

**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: _____
MOTHER'S NAME: _____
FATHER'S 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: \_\_\_\_\_

Please attach any psychological, educational, psychiatric or relevant evaluations.

\_\_\_\_\_  
**PLEASE CHECK HERE IF YOU WOULD LIKE A COPY OF THE DIAGNOSTIC ASSESSMENT.**

**Physician Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_



**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 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?

---

---



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.

<b>POSSIBLE PREGNANCY PROBLEMS</b>	<b>TRUE</b>	<b>NOT TRUE</b>	<b>NOT SURE</b>
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 than 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: \_\_\_\_\_

\_\_\_\_\_

<b>NEWBORN INFANT PROBLEMS</b>	<b>TRUE</b>	<b>NOT TRUE</b>	<b>NOT SURE</b>
--------------------------------	-------------	-----------------	-----------------

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.

<b>HEALTH PROBLEMS</b>	<b>X</b>	<b>Age(s) problem occurred</b>
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.

<b>EARLY DEVELOPMENT</b>	<b>X</b>	<b>Age</b>	<b>Not Yet</b>
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.

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

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

<b>ACTIVITY-ATTENTION PROBLEMS</b>	<b>Definitely Applies</b>	<b>Applies Somewhat</b>	<b>Does Not Apply</b>
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 gets 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

<b>ASSOCIATED BEHAVIORS</b>	<b>Definitely Applies</b>	<b>Applies Somewhat</b>	<b>Does Not Apply</b>
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			

<b>ASSOCIATED BEHAVIORS CONT'D.</b>	<b>Definifely Applies</b>	<b>Applies Somewhat</b>	<b>Does Not Apply</b>
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.

<b>ASSOCIATED STRENGTHS</b>	<b>Definitely Applies</b>	<b>Applies Somewhat</b>	<b>Does Not Apply</b>
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			



