PLEASE RANK IN ORDER OF SEVERITY: 0 = No Problem, 5 = Severe Problem

Parent Completing Form: _____ _____ _____ _____

1st Visit Date:_____Date:_____Date:_____Date:_____

↓ ↓ ↓

(In own world) Awareness				
Expressive Language				
Receptive Language				
(conversational) Pragmatic Language				
Focus, Attention				
Hyperactivity				
Impulsivity				
(persistent repetition) Perseveration				
Fine Motor Skills				
Gross Motor Skills				
(low muscle tone) Hypotonia				
Tip Toeing				
Rocking / Pacing				
Hand Flapping / Finger Stimming				
Obsessions/Fixations				
Eye Contact				
Sound Sensitivity				
Light Sensitivity				
Tactile Sensitivity				
Pica/ eats dirt, metal,				

Patient Name:_____Date:_____DOB:_____