two years _____

Number of times you had antibiotics in the first two years_____

Number of courses of prophylactic antibiotics in first two years_____

First antibiotic at_____months

First illness at_____months

Other Medical History: Please indicate if the child has received any of these items and the age of the child at the time.

Please indicate approximate age	AGE	Please describe any injuries	AGE
Appendix		Head Injury	
Circumcision		Broken Bone	
Hernia		Broken Bone	
Tonsils		Eye Injury	
Adenoids		Neck Injury	
P.E. Tubes in Ears		Abdominal Injury	
Other Surgery: _____ _____ _____		Other Injuries: _____ _____ _____	

VESTIBULAR FUNCTIO*N CHECKLIST*

The vestibular system is all about balance and spatial awareness. These are signs of a problem in this area. Read each of the following symptoms and place a check in the box that most closely fines how it describes your child. Number 1 indicates "doesn't apply at all" and a 10 is "almost always". Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100).

		1	2	3	4	5	6	7	8	9	10
1.	Exhibits poor balance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Had delayed crawling, standing or walking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Poor muscle tone (extremely flexible)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Experiences motion sickness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Dislike of heights, swings, carousels, escalators, elevators	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Easily disoriented &/or poor sense of direction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Clumsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	Difficultly remaining still; may actively seek movement such as spinning &/or rocking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Difficulties with space perception	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	Walks or walked on toes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Total _____

AUDITORY FUNCTION Checklist

These are the symptom of a problem with the auditory sensory system. Read each of the following symptoms and place a check in the box that most closely fines how it describes your child. **Number 1 indicates "doesn't apply at all" and a 10 is "almost always"**. Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100).

	1 2 3 4 5 6 7 8 9 10
1. Concerned about hearing as an infant	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
2. Inability to sing in tune	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
3. Hypersensitive to sounds	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
4. Misinterprets questions	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
5. Confuses similar sounding words; frequently need to have words repeated	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
6. Unable to follow sequential instruction	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7. Flat and monotonous voice	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
8. Hesitant speech	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
9. Small vocabulary	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
10. Confusion or reversal of letters	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Total: _____

VISUAL DYSFUNCTION CHECKLIST

This checklist focuses on symptoms that make reading difficult. If you are unsure, talk to your child's teacher or do some reading exercises with your child. Read each of the following symptoms and place a check in the box that most closely defines how it describes your child. 1 indicates "doesn't apply at all" and a 10 is "almost always". Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100).

		1 2 3 4 5 6 7 8 9 10
1.	Misreads words	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
2.	Misses or repeats words or lines	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
3.	Reads slowly	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
4.	Needs to use finger or marker as a pointer	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
5.	Inability to remember what was read	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
6.	Poor concentration	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7.	Poor focus while reading I.E. Letters move or jump around on the page	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
8.	Crooked or sloped handwriting	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
9.	Letters poorly balance with one eye covered or while trying to read sideways	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
10.	Sensitivity to light	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Total _____

PROPRIOCEPTIVE FUNCTION CHECKLIST

This checklist will help judge how well your child feels his or her body in space. Read each of the following symptoms and place a check in the box that most closely fines how it describes your child. Number 1 indicates “doesn’t apply at all” and a 10 is “almost always”. Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100).

	1	2	3	4	5	6	7	8	9	10
1. Poor posture	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Constant fidgeting or moving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Excessive desire to be held	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Provokes fights	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Hooks feet around legs of desk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Problem identifying body parts in space										
7. Bumps into things often	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Poor balance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Rocks body or bangs head	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Does not like heights	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Total:_____

TACTILE FUNCTION CHECKLIST

These symptoms indicated either and under of over sensitivity to touch. Read each of the following symptoms and place a check in the box that most closely fines how it describes your child. A 1 indicates “doesn’t apply at all” and a 10 is “almost always”. Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100).

HYPOTACTILE (oversensitivity) Symptoms

	1	2	3	4	5	6	7	8	9	10
?? Hypotactile to most things	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Doesn’t notice or respond when cut	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? High threshold for pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Doesn’t sense the feeling of cold or hot	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Craves contact sports	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Doesn’t notice when sits down on an object ☐ ☐☐☐					☐	☐	☐	☐	☐	☐
?? Provokes roughhousing or fighting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Not ticklish	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
?? Compulsively touches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
??? Acts like a bull in china shop	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

TOTAL _____

HYPERTACTILE (Undersensitivity) Symptoms

		1	2	3	4	5	6	7	8	9	10
1	Seems hypersensitivity all the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	Dislikes playing sports	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Dislikes being touched	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	Hates tags on clothes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Allergic skin reactions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Hates makeup and/or jewelry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	Poor body temperature control	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Does not like clothing on arms or legs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Low external pain threshold	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	Doesn't like touching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

TOTAL _____

OLFACTORY FUNCTION CHECKLIST

These two checklists will help you ascertain if your child has deficiency in the senses of\ smell and taste. One list checks for oversensitivity and the other under-sensitivity. Read each of the symptoms in both lists and place a check in the box that most closely defines how it describes your child. A 1 indicates "doesn't apply at all" and a 10 is "almost always". Add up the numbers and record the total. (The lowest possible score is a 10 and the highest is 100). Total each list.

Hypersensitive Smell and Taste Checklist

		1	2	3	4	5	6	7	8	9	10
1	Exhibits increased sensitivity to taste and smell	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	Gags at the smell of certain foods	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Avoids going to bathroom at the risk of wetting pants the smell is repugnant	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	Likes bland foods	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Avoids children w/dirty or smelly clothes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Complains about other's bad breath										
7	Misbehaves after house is cleaned with solvents	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Sensitive to smoke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Avoids foods and places with strong cooking smells.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	Sniffs everything	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Total __

Hyposensitive Smell Checklist

		1	2	3	4	5	6	7	8	9	10
1	Never comments on strong smells	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	Never notices baking smells, such as cookies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Overfills mouth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	Avoids foods because of the way it looks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Never sniffs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Hates to eat, even sweets	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	Chews on things like pens	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Does not notice strong smells like something burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Eats indiscriminately; will reach for anything, even some at risk, like poison	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	Extremely picky eater	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Total _____

Please describe your child and his/her biggest obstacles and challenges: _____

Please list other information you feel is important for the doctor to know: